

**The Experiences of Stigma and Coping Mechanisms among
Intimate Partner Violence Survivors in Kolfe Keranio Sub-city,
Addis Ababa**

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Addis Ababa**

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**A Thesis Submitted to the School of Psychology in Partial
Fulfillment of the
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Advisor: Habtamu Wondimu (Professor)

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Dedication

This work is dedicated to my precious and lovely kids, Abdellah Nebyou, Aiesha Nebyou and Rahma Nebyou. You were the most powerful back stoppers that gave me all I needed to finish this thesis while passing through different challenges. Indeed, you are always special to me! It is also dedicated to those courageous women and girls who have faced different life challenges but continue to shine and pursue their dreams.

Declaration

I, Birtukan Seid, hereby declare that this thesis titled “The Experiences of Stigma and Coping Mechanisms among Intimate Partner Violence Survivors in Kolfe Keranio Sub-city, Addis Ababa” is my original work, completed in partial fulfillment of the requirements for the MA Degree in Social Psychology at Addis Ababa University.

This work has not been submitted for any other degree or qualification at any institution. All sources of information and assistance used in this thesis have been properly acknowledged.

I affirm that I have adhered to the ethical guidelines set forth by Addis Ababa University and that this research is conducted with integrity.

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ABSTRACT

Intimate partner violence (IPV) is a global public health concern and a serious violation of human rights that refers to any behavior by current or ex-intimate partner resulting with any harm. IPV survivors face additional victimization when they reach out for help called stigma (mark of disgrace) that hinders their help seeking and recovery process. As there is limited empirical evidence documenting IPV related stigma in Ethiopia, the aim of this study was to investigate the experience of IPV stigma, its contributing factors and coping mechanisms among IPV survivors in Kolfe Keranio sub-city of Addis Ababa, Ethiopia. The study employed a mixed method cross-sectional study design. The study involved 221 IPV survivor women to investigate the experience of stigma using structured questionnaire and their coping mechanisms using semi-structured questionnaire. The collected data was analyzed using descriptive statistics such as frequency, mean, standard deviation, One-way analysis of variance (ANOVA), T-test and Regression Analysis. The study revealed that 44.3% of IPV survivors experienced at least one type of IPV stigma. Perpetrator stigma was the most common IPV stigma faced by about 73% of IPV survivors, followed by Isolation (62.4%). The prevalence of anticipated stigma was 29.9% and Internalized IPV stigma was 38.5%. As to their abusive experience coping, 76% of them used help and support seeking as a coping strategy for their stigma experience. Age of IPV survivors, type of relationship with the abuser, duration of abuse and experiencing physical abuse have shown a significant mean difference on the level of stigma experience across different categories. In addition, different social, institutional, and cultural factors were identified affecting the level of stigma experience. In conclusion, IPV stigma was a major challenge faced by many IPV survivors.

Keywords: Intimate Partner Violence, IPV stigma, stigma types, coping strategies, stigma effect and help seeking.

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LIST OF ABBREVIATIONS AND ACRONYMS

AWSAD	Association for Women’s Sanctuary and Development
AAU	Addis Ababa University
EDHS	Ethiopian Demographic and Health Survey
EWLA	Ethiopian Women Lawyers Association
FDRE	Federal Democratic Republic of Ethiopia
IPV	Intimate Partner Violence
IPVSS	Intimate Partner Violence Stigma Scale
KII	Key Informant Interview
KK	Kolfe Keranio sub city
MOWcY	Ministry of Women, Children and Social Affairs
NGOs	Non-Governmental Organizations
PTSD	post-traumatic stress disorder
UN	United Nations
VAW	Violence against Women
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1. Background

Intimate partner violence (IPV) is a global public health concern and a serious violation of human rights that refers to any behavior by current or ex-intimate partner resulting with any physical, sexual or psychological harm including controlling behaviors, physical aggression and sexual coercion (World Health Organization, 2021). IPV is the most common type of violence against women (VAW) that affects nearly a third (27%) of ever partnered women in the reproductive age group. It involves different forms of physical and/or sexual violence and the life time prevalence ranges from 15% in Japan to 71% in Ethiopia (WHO, 2005). Though IPV is a pervasive issue that affects individuals across all social and demographic divisions at alarming rates, women and girls are disproportionately affected (Murray & Crowe, 2017; WHO, 2024).

Intimacy ideally is expected to be where both partners seek love and protection. However, it is not always that both parties are benefiting from the outcome of intimacy (Davis, 1994). For instance, intimate partners are responsible for about 38% of all murders of women worldwide (WHO, 2024). Besides the negative effects of IPV on physical, mental, sexual and reproductive health, of women, IPV survivors also suffer yet with another kind of victimization called Stigma. Moreover, children who witnessed violence in their families may suffer with different behavioral and emotional consequences which in return can also be associated with experiencing or perpetrating violence in their adulthood (Overstreet et al., 2019; WHO, 2024).

According to a systematic review of scientific literature on the prevalence of VAW, nearly 37% of ever partnered women in Africa faced one or more form of IPV (WHO, 2013). In Ethiopia, research conducted by the Ethiopian Demographic Health Survey (EDHS), data of 2016 revealed that more than 30% of ever married reproductive age group women were subjected to some form

of IPV. Whereas in Addis Ababa, the prevalence of IPV among ever married reproductive age group women reached 27.6% (Chernet & Cherie, 2020; Mulatu et al., 2024; Yitbarek et al., 2019). Other recent studies conducted in Ethiopia also revealed its high prevalence (Ashenafi et al., 2020; Muche et al., 2017; Muluneh et al., 2021; Semahegn & Mengistie, 2015; Tiruye et al., 2020). In a study done with the data analyzed from EDHS (2016), emotional type of abuse was reported more frequently (24%) followed by physical and sexual violence with a prevalence of 23.1% and 10.1% respectively (Ebrahim & Atteraya, 2021).

According to a systematic review conducted by Cordon and colleagues (2018), VAW remains a major widespread problem of Ethiopia despite the presence of different legal and policy provisions to promote the rights of women and girls. For instance, Ethiopia has revised the Family Code in 2000 and the Criminal Code in 2005 to protect women's rights in family and marriage, and also to address VAW by criminalizing domestic violence (Cordon et al., 2018). However, the above systematic review indicated that, neither of the revised policies adequately addresses psychological violence and/or economic violence against women in the context of marriage and family. In addition, the presence of inconsistency in enforcing laws and protection frameworks made the survivor to face challenges such as to access justice due to significant delays, poor documentation and inadequate investigation (FDRE MoWCY, 2019). Beside this, though disclosure is considered as a crucial step to find an ever-lasting solution and to break the chain of IPV (Agenagnew et al., 2020), most victims of IPV keep silent and only 20% of IPV victim women worldwide disclosed violence to others (United Nation, 2015). Research conducted in different parts of Ethiopia also revealed that there is an under-reporting or low level of disclosure of IPV by IPV survivors (Agenagnew et al., 2020; Biftu et al., 2019).

Besides the huge prevalence and under reporting of IPV, most survivors face stigmatizing reaction when they reach out to seek help which also influence their recovery process after the end

of abusive relationship (Crowe & Murray, 2015; Murray & Crowe, 2017; Overstreet & Quinn, 2013). Stigma surrounding IPV remained as a major barrier to prevent further violence and support victims and survivors of IPV. It also caused so many added challenges to address domestic and sexual violence at both individual and societal levels (Murray, Crowe, & Akers, 2015). Survivors usually face stigmatizing reactions from family members, friends, society at-large, and even from professionals whom survivors go to seek help. Stigma can come from many sources, including formal and informal support networks, perpetrators, professionals, and from internalized beliefs that survivors accepted by themselves (Crowe & Murray, 2015, 2022). Informal sectors of help-seeking for IPV survivors include family, friends and other sources of social support, such as trusted elders and religious leaders. Also, formal support is provided by skilled experts within the law enforcement, health care or social service sectors (McCleary-Sills et al., 2016).

Goffman (1963), defined stigma as social devaluation associated with attributes that are considered discrediting or a mark of failure or shame in the eyes of others, dictated by the more powerful group. Though the concept of stigma dates back to 1963 with Goffman's definition and his seminal book notes on the Management of Spoiled Identity (Goffman, 2009), it has been confined with some marginalized groups such as person with physical disabilities, mental illness, substance use disorders and the likes for decades (Crowe & Murray, 2022). Thus, stigma surrounding IPV experience has gained attention of many researchers in recent years following the study conducted by Overstreet and Quinn in 2013. They pointed out the existence of social construction towards IPV victim's labeling as passive, weak and responsible for the abuse they face (Crowe & Murray, 2015; Murray, Crowe, & Brinkley, 2015; Murvartian et al., 2023).

The detrimental consequences of victim blaming and myths related to IPV experiences have been well established. Accusations that make survivors responsible for the abuse they face like "What have you done to provoke this? ...blaming victims than perpetrators and misconceptions

such as “Domestic violence is a private issue” or those messages which push IPV survivors to save their marriage at all costs caused to continue abuse and violence in intimate relationships (Crowe & Murray, 2022).

Stigma should be investigated as it has multiple consequences like internal damage (e.g., lowered self-esteem, shame and isolation), external effects (e.g., decreased help-seeking and increasing discriminatory behaviors towards IPV survivors) and it will also be a barrier to recovery for survivors of IPV (Crowe et al., 2021; Murray et al., 2018; Overstreet & Quinn, 2013). Victim blaming and myths related to IPV experience were identified as harmful for survivors of IPV (Crowe & Murray, 2022).

1.2. **Statement of the problem**

Intimate partner violence is a widespread problem of the country impacting many of women and girls from various backgrounds, causing profound physical, emotional, and psychological harm. One of the overlooked but equally damaging consequences of IPV is the stigma faced by survivors, which often impede their ability to seek help, access support services, and their recovery process to rebuild their lives. Stigma associated with IPV can take different forms such as self-blame, social isolation, discrimination, and judgment from others, which can exacerbate the trauma experienced by survivors.

It has been documented that stigma on IPV survivors has different consequences including impacting their psychosocial wellbeing, help-seeking behaviors, and their safety (Taccini & Mannarini, 2023). It usually hinders or delays the recovery process of overcoming abuse for IPV survivors (Crowe et al., 2021). IPV related stigma also influences the type of sanctions imposed on perpetrators, survivors’ willingness to seek help, and the reactions of bystanders towards IPV incidents (Crowe & Murray, 2015).

While research on prevalence and contributing factors for IPV has grown in recent years, the exploration of stigma experience by IPV survivor women and their coping mechanisms remained scarce in Ethiopia. There is a significant gap in understanding the complex experiences of stigma among IPV survivors and how they cope with these challenges. Existing studies have primarily focused on the prevalence and impact of IPV, with limited exploration of the lived experiences of stigma and the specific coping mechanisms survivors employ to manage stigma-related stress. Without a clear understanding of how stigma affects IPV survivors and the strategies they use to cope, service providers may struggle to offer meaningful support that promotes healing and resilience.

This knowledge gap has limited our understanding of the complex dynamics surrounding stigma related to IPV and its impact on survivors' healing process, hindering the development of effective targeted interventions and comprehensive support systems that can effectively address the unique needs of IPV survivors. As a result, this study seeks to fill this critical gap by investigating experience of stigma surrounding IPV and its coping mechanisms among IPV survivor women.

By examining these aspects, this research aims to provide a deeper understanding of the challenges IPV survivors encounter, inform the development of policies and programs, and contribute to the design of more compassionate, effective, and culturally sensitive support systems for those affected by IPV.

Furthermore, it will provide a clear picture about prevalence of IPV stigma and its contributing factors among women who experienced IPV in Kolfe Keranio Sub-city of Addis Ababa.

1.3. Objectives

1.3.1. General objective

This study focuses on investigating the experiences and coping mechanisms of IPV stigma and determining the contributing factors to IPV stigma among IPV survivors in Kolfe Keranio Sub-city of Addis Ababa.

1.3.2. Specific objectives

This study:

- investigate the experiences of stigma on IPV survivors
- identify contributing factors for stigma surrounding IPV
- determine their coping mechanisms when they feel stigmatized as a result of IPV experiences.
- indicate ways of reduction of IPV and stigma and future study areas.

1.4. Significance of the study

The study is significant for several reasons such as it fills the knowledge gaps on existing literatures by providing a comprehensive understanding of stigma experiences of IPV survivors and the various coping strategies they employ to deal these challenges. In order to design and implement proper prevention, rehabilitation and support for IPV and related consequences like stigma; it must be clearly understood and uncovered. Having better understanding of these experiences will help to identify and develop comprehensive programs to end and overcome the stigma surrounding IPV and its impacts that survivors of IPV encounter.

This study contributes to a body of knowledge by enhancing deeper understanding of the psychological, social, and emotional burdens that IPV stigma imposes. The findings of the study will provide information for stakeholders like government and civil society organizations, women's right advocates, health program managers, as well as community structures that intervene to end VAW (IPV) and stigma surrounding IPV. It will give voice to the experiences of stigma and

coping among IPV survivors that can foster empathy and reduce stigma within communities, encouraging survivors to seek help they need without fear of judgment. Furthermore, it has the potential to inform the development of policies and support systems tailored to the needs of IPV survivors as it can inform policymakers about the broader implications of stigma on IPV survivors, including how stigma affects survivors' willingness to seek legal and social support. As a result, policies and programs will be formulated and implemented in order to promote a more supportive environment for survivors, ensuring that stigma reduction strategies are integrated in to public health, legal, and social service frameworks.

The study acknowledges that stigma experiences and coping strategies can vary based on different demographic factors. By exploring these differences, it emphasizes the need for tailored approaches in the support and treatment of IPV survivors, ensuring that interventions are respectful and inclusive to diverse survivor experiences. In addition, the study will help to clearly understand the subject matters in the context of urbanized community and also it will provide a valuable resource for future studies and serves as a foundation for subsequent studies that can build upon its findings to further explore the complexities of IPV Stigma.

Overall, this study aims to contribute to a more nuanced and compassionate understanding of IPV survivors' experiences, with the ultimate goal of creating a more supportive environment that prioritizes IPV survivors' well-being and recovery.

1.5. **Delimitation of the study**

Scope of the study is limited to only in Kolfe Keranio sub-city of Addis Ababa woreda 6, 7 and 9. It was aimed to investigate only the experience, contributing factors and coping mechanisms of IPV stigma among IPV survivor women. Thus, stigma related with other forms of violence such as non-partner violence against women is not addressed.

Limitation of the study

The study only involved IPV survivor women who came out to seek help from the formal support sources (Women affair office and police office). As they sought help and received some kind of support, the stigma level between them and those who did not seek help might have different levels of suffering. It also includes both women who still are in the abusive relationship and those who terminated their relationship. Staying in abusive relationship or leaving might have an effect in experiencing IPV stigma. Those who still are staying in an abusive relationship face more stigma than those who left.

As IPV and its related stigma is a painful experience, participants might try to avoid the real suffering they have been through. The researcher tried to control this recall bias by employing a mixed method approach to triangulate the data, used a validated stigma scale and tried to focus on their recent IPV experiences. Service providers' responses also were triangulated with other sectors service providers' response due to they are working as a team to respond to IPV.

In addition, as IPV and its stigma are sensitive topics, female data collectors were trained and assigned to collect the data from IPV survivor women. This helped IPV survivor women to express their experiences more openly and to feel comfortable to discuss on the topic. Efforts have been made to triangulate the data by using survey questionnaire and KII of different service providers involved in responding IPV.

1.6. **Definitions of terms**

Intimate partner: A husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend or ex-lover.

Intimate Partner Violence (IPV): is used to indicate any report of women experience of spousal emotional, physical, and sexual violence including controlling behavior. It covers violence by both current and former spouses and other intimate partners.

VAW: is used to indicate any form of violence against women including Female Genital Mutilation (FGM), marriage inheritance, early marriage, non-partner violence and intimate partner violence.

Emotional violence: If her spouse says or does something to humiliate her in front of others; threaten to hurt or harm her or someone close to her; insult or make her feel bad about herself.

Physical violence: If a spouse pushes, shakes, or throw something at her; slap her; twist her arm or pull her hair; punch her with his fist or with something that could hurt her; kick, drag, or beat her up; try to choke or burn her on purpose; or threaten or attack her with a knife, gun, or any other weapon.

Controlling behavior: If a husband/partner demonstrates at least one of the following controlling behaviors: he is jealous or angry when she talks to other men; frequently accuses her of being unfaithful; does not permit her to meet her female friends; tries to limit her contact with her family; and insists on knowing where she is at all times.

Stigma: is a social devaluation towards IPV survivors linked to their abusive experience in intimate relationship resulted with discrediting or a mark of failure or shame in the eyes of others and themselves (Goffman, 1963).

Internalized Stigma: is the extent to which people come to believe (or even just consider) that the negative stereotypes about their stigmatized identity might be true of themselves.

Anticipated Stigma: the degree to which people fear or expect stigmatization (negative reaction) if others know about their experiences of IPV.

Cultural Stigma: societal ideologies that delegitimize and shame people who experience IPV; it is a norm of negative stereotypes and ideologies that invalidate survivors of IPV, often perpetuating a cycle of silence and suffering.

Perpetrator Stigma: stigmatizing messages from one's perpetrator that include emotional, verbal, and psychological abuse but may also be connected to isolation or devaluation of survivors.

Enacted stigma: is people's perceptions of discrimination and prejudice experienced by others, reflects the extent to which people feel they have been the targets of others' prejudice.

Contributing Factors: demographic, social and cultural variables that have contributed to IPV stigma to occur.

Coping Mechanisms are adaptations to withstand stress due to IPV and related stigma that enhances control over behavior or gives psychological comfort.

IPV Stigma experience: this is an experience to be seen or treated in a negative way by others and by themselves because of their IPV experience.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter presents the review of different literature on stigma surrounding IPV and its effects on survivors, contributing factors for experiencing IPV, and IPV stigma, IPV stigma types and discussing the relationship among them, and IPV survivors coping mechanisms. It also reviews the development of stigma scale to measure stigma experiences among IPV survivors from theoretical background and empirical findings done elsewhere.

2.1. Overview of Stigma and its Effect on IPV Victims

Stigma occurs when groups of people are marginalized as a result of negative labeling, stereotyping, and isolation that will result in status loss and discrimination compared to a more powerful groups within the population (Link & Phelan, 2001). These researchers proposed a five-component framework to define stigma among mental illness patients. Namely: (a) Labels are assigned to distinguish differences between group of people; (b) The labels are associated with negative stereotypes about the labeled identity; (c) people create a sense of separation (isolation) between themselves and those labeled leading to “separation of ‘us’ from ‘them’”; (d) The people who are labeled experience a reduced status and discrimination from others or they may be treated differently from others due to their abuse; and (e) The stigmatized people are denied access from social, economic, and political power or they may lose power within social networks as a result of their abuse experience. Therefore, stigma can be seen as a process that occurs among groups of people and results in negative outcomes for the stigmatized groups (Link & Phelan, 2001; Murray et al., 2018).

Stigma significantly affects a large number of IPV survivors and also hinders their ability to identify when they are being abused and to seek the required help during, when they leave, and after the abusive relationship is ended (Crowe & Murray, 2022). They also explained that negative

attitudes, victim blaming, and stigma are the most common, and damaging problems faced by IPV survivors, yet are so embedded even they oftentimes go unrecognized or accepted. For instance, in a qualitative study conducted in Tanzania, it was revealed that stigma, shame and fear were among the common factors that hinder women's agency to disclose their abusive experience in intimate relationship. IPV survivors are afraid of bringing stigma and shame to their own and their families if they disclose and find for a solution to end their abusive relationship (McCleary-Sills et al., 2016). In a systematic review conducted to analyze public stigma towards women victims of intimate partner violence (IPV), stigma surrounding IPV found to be a major barrier for disclosure of their abusive experience and looking for help that hindered their recovery (Murvarthian et al., 2023).

Stigma surrounding IPV has also impact on physical, psychological, economic, and social wellbeing of IPV survivors. The various forms of stigma deepen the difficulties survivors face in accessing support, rebuilding their lives, and protecting their mental and physical health (Murray et al., 2018). According to Overstreet and Quinn (2013), IPV-related stigma contributes to heightened psychological distress, as survivors often blame themselves for the abuse or feel unworthy of support. The stigma can increase feelings of isolation and exacerbate conditions such as post-traumatic stress disorder (PTSD). This isolation due to fear of being judged, blamed, or ostracized by their family, friends or community members not only worsens the survivor's emotional state but also cuts them off from important support networks that could help them leave abusive situations (Murray et al., 2018). According to a systematic review finding, IPV-related stigma can delay help-seeking behaviors, causing worsened health outcomes for survivors. Survivors' fear of being judged often results in untreated physical injuries and mental health conditions such as anxiety and depression (Dillon et al., 2013).

Economic instability due to IPV stigma also mentioned as a barrier to leaving abusive relationships among IPV Survivors. For instance, a qualitative study conducted in United States has shown that employment has financial, social and emotional advantages for IPV survivors which can be crucial for both their short-term and long-term safety. In particular, their ability to leave an abusive partner may be closely linked to the income they earn from their job. However, challenges such as workplace disruptions due to the abuse, stigma, and economic dependence may hinder survivors' ability to maintain stable employment (Rothman et al., 2007). A systematic review from low and middle income countries also has highlighted that income stability allows women to leave abusive relationships, but workplace challenges, such as disruptions and stigma, still hinder survivors (Vyas & Watts, 2009).

IPV Survivors usually receive stigmatizing messages like “Why didn't she just leave? You must have done something to deserve this. Why would you stay in abusive relationships? And the likes” from family members, friends, society at-large and also from professional helpers when they try to seek help. These messages originate sometimes from IPV survivors themselves (Crowe & Murray, 2022).

Stigma surrounding IPV can be experienced at an individual, interpersonal, and structural levels (Murray & Crowe, 2017). The stigma process is even more dangerous when it comes from professional helpers while they were supposed to protect them from further IPV related harms (Murvartian et al., 2023). Though IPV survivors felt stigmatized by different service providers such as mental health professionals, attorneys and judges, health care professionals, law enforcement, professionals in the employment or education systems, parenting-related professionals, as well as friends and family members, it was more frequently experienced from law enforcement and the court system than other sources of help. The most frequently occurring stigma categories IPV survivors faced were feeling dismissed, denied, and blamed (Crowe & Murray, 2015). A qualitative

study conducted in five counties of Massachusetts has also shown that the majority of IPV survivor women in their research indicated that they faced bad treatment and criticism from court officials when they sought custody of one or more children in Probate and Family Court (Gutowski & Goodman, 2020).

Victim blame and self-blame were found to be among stigma components that contribute to low help-seeking and poorer mental health conditions among IPV survivors (Murray et al., 2016; Murray & Crowe, 2017), as it was noted that blame is one component of the stigma process for IPV experiencing women (Murray et al., 2018; Overstreet & Quinn, 2013).

In Ethiopia, parallel to the formal criminal and civil justice system where survivors of violence may seek help, various kinds of informal and customary dispute resolution mechanisms have been well established with the aim of reconciliation, restoration of the relationship and peace in the family or community by using elders as mediators (Enyew, 2014). In the same study, even though the Federal Democratic Republic of Ethiopian constitution of 1994 has given a constitutional right to handle personal and family matters if the conflicting parties give their consent to get decision by these institutions, the customary dispute resolution are excluded to be applied in criminal matters. However, they are still influential and applicable to the rural and peripheral communities than the formal justice system and the use of customary dispute resolution mechanism has been practiced in different regions of Ethiopia even after passing through the formal criminal court in order to have reconciliation and avoid acts of revenge. Beside this, none of the customary dispute resolution mechanisms including “shimgilina” include women as part of the team (Asmare, 2021; Eneyew & Ayalew, 2023). The participation of women in customary dispute resolution systems are usually limited even when they are involved in the marital and other conflicts. Mostly they are represented in the conflict resolution process through their male relatives

to resolve disputes or they only have the right to select the elders who deal with their issues (Tesfaw, 2015).

Different researchers conceptualize IPV as stigmatized identity in their models (Murray et al., 2018; Overstreet & Quinn, 2013). The first IPV stigmatizing model to describe IPV related stigma experience of IPV survivors was formulated by Overstreet and Quinn's (2013). The model pointed out three components of stigma as a barrier for help seeking behaviors of IPV survivors which includes cultural stigma, internalized stigma and anticipated stigma. It also described how IPV survivors are labeled, stereotyped, and isolated, which may ultimately result in their loss of status and discrimination. In addition, the model highlighted how these components of stigma interact and influence each other at both personal and interpersonal levels.

However, Murray and colleagues (2015) argued that the IPV stigmatizing model was only confined with perception of stigma experiences by the victims or did not focus on the other side of stigma which are external to the IPV survivors. As a result, they came up with The Integrated IPV Stigmatization Model (2015) which is an extension of IPV Stigmatizing Model by incorporating additional two sources of stigma called perpetuator stigma and enacted stigma on the previous IPV Stigmatizing Model.

2.2. **Types of IPV stigma**

Murray et al. (2018) explained that since the concept of stigma surrounding IPV is introduced, it has become increasingly clear it is a complex process, which involves more than just victim blame and spreading common myths. Instead, it involves several different types of stigma. In addition, they highlighted that the experience of stigma is found to be unique and varies from survivor to survivor depending on the variety of components and sources. Despite this, certain patterns have been identified in research concerning stigma and IPV.

Many researchers have contributed for the understanding and conceptualizing of stigma surrounding IPV and they built upon previous work in the topic. Some of the researchers introduced and explored the concept that stigma surrounding IPV dividing in to two types namely public stigma and self-stigma (Murray, Crowe, & Brinkley, 2015; Taccini & Mannarini, 2023); A systematic review conducted to conceptualize stigma surrounding IPV revealed that majority of studies investigated public stigma have shown its contribution towards the development of mental health problems such as Post Traumatic Stress Disorder (PTSD) and depression. The study also explained that self-stigma is experienced when the stigmatizing reaction is done by individuals among the stigmatized group against themselves. They experience feelings of shame and blame which may in turn affect the help-seeking process, people's self-esteem and self-efficacy (Taccini & Mannarini, 2023).

On the other hand, aside from the stigma that exists from others (public stigma), self-stigma, or the stigma one internalizes a negative attitude, labeling and devalued attributes, is another component (Vogel et al., 2009). Self-stigma or internalized stigma arises from the internalization of stereotypes about one's stigmatized identity, even in a situation where others are not aware of the identity (Link & Phelan, 2001; Overstreet & Quinn, 2013). Self-stigma also has different negative outcomes such as shame, embarrassment, and a "why try" phenomenon that hinders recovery for the survivors (Corrigan et al., 2016).

The Integrated IPV Stigmatization Model developed by Crowe and Murray (2015) used the Link and Phelan's (2001) definition of stigma to categorize the sources and types of stigmatization faced by IPV survivors (Murray et al., 2018). It is an extension of the IPV Stigmatization Model developed by Overstreet and Quinn (2013). As stated previously, the original model proposed by Overstreet and Quinn (2013) described three components of IPV related stigmas that influenced their help seeking process: internalized, anticipated, and cultural stigma and how they influence

each other to act as a barrier for help seeking of IPV survivors. Moreover, their literature review findings revealed that women showed higher level of internalized stigma following an experience of psychological or physical abuse. Two additional stigma processes are included in the integrated model by Murray et al. (2018): enacted and perpetrator stigma. Enacted stigma, or people's perceptions of stigmatizing reactions experienced from others, reflect the extent to which people feel they have been the targets of others' prejudice. Definitions of each of the stigma sources in the Integrated IPV Stigmatization Model are as follows: (a) Anticipated Stigma: mainly concerned about others' reaction when they disclose experiences of IPV such as social rejection or disapproval. Expectations of survivors that others will react in stigmatizing ways if they find out about stigmatizing identity or survivors' belief that others will discriminate or socially reject them.

(b) Internalized Stigma: The extent to which people come to believe and accept negative and stigmatizing views about themselves which can result with feelings of shame, guilt, and self-blame. (i.e., based on views that are perpetuated in the larger community or societal stigmatizing reaction). (c) Enacted Stigma: Survivors' perceptions of discrimination and prejudice experienced from others, as well as the extent to which people feel they have faced others' prejudice (e.g., negative comments, public humiliation, being denied housing, physical threats). (d) Cultural Stigma: Ideologies that devalue experiences of IPV such as the belief that IPV victims caused their own victimization), as well as the ways that negative beliefs and stereotypes about IPV at the societal level influence the experience of IPV stigmatization at individual and interpersonal levels. (e) Perpetrator Stigma: refers to stigmatizing messages directly from one's perpetrator, which can include emotionally, verbally, and/or psychologically abusive actions that further caused to perpetuate the stigma surrounding IPV. (f) Another category is also included to reflect that stigma may be experienced from other sources than those listed. Four main outcomes of stigma are also

well defined in the Integrated IPV Stigmatization Model: blame, isolation, negative emotions, loss of status, as well as other (Murray et al., 2018).

According to a hierarchical cluster analysis conducted to explore IPV related stigma, it was revealed that four clusters of IPV stigma based on survivors' IPV related stigma experiences. Low stigma: participants with minimal stigma, Blamed and Black sheep: those who felt blamed and isolated, Shame and Separation: participants who experienced shame and detachment, and High Stigma: those participants who reported the highest level of stigma due to highest rates of verbal abuse and emotional abuse (Murray, Crowe, & Brinkley, 2015).

2.3. Factors contributing to the experience of IPV among women

IPV is a widespread issue that affects millions of women globally, cutting across socio-economic, cultural, and geographical boundaries (WHO, 2024). However, various studies highlighted a complex interplay of factors at individual, relational, community and societal level that contribute to the experience of IPV among women.

Individual Level Factors

According to findings from the WHO multi-country study on women's health and domestic violence population-based survey, higher education level, high socio economic status, and being in a formal marriage offered protection against IPV. On the other hand, alcohol abuse, cohabitation, younger age, attitudes supportive of wife beating, having outside sexual partners, experiencing childhood abuse, witnessing domestic violence during upbringing and experiencing or perpetrating other forms of violence in adulthood were all factors that increased the risk of IPV. The risk was particularly pronounced when both the woman and her partner exhibited these risk factors (Abramsky et al., 2011). A study conducted in Ghana also highlighted that having a senior high school education or higher was associated with a lower risk of IPV (AOR = 0.51 [0.30–0.86]). In

contrast, factors that significantly increased the likelihood of experiencing physical or sexual IPV included depression (AOR = 1.06 [1.04–1.08]), disability (AOR = 2.30 [1.57–3.35]), witnessing maternal abuse (AOR = 1.98 [1.44–2.72]), childhood sexual abuse (AOR = 1.46 [1.07–1.99]), having multiple sexual partners in the past year (AOR = 2.60 [1.49–4.53]), male partner control (AOR = 1.03 [1.00–1.06]), male partner’s alcohol use in the past year (AOR = 2.65 [2.12–3.31]), and male partner infidelity (AOR = 2.31 [1.72–3.09]) (Ogum Alangea et al., 2018). Similar findings were also observed in a study conducted in India that identified several factors associated with severe physical IPV and resulting injuries among women, including having low or no education, low socioeconomic status, living in rural areas, having more children, and being separated or divorced. Additional risk factors included the husband’s problematic behaviors, such as excessive drinking, jealousy, suspicion, controlling tendencies, and emotional or sexual abuse. Women’s own experiences of domestic violence during childhood, engaging in IPV, and adhering to societal norms that condone spousal violence also increased their vulnerability (Sabri et al., 2014). According to Ellsberg et al (2015), younger women and those with limited financial resources or women with economic dependence on their partners are at a higher risk of IPV. A systematic review conducted from Low-and Middle-Income Countries (LMICs) revealed that factors such as limited education, early marriage, low economic status, living in rural areas, and adherence to traditional gender norms contribute to the high rates of IPV in LMICs (Gunarathne et al., 2023).

Similarly, IPV in Ethiopia is driven by a range of factors that are deeply rooted in the country’s social, cultural, economic, and legal structures. For instance, study conducted from 2016 EDHS data revealed that rural residence, being from poor family, being divorced and being at the age of 25-39 years old were identified as significant factors for experiencing IPV among ever married women of reproductive age (Chernet & Cherie, 2020). In Ethiopia, about 40% of girls are

married by the age of 18, and 14% by the age 15 (CSA & ICF, 2016). The presence of highest rates of child marriage in the country makes young girls vulnerable to IPV due to having less power to negotiate and to make decisions within their marriages. Different reports highlighted how child brides in Ethiopia experience isolation, violence, and a lack of decision-making power within their marriage due to their young age and limited education that eventually contributed to experience IPV across generation (CSA & ICF, 2016; UNICEF, 2018). According to a comparative multi country study done by Kidman (2017), child marriage was found to be the strong predictive factor for experiencing IPV. The study highlighted that young women aged 20-24 who married as children face a higher risk of experiencing physical and/or sexual IPV in the past year compared to those who married as adults. Additionally, another multi-country analysis, which includes demographic and health surveys along with data from the current study, indicates that marrying very early (at or before 15 years old) is linked to an increased risk of IPV and reduced decision-making power (Wodon et al., 2017). Early marriage and having husbands who decides on every issues of the households were also identified as a significant predictors of IPV among married women in Ethiopia (Mulatu et al., 2024).

According to Chernet and Cherie (2020), rural area residence, being divorced, having primary and secondary education, being 25–39 years old, and being poor were found to be predictors of IPV against women. Several studies conducted in Ethiopia had shown that women who experienced trauma, such as childhood abuse or witnessed domestic violence, are at a higher risk of entering abusive relationships in adulthood (Deyessa et al., 2010; Feseha et al., 2012; Gedefa et al., 2024; Mulatu et al., 2024; Tiruye et al., 2020). It has been also reported that substance use by women or their partners, having low monthly income, having four or more children to be

significant factors associated with IPV among the study participants in a study conducted in Gambella town (Gedefa et al., 2024).

Relational Level Factors

Gender based power imbalance and gender roles in a relationship, having frequent conflicts, unresolved disputes and poor communications among partners are identified as a major contributing factors for the occurrence of IPV at a relational level. According to Chrisler and McHugh (2018), patriarchy social structure reinforces the male authority which can be manifested as control over female partners through violence. Moreover, they discuss the entrenched belief that men should discipline women is further supported by societal and cultural expectations, making it difficult for women to challenge these roles without repercussions, such as IPV (Chrisler & McHugh, 2018). These arguments are also supported by different qualitative studies conducted in Africa and South Asian regions that have shown patriarchal systems often view violence as an acceptable form of discipline within marriage, with gender norms dictating that women should endure such treatment as part of their roles as wives (Dahal et al., 2022; Sikweyiya et al., 2020).

These patterns are similar to those in Ethiopia, where deeply rooted patriarchal beliefs perpetuate the normalization of IPV, making IPV a pervasive issue in the country. According to Gossaye et al., (2003), the presence of patriarchal social structure in Ethiopia places men in positions of authority, where dominance and control over women are widely accepted. This cultural framework fosters the gender-based power imbalances and often justifies violence as a disciplinary measure against women. Research conducted in Northern Ethiopia has shown that women are expected to accept violence as a form of discipline and control, making it more difficult for them to resist abuse (Feseha et al., 2012). The power imbalance in relationships makes women vulnerable to IPV when they challenge traditional roles or assert independence. In Ethiopia, 63%

of women justify husbands' wife beating in different circumstances as a corrective measure showing societal tolerance for violence perpetuates IPV across generation (CSA & ICF, 2016). According to a systematic review study finding, approximately three quarter of women believe that wife beating is acceptable if husband has at least one reason he considers justified (Semahegn & Mengistie, 2015).

The presence of frequent conflict in a relationship, poor communication and unresolved disputes found to be contributing factors to IPV incidents in the household. Several studies conducted in Ethiopia identified that relationship dynamics such as jealousy, frequent conflicts, and the absence of emotional support in the relationship as a critical factors in the prevalence of IPV (Deyessa et al., 2010; Feseha et al., 2012; Namer et al., 2024; Yigzaw et al., 2004). Disagreements in sexual intercourse found to be another relational level risk factor to experience IPV in a cross sectional study conducted in Gambella town, where women who had disagreements with their husbands about sexual intercourse were 3.2 times more likely to experience intimate partner violence [AOR: 3.2, 95%CI (1.8–5.7), $p < 0.01$] compared to those who did not have such disagreements (Gedefa et al., 2024). In addition, women who had spouses with varying levels of literacy had shown the highest odds of IPV than their counterparts (Deyessa et al., 2010).

Community level factors

Social isolation increases women's vulnerability to intimate partner violence (IPV), as it limits their access to external support and heightens their dependence on abusive partners. Studies conducted in different parts of Ethiopia supported that women who lack strong social connection from families and friends are more vulnerable to experience IPV (Gossaye et al., 2003). Deyessa et al. (2010) supported that woman in rural areas, where social isolation is more common due to geographic and cultural factors, were at higher risk of IPV. The lack of strong support networks

further limits their access to community resources, which makes them dependent on their abusive partners.

Another common contributing factor at community level is cultural norms and acceptance of violence that normalize or tolerate violence against women. Studies conducted in different parts of Ethiopia has shown that community norms which tolerate or normalize violence against women play a significant role in sustaining IPV. These cultural norms typically reinforce male authority, discourage women from seeking help and frame IPV as a private issue rather than a societal concern, thus perpetuating the cycle of abuse (Deyessa et al., 2010; Yigzaw et al., 2004).

Societal Factors

Societal norms that reinforce patriarchy and gender inequality play a major role in fostering IPV. Systems that marginalize women and maintain male dominance create conditions where IPV is more likely to occur, as these structures reinforce the power imbalances and limit women's ability to resist or escape abusive situations. Different studies conducted in Ethiopia supported the presence of patriarchal systems that marginalize women and uphold men authority contribute the perpetuation of IPV (Deyessa et al., 2010; Yigzaw et al., 2004).

Lack of strong legal protection and weak law enforcement also another societal level contributing factor for the perpetuation of IPV. It makes challenging for women to leave abusive relationships or seek help from authorities. Despite the country signed international and continental agreements and revised criminal codes to address acts of violence against women and the presence of different legal frameworks and policies the government has set, gaps in legal frameworks and weak enforcement remain as a significant barriers to address IPV in Ethiopia (Muluneh et al., 2021). Fesseha et al. (2012) explored how the legal system's failure to provide adequate protections for

women in Northern Ethiopia that contribute to under reporting of IPV. Many IPV survivor women did not report abuse due to the ineffective response from law enforcement, coupled with cultural beliefs that dictate IPV as a private family issue.

2.4. **Factors contributing to stigma experience on IPV survivor women**

According to Overstreet and Quinn's (2013) IPV Stigmatization Model, the sociocultural context in which IPV occurs can increase cultural stigma and heighten both internalized and anticipated stigma against survivors of IPV. In the same model, it was explained that the relationship between internalized and anticipated stigma is bidirectional, so that having more internalized stigma can result to experience more anticipating stigma from others among IPV survivors. The presence of gender norms that encourage women to tolerate abuse in marital relationship and to accept or normalize the abusive behaviors of men is found to be a major predictor of stigma towards IPV survivors. This norm also increases the expectation of women to tolerate and withstand the abusive behavior of their spouses. For example, marital rape is not considered as an abuse or a crime in a legal framework of Ethiopia and Tanzania (FDRE MoWCY, 2019; McCleary-Sills et al., 2016).

According to a study on the stigma surrounding IPV, certain types of stigma are more likely to co-occur (Murray, Crowe, & Brinkley, 2015). Stigma surrounding IPV among female survivors is high, and this is especially true for minority survivors like racial and cultural minority and those IPV survivor women with children (Maghsoudi, 2019). Type of relationship and the decision to stay or return to the abusive relationship were also another predictor of stigma among IPV survivors. Stigmatizing reactions like blaming of IPV survivors were more when the abuse occurs in dating the abuser than when married. In addition, the decision not to leave the abusive relationship resulted to higher levels of victim blaming (Yamawaki et al., 2012).

The presence of self-blame among IPV survivors which often increase the level of stigma and shame and having mental health conditions such as anxiety, depression, and PTSD are among individual level factors that can exacerbate feelings of isolation and stigma among IPV survivors (Murvartian et al., 2023). In the same study, it was also noted that public stigma is amplified when it intersects with other stigmatized identities (for example women diagnosed with HIV). In addition, the beliefs that survivors themselves provoked or deserved their abuse, especially if they returned to their abusers afterwards, the assumptions that survivors can easily or simply leave their abusers and the beliefs that survivors secretly desire to be abused are contributing factors to the experience of IPV related stigma among IPV survivors (CAWC, 2023).

2.5. Coping mechanisms

IPV survivors use different coping strategies while they are in and after they left the abusive relationship. These strategies are part of a wide range of support that can help IPV survivors to navigate their journey towards healing and safety. Knowing these coping strategies is crucial for service providers and support networks to offer appropriate assistance and resources (Shah et al., 2024).

A systematic review and Meta-Synthesis conducted among South African IPV survivor women has shown that IPV survivors used a variety of coping mechanisms such as help- and support-seeking coping, emotional regulation coping, and problem avoidance and distraction coping in order to cope the stress caused by IPV and its consequences like stigma (Sere et al., 2021). Help-and support-seeking coping is a coping strategy by which they try to interact with various sources of potential support such as perpetrators themselves, law enforcement; court officials; medical and mental health professionals; religious leaders, family members and friends (Crowe & Murray, 2015; Sere et al., 2021). Emotional regulation coping is a strategy by which

IPV survivors express and regulate their emotions whereas problem avoidance and distraction coping encompasses those efforts by which IPV survivors try not to think about the abuse and to distract their focus (Sere et al., 2021).

Another qualitative study conducted to assess coping strategies to IPV related stress revealed that IPV survivors use 10 different coping strategies to minimize or overcome the negative outcome of IPV such as; (a) religious coping strategies, (b) emotion-focused coping strategies, (c) distraction/avoidance strategies, (d) cognitive coping strategies, (e) safety planning strategies, (f) placating strategies, (g) resistance/defiance strategies, (h) direct attempts to address the stressor, (i) help-seeking, and (j) other coping strategies (Rizo, 2015).

Help seeking from both formal and informal support networks was cited in many different literatures as the most common coping strategies to cope with a stress related to IPV experiences (Rizo, 2015; Sere et al., 2021; Shah et al., 2024). However, the literatures also revealed that there has been reported different process that IPV survivors pass through before they reach out to seek help from others. Among these, passive resistance (such as self-distraction, keeping quiet during violent outbursts, and leaving the home temporarily) and hoping for the situation to get better (Rizo, 2015; Shah et al., 2024).

While help seeking was cited as the most common strategy to cope, different empirical findings showed that there is a low rate of help seeking among IPV survivors. For instance, a systematic review finding revealed that the majority of IPV survivor women in Ethiopia remained silent and did not report the violence to the appropriate authorities. Around three –quarters of women believe that wife-beating is acceptable if the husband has at least one justification (Semahegn & Mengistie, 2015). In a study conducted from recent DHS data of eighteen sub-

Saharan countries, less than half (38.77%; 95% CI = 38.26-39.28) of IPV experienced women sought help. The study also has shown that the least prevalence of help seeking among IPV survivors reported in Ethiopia (19.75%; 95% CI = 17.58-21.92) whereas Tanzania reported the highest prevalence of help seeking among the compared countries in the study (57.56%; 95% CI = 55.86-59.26) (Aboagye et al., 2023). In Ethiopia, according to the data analyzed from Ethiopian Demographic Health Survey (2016), only 25% of women who experienced IPV sought help. Moreover, the study has shown that only 3.8% and 4.4% of IPV survivors with physical and sexual violence respectively went to seek help from formal sectors (Ebrahim & Atteraya, 2021). The same survey report also revealed that IPV survivors rarely seek help from the formal structure. For instance, among IPV survivors who experienced physical violence (22%) such as cuts, bruises, pain, and even those with severe wounds, only 8% of them had sought help from the police (CSA & ICF, 2016). In a similar manner, a study conducted in India showed that less than a quarter (23.7%) of IPV survivors had sought help where almost all of them were looking for help from informal sectors (Leonardsson & San Sebastian, 2017). According to the Demographic and Health survey conducted in Tanzania (2010), only nearly half of IPV survivors of physical or sexual violence sought help though the majority of them were from informal sectors such as own family and religious leaders, 47% and 33% respectively (McCleary-Sills et al., 2016).

Beside this low prevalence of help seeking behavior among IPV survivors, the majority of them sought help from informal support structures like families and friends (Aboagye et al., 2023; McCleary-Sills et al., 2016; Shah et al., 2024). However, it has been noticed that the formal support seeking was mainly facilitated through some informal support network (Shah et al., 2024). Another study in Uganda also shown us fear of stigma was discussed as the main barrier to use the available formal services among IPV survivors (Anguzu et al., 2023).

2.6. Theoretical and Empirical Framework

A study conducted to check an ‘Overview of the Existing Theories, Conceptual Frameworks, and Definitions of an Intimate Partner Violence’ suggested that there is no universally accepted definition of Intimate Partner Violence (IPV) or a comprehensive conceptual framework to capture its complexity. It also highlighted that while some theoretical frameworks for studying IPV appear to provide potential advantages over others, their empirical validity remains uncertain. They argue that a narrow theoretical perspective could hinder understanding by excluding various exploratory factors related to this multifaceted phenomenon (Burelomova et al., 2018). However, theories such as social learning and Feminist would be relevant to explain the overall situation of IPV. These would mean some may learn from the culture and the community in our patriarchal society might be appropriate.

2.6.1. Social Learning Theory

Albert Bandura’s social learning theory (1977) explains that people learn by observing and imitating others. It posits that individuals learn through observation, imitation, and modeling unlike other behavioral learning theories who suggested all learning resulted from associations formed through conditioning, reinforcement, and punishment. He explained that people acquire knowledge, skills, attitudes, and beliefs by simply watching the actions of others through social interactions or by observing behaviors through media and when nothing follow as a consequence. People tend to imitate other’s behaviors more likely that are rewarded, while avoiding those that are punished (Cherry, 2022). According to this theory, cognitive processes play a crucial role in observational learning. Bandura’s theory considers the interaction of environmental and cognitive elements that affect how people learn behavior (Bandura, 1977). The process of social learning is influenced by factors like attention, motivation, attitudes, and emotions. Before imitating a

behavior, individuals engage in mediational processes to decide whether to imitate it or not (Bandura, 1977; Cherry, 2022).

Likewise, in a systematic review conducted on ‘Childhood Exposure to Intimate Partner Violence and Effects on Social Emotional Competence’ it has been observed that, children may internalize aggressive behaviors as normative ways to resolve conflicts when they witness IPV (Bender et al., 2022; Lee et al., 2022). In addition, according to Social Learning Theory, rates of IPV may be influenced by media events where a model is either rewarded or punished for aggressive behavior. The theory also suggests that media representations and model-perpetrator similarity play a role in shaping aggressive behaviors including IPV (Muellerleile, 2004).

2.6.2. Feminist Theory

Even if multiple theories such as psychological, sociological, and biological theories have been used to explain the phenomenon of IPV and have influenced the ways people conceptualize IPV, feminist frameworks had a significant impact on conceptualization of IPV over the past decades (McLeod et al., 2020).

The feminist theory believes that women face oppression and/or disadvantages by various social institutions. Due to resource scarcity, ownership and decision making, women are usually dependent on men which made them vulnerable to IPV. According to the feminist theory, IPV is a result of misuse of power and control making perpetrators, often men who misuse power and control over their intimate partners (Becker et al., 2021; Guy-Evans, 2022; McPhail et al., 2007). Feminist theory also highlighted patriarchy which allows male oppression of women within a patriarchal system that makes men primary perpetrators and women the primary victims (McPhail et al., 2007).

In sociology, feminist theories focus to understand and challenge the social inequalities and injustices resulted from gender bias and patriarchy (Guy-Evans, 2022). According to Swati (2020), feminist theory has four types as outlined by Judith Lorber in her 1997 work entitled as “The Variety of Feminisms and their Contributions to Gender Equality.”(Lorber, 1997; Swati, 2020) namely;

Liberal Feminism: also known as mainstream feminism, focuses on achieving gender equality through political and legal reform within the framework of liberal democracy. It asserts that women’s oppression is the result of unequal opportunities in education, politics, and law. Liberal feminists advocate for equal rights and opportunities, emphasizing that women, like men, should have equal access to these rights. They work within the existing social structures to see integration of women into mainstream society, and to be treated equally under the law and get access of equal opportunities. Their efforts have contributed a lot towards the representation of women in different public spheres and securing abortion and reproductive rights.

Radical Feminism: tries to challenge the fundamental structures of patriarchy. Radical feminists view patriarchy as the root cause of women’s oppression and advocate for a more transformative approach to bring a fundamental societal changes and challenge traditional gender roles and norms. They critique the root causes of gender inequality, including societal norms, language, and power dynamics and seek to dismantle oppressive systems through redefining gender roles.

Marxist Feminism: combines feminist analysis with Marxist theory. This theory analyses how capitalism and patriarchy intersect to bring gender inequality or oppression of women. According to Marxist feminists, capitalism perpetuates gender inequality, emphasizing in economic factors. They argue that as true equality requires addressing both class and gender

differences through equitable distribution of resources and power, they seek to eradicate these oppressive structures.

Intersectional Feminism/Difference Feminism: recognizes the unique experiences of women are influenced by different intersecting factors, such as class, race, and sexuality. Intersectional feminists emphasize diversity and challenges the idea of universality in experiences of women. They believe addressing these intersections are needed in order to bring true equality.

2.6.3. IPV Stigmatization Model

The first IPV stigmatizing model that described IPV related stigma experience of IPV survivor was formulated by Overstreet and Quinn's (2013). The model pointed out three components of stigma as a barrier for help seeking behaviors of IPV survivors which includes cultural stigma, internalized stigma and anticipated stigma. The model provided a useful framework for understanding the different levels (i.e., internal, relational, or societal) at which IPV survivors may experience stigma. It also described how IPV survivors are labeled, stereotyped, and isolated, which may ultimately result in their loss of status and discrimination. In addition, the model highlighted how these components of stigma interact and influence each other at both personal and interpersonal levels. Moreover, their literature review findings revealed that women showed higher level of internalized stigma following an experience of psychological or physical abuse (Overstreet & Quinn, 2013).

2.6.4. The Integrated IPV Stigmatization Model

The Integrated IPV Stigmatization Model is developed in 2015 which is an extension of IPV Stigmatizing Model by incorporating additional two components of stigma called Perpetuator stigma and Enacted stigma on the first IPV Stigmatizing Model. Murray and colleagues argued

that the IPV stigmatizing model was only confined with perception of stigma experiences by the

		Stigma Source					
		Internalized	Anticipated	Enacted	Cultural	Perpetrator	Other
Type of Stigma	Blame	Internalized Blame	Anticipated Blame	Enacted Blame	Cultural Blame	Perpetrator-Blame	Other-Blame
	Isolation	Internalized Isolation	Anticipated Isolation	Enacted Isolation	Cultural Isolation	Perpetrator-Isolation	Other-Isolation
	Negative Emotions	Internalized Negative Emotions	Anticipated Negative Emotions	Enacted Negative Emotions	Cultural Negative Emotions	Perpetrator-Negative Emotions	Other-Negative Emotions
	Loss of Status	Internalized Loss of Status	Anticipated Loss of Status	Enacted Loss of Status	Cultural Loss of Status	Perpetrator-Loss of Status	Other-Loss of Status
	Other Stigma	Internalized Other Stigma	Anticipated Other Stigma	Enacted Other Stigma	Cultural Other Stigma	Perpetrator-Other Stigma	Other-Other Stigma

Figure 1. The Integrated IPV Stigmatization Model BY Murray et.al. (2018)

victims or did not focus on the other side of stigma which are external to the IPV survivors and also the model focused primarily on the source of the stigma. As a result, they came up with The Integrated IPV Stigmatization Model by incorporating two sources of stigma and type of stigma that IPV survivors experience at different levels (Murray et al., 2018). The different types of stigma included in this model includes; blame, isolation, negative emotions, loss of status and other stigma. This model integrates previous research on the components and sources of stigma related to IPV. It examines how stigma affects survivors experience to seek help and their recovery process after ending abusive relationship and how these components interact and co-occur among IPV survivors. (See figure 1).

2.6.5. Intimate Partner Violence Stigma Scale (IPVSS)

The Intimate Partner Violence Stigma Scale is a recent scale developed to assess the experiences of stigma for IPV survivors by Allison Crowe, Nicole M, Overstreet and Christine E. Murray (2019) which offered valuable insights for both clinical and research purposes. They developed and validated the IPVSS which was designed as a tool to measure stigma related to IPV with four subscales: internalized stigma, anticipated stigma, perpetrator stigma and isolation. The study also highlighted that stigma is a major barrier for help seeking among IPV survivors and

recognized perpetrators to play a significant role in sustaining stigma IPV survivors encounter (Crowe et al., 2021).

2.7. Conceptual Framework

This framework visually represents the interconnected nature of the factors contributing to IPV stigma, the experiences of IPV survivors, and their coping mechanisms. It highlights how demographic and relational factors influence IPV stigma, which in turn affects how survivors cope and the broader impacts on their lives. This framework was used as a guide for this study, helping to structure the investigation into each research question and ensuring a comprehensive understanding of the problem. The framework was developed based on theoretical frameworks, prior studies, and the context of the current problems that IPV survivors are facing.

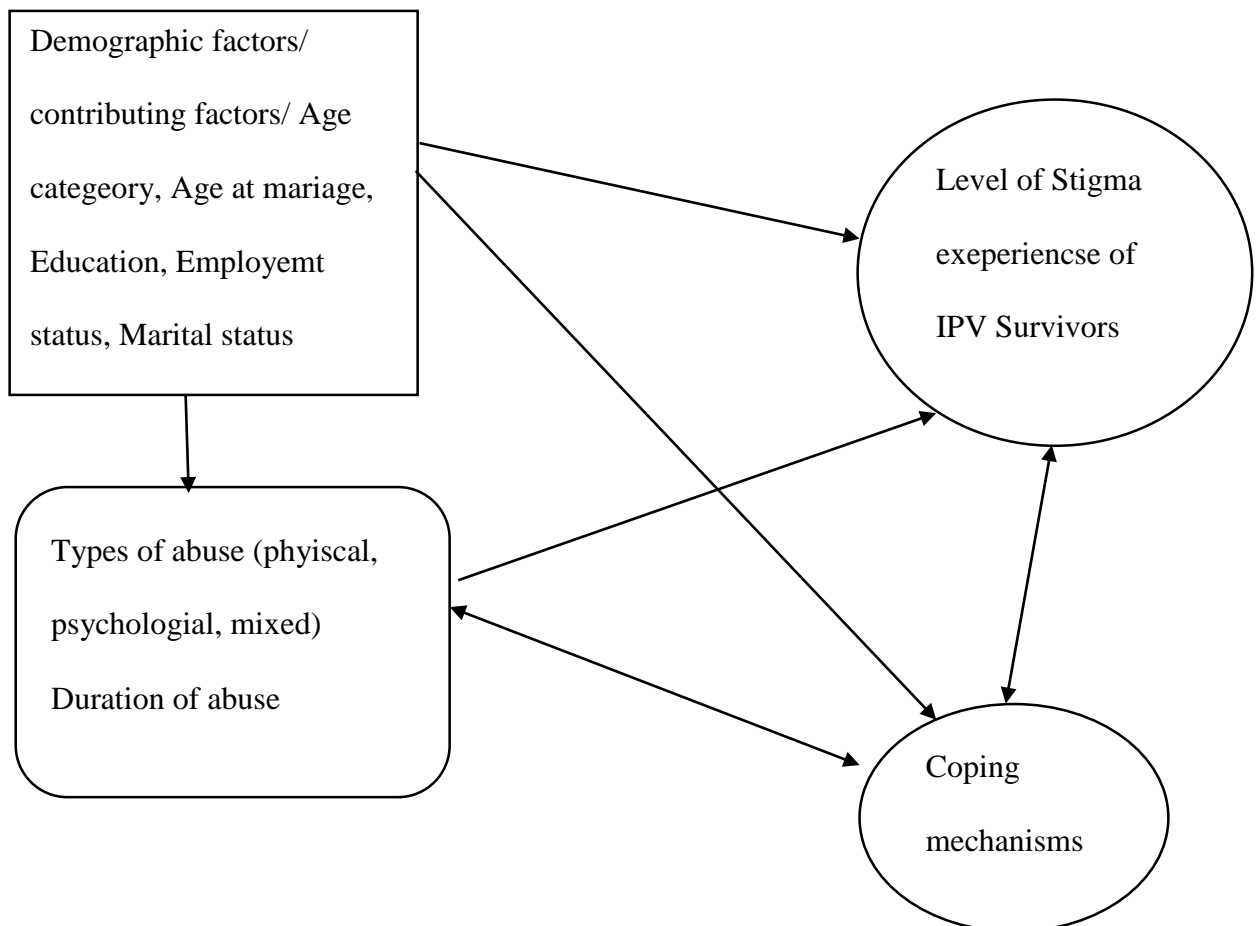


Figure 2: Conceptual Framework Developed by the Author, Based on Different Sources

The conceptual framework was developed to compare the factors like age, relationship type, employment, age at first marriage, and education level contribution to the experiences of IPV stigma. As indicated above, the objective was also to check where there existed a significant relationship between the types of abuse and the duration of abusive relationship with the level of stigma of IPV.

CHAPTER THREE

METHOD

This chapter explains the research design, study setting, the study population, data gathering tools, sample and sampling techniques. The description of tools, data collection procedures, data analysis procedures and ethical issues are also presented.

3.1. Research Design

A mixed method cross-sectional study design was employed. The study used both Quantitative and Qualitative methods to investigate the experiences of stigma among IPV survivors and its contributing factors, and IPV stigma coping strategies. An explanatory sequential design was used to understand the why and how of the events in this study that helped the findings and conclusions to consist of the deepest level of knowledge and to provide broader insights. The study was cross-sectional because of time and resource constraints, the data were collected at a single point in time.

3.2. Research Setting

The study is conducted in Kolfe Keranio Sub-city of Addis Ababa. It was selected due to my personal observations, having discussions with colleagues who are working at KK sub city women affair office and discussion with AA police GBV focal person. The sub-city has a population of 546,219 (male: 220,859 & female: 235,360) with 11 districts (KKSCWSAO, 2023). Woreda 6, 7 and 9 were selected by convenient sampling method for data collection. The woredas were convenient for data collection due to ease of geographical access and to keep the participants availability. Annually, about 2,500 IPV victim women report on average seeking help in KK sub-city of Addis Ababa. Of these, some of the cases are resolved and re-conciliation will be made by the experts and the severe ones will be referred for further legal support to law enforcement bodies.

3.3. Population, sample and sampling

Women with the experience of any form of IPV who ever reported to the police and women affair office for help residing in 06, 07 & 09 districts of Kolfe Keranio sub-city of Addis Ababa were the study population. Employees serving at the Head Office level of the Sub City (police office, health office and women affairs representatives) were also among the study population.

Single population proportion formula was used to determine the sample size of quantitative data (Fowler, 2002).

$N = (Z_{\alpha/2}/d)^2 \times p(1-p) \times DE$ where N stands for the number of IPV survivor women planned to be participants in the study, Z stands for the standard score corresponding to 95% confidence level or 5% level of significance ($\alpha = 0.05$), $Z = 1.96$, P stands for prevalence of IPV in Addis Ababa city, Degree of sampling error which is usually 5% confidence limit.

$$N = (1.96/0.05)^2 \times 0.276(1-0.276) \times 1$$

$$N = 307$$

Contacts of IPV victims from registration of woreda women and social affairs, police offices were collected to select the study participants. IPV survivors were contacted if they were volunteers to participate in the study. Nearly 7% (21 IPV survivor women) participated in the pretest study while 72.64% of the required sample size (221 women) voluntarily participated in the study. However, 63 participants either refused to participate or they were not available in the study area during the study period. Their coping mechanisms and help seeking experiences was also assessed through an interview with semi structured interview questions.

For qualitative data, local professionals who have experience of working with IPV survivors service provision (polices, counselors, legal advisors, judges, social workers and representatives of women and social affair office) were involved in the key informant interview because they have direct contact in handling and giving the formal support type for IPV survivors.

3.4. **Tools/instruments of data collection**

Questionnaire: a structured interviewer-administered questionnaire was used for collecting quantitative data from the selected IPV survivors if they have experienced any form of stigma because of the abuse experience in their intimate relationship. In addition, the type of the abuse they experienced in their intimate relationship was also examined by using a structured questionnaire which has been contextualized from “The Abusive Behavior Inventory: A measure of psychological and physical abuse developed by Shepard & Campbell (1992). In the original tool, there were 30 behaviors many women have used to report their IPV experience and also measures how often (the frequency of) the behaviors occurred. However, in this study, 4 behaviors such as ‘Used your children to threaten you (example: told you that you would lose custody, said he would leave town with the children)’, ‘Became very upset with you because dinner, housework, or laundry was not ready when he wanted it or done the way he thought it should be’, ‘Drove recklessly when you were in the car’ and ‘Refused to do housework or child care’ were excluded because they are not relevant in Ethiopian context. The remaining 26 behaviors were used in this study. In addition, measurement of the frequency of the abuse was changed to be expressed in number in this study than using the Likert scales mentioned as ‘never, rarely, occasionally, frequently and very frequently’ in the original scales.

The quantitative data was collected using kobo tool. Hence, the Intimate Partner Violence Stigma Scale (IPVSS) developed and validated by Crowe et al. (Crowe et al., 2021) has been

adapted to assess the experience of Stigma among IPV survivors of Kolfe Keranio sub-city after pilot test of the instrument is conducted. Cronbach's alpha test also was used to do a test reliability on the first 21 IPV survivor responses. The Cronbach's alpha test for all (20 items) in the pilot test data was 0.913 which is almost similar with the initial IPVSS total scales of $\alpha = .92$, whereas it was more than 0.7 for all the different types of stigma experience (Internalized Stigma $\alpha = .709$ Anticipated Stigma $\alpha = .701$, Perpetuator Stigma $\alpha = .727$, and Isolation $\alpha = .726$). Cronbach's alpha levels for each factor in the IPVSS were as follows: Factor 1 (internalized stigma) $\alpha = .85$, Factor 2 (anticipated stigma) $\alpha = .88$, Factor 3 (perpetrator stigma) $\alpha = .83$ and Factor 4 (isolation) $\alpha = .81$. The Items are answered on a 6-point Likert type scale ranging from 1 (Strongly Disagree) to 6 (Strongly Agree). Summation of Items indicate the level of stigma where higher total scores indicate more experiences of stigma.

Interview guide: an open-ended questionnaire is used to interview key informants (women affair representatives, sub city and woreda police and key actors on IPV including counsellors of safe houses, legal advisors and judges/attorneys were included in the interview). A total of 13 participants were involved in the key informant interview.

3.5. Procedures of data collection

Data collectors were trained by the researcher for two days. Explanatory sequential method was used to collect the data. First quantitative data was collected by interviewing women if they have ever experienced stigma related to their IPV experiences prior to the data collection and then their coping and help seeking experiences was explored using a semi-structured question. Based on the information got from the IPV survivors, the topics for further explanation were identified and used for key informants' interviews. The sequential order was kept on the analysis and

interpretation of results too. The data collection tools were translated to the local language (Amharic), by language experts before data collection process.

3.6. **Methods of data analysis**

The data quality check (data cleaning) was done by the researcher after quantitative data was collected by the trained data collectors. The researcher checked for its completeness and consistency. While the items in the IPVSS used to assess the experience of stigma among IPV victims were negative statements or connotations, there are three items that were reverse coded scales namely “I knew the abuse was not my fault” in the Internalized stigma scale, “people supported me when I told them about the abuse” and “people in my community encourage me to talk about my experience” in the Anticipated stigma scales (Crowe et al., 2021). This reverse coding is a way that researchers use to make sure participants are giving consistent responses (Bobbitt, 2021). As a result, the above-mentioned items were reverse scored before the data analysis according to the definition and examples given by Bobbitt (2021).

Quantitative data was analyzed with SPSS version 25.0 software, One-way ANOVA, T-test and Multiple Regression Analysis were used to analyze the quantitative data. Whereas KIIs were collected by the researcher and transcribed and analyzed using thematic analysis. Qualitative data collected from key informant interviews and from study participants were categorized into themes and triangulated with the quantitative result.

3.7. **Ethical issues**

Regarding the ethical consideration of the research, approval of the research proposal from the School of Psychology of Addis Ababa University was received as the first step ahead in the research process. Then, the School of Psychology provided a formal letter to different bodies where

the study was conducted. The contacts of IPV survivor were collected from women affairs and police office and contacted if they were willing to participate in the study.

In addition, the aim of the study was fully explained to all study participants in order to obtain their verbal consent before participating in the study and informed consent from all respondents was received during data collection. Respondents were also given a right to refuse to answer to few or all of the questions. Furthermore, privacy and confidentiality of respondents were strictly respected by not documenting name and address of interviewees and by conducting interviews in a private setting out of earshot of others, in a private setting suitable to the women.

CHAPTER FOUR

FINDINGS

In this chapter, the data gathered through quantitative survey and interview is displayed using frequency tables, charts and figures. The findings are presented and interpreted using statistical values in different separate sections namely, demographic characteristics of participants, IPV experience, stigma experience and its effects, contributing factors for IPV stigma, and coping mechanisms of IPV survivors.

4.1. Demographic characteristics

The study participants' socio demographic characteristics collected include age, education level, employment status, religion, marital status, role in the household, age at first marriage, and monthly income to show their characteristics distribution and to check if these characteristics of study participants affect the stigma experience of IPV survivors. A total of 221 women IPV survivors participated in this study.

The average age of the women was 33 years with SD of 8.649. Their age ranges lie between 15 and 56 years. Most of the study participants, 81 (36.7%), had secondary school education level, 49 (22.2%) can read and write and only 26 (11.7%) had graduate and postgraduate level of education. Majority of participants, 87 (39.4%), were married (either in monogamous or polygamous relationships) followed by divorced 46 (20.8%) and 37(16.7%) of them were never married during data collection. Most of participants, 78 (42.4%) of women got married at the age of 18 and below for the first time and 9 (5%) of them got married or engaged at the age of 15 and below. Regarding their roles in the household, more than half, 118 (53.4%) were spouses (housewives) and 66 (29.9%) were head of the household. Majority of respondents follow Islam, 103 (46.6%), followed by 85 (38.5%), said they follow Orthodox Christianity and 33(14.9%)

follow Protestantism as a religion. Nearly half, 110 (49.8%) of the respondents were unemployed and the rest half had wage-based employment, 71 (32.1%) or self-employment, 40(18.1%) in the last 12 months. (see Table 1).

Table 1: Socio-demographic characteristics of study participants

Variable	Label	Number	Percent
Age group	15-19	9	4
	20-24	30	14
	25-29	46	20.8
	30-34	34	15.4
	35-39	45	20.4
	40-44	30	13.6
	45-49	19	8.6
	50+	8	3.6
Level of education	Able to read and write	49	22.2
	Primary education	34	15.4
	Secondary education	81	36.7
	College diploma	31	14
	Bachelor degree	20	9
	Master's degree	6	2.7
Marital status	Never Married	37	16.7
	Married - Monogamous	44	19.9
	Married - Polygamous	43	19.5
	Divorced	46	20.8
	Separated	29	13.1
	Widow or Widower	13	5.9
	Living Together	9	4.1
Age at first marriage	10-15	9	4.9
	16-18	69	37.5
	19-21	36	19.6
	22-25	53	28.8
	26-29	13	7.1
	30-32	4	2.2

Role in the household	Head of the household	66	29.9
	Spouse	118	53.4
	Daughter	6	2.7
	House maid	17	7.7
	Other	14	6.3
Religion	Orthodox	85	38.5
	Islam	103	46.6
	Protestant	33	14.9
Employment status in the last 12 months	Self employed	40	18.1
	Wage-based employment	71	32.1
	Not employed	110	49.8
Income in the last 12 months	Yes	105	47.5
	No	116	52.5
Monthly income (in ETB)	<1000	3	2.9
	1001-2500	23	21.9
	2501-5000	38	36.2
	5001-7500	25	23.8
	7501-10000	8	7.6
	>10000	8	7.6

A total of 13 service providers were involved in the KII. The age range of respondents in the KII is from 27 to 45 years ($M=34.73$; $SD=5.56$). All of them had an educational level of graduate or postgraduate degree. Of them, 4 (26.7%) were male while the rest are female service providers.

4.2. Intimate Partner Violence Experience

The study revealed that there is a high tendency of experiencing both physical and psychological abuse. Almost all, 219 (99.1%) respondents had psychological abuse and 170 (76.9%) of them had physical abuse. Whereas the majority, 168 (76%) of the participants experienced both/mixed types of violence. The frequency of abuse ranges from 1time/month to 30 times/month or they were subjected to experience IPV throughout the month. Regarding the

duration they stayed in an abusive relationship, they stayed from 1-26 years in an abusive relationship and most of them, 94 (42.5%) of participants said they stayed for 1-2 years, more than half of them (51.2%) of them stayed between 3 and 10 years. Whereas 14 (6.4%) of the participants stayed more than 10 years in an abusive relationship. Please refer to Table 2 for the details.

Table 2: Distribution of IPV Experience Frequency in a Month or Year

		Frequency	Percent
Time of last abuse	In 1 month	23	10.4
	In 2 - 3 months	24	10.9
	In 4 - 6 months	40	18.1
	In 7 - 12 months	46	20.8
	In 1 - 2 year	55	24.9
	Before 2 years	33	14.9
Frequency of abuse in a month	1-5 times/month	77	34.8
	6-10 times/month	74	33.5
	11-15 times/month	33	14.9
	16-20 times/month	14	6.3
	21-25 time/month	5	2.3
	26-30 times/month	18	8.1
Duration of abusive relationship	1-2 years	94	42.5
	3-4 years	45	20.4
	5-10 years	68	30.8
	11-15 years	7	3.2
	16-26 years	7	3.2
Type of abuse exposed*	Physical abuse	170	76.9
	Psychological abuse	219	99.1
	Both	168	76.0

*Please note that the respondents could choose physical, psychological and both types of abuse.

4.3. Experience of Stigma and its Effects

As a measure of the level of stigma that the survivors were exposed to, the study participants were asked to rate their agreement to different types of stigmas on a 1-6 Likert scale which extends from “strongly disagree” (1) to “strongly agree” (6). The overall level of stigma, as to the survivors, is 3.86 on the 6-tier Likert scale.

Table 3: Level of Stigma and Participants' Level of Agreement

Type and Level of Stigma	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
Internalized (38.5%)						
People blamed me for staying in the relationship despite the abuse I experienced.”	5(2.3%)	39(17.6%)	9(4.1)	60(27.1%)	71(32.1%)	37(16.7%)
I felt that the abuse was my fault.	37(16.7%)	87(39.4%)	11(5%)	46(20.8%)	22(10%)	18(8.1%)
People said the abuse was my fault.	8(3.6%)	48(21.7%)	23(10.4%)	64(29%)	59(26.7%)	19(8.6%)
I knew the abuse was not my fault (Reversed)	68(30.8%)	87(39.4%)	19(8.6%)	12(5.4%)	20(9%)	15(6.8%)
I felt like I deserved it.	82(37.1%)	78(35.3%)	7(3.2%)	22(10%)	16(7.2%)	16(7.2%)
People viewed me as damaged once I shared my experience with the abuse.	6(2.7%)	48(21.7%)	8(3.6%)	83(37.6%)	57(25.8%)	19(8.6%)
Isolation (62.4%)						
I wasn't allowed to go anywhere or do anything by my abuser.	2(0.9%)	28(12.7%)	10(4.5%)	42(19%)	82(37.1%)	57(25.8%)
I didn't know whom I could tell about the abuse without it being used against me.	4(1.8%)	57(25.8%)	12(5.4%)	60(27.1%)	66(29.9%)	22(10%)
My abuser told me not to tell others how he treated me.	4(1.8%)	44(19.9%)	10(4.5%)	40(18.1%)	49(22.2%)	74(33.5%)
I didn't tell others about the abusive relationship because I felt ashamed of the abuse.	5(2.3%)	53(24%)	30(13.6%)	61(27.6%)	59(26.7%)	13(5.9%)
Anticipated (29.9%)						
If I told people about the abuse, I worried that they would think I “asked for it.”	13 (5.9%)	51 (23.1%)	22 (10%)	43 (19.5%)	76 (34.4%)	16 (7.2%)
I believed that if I shared details about my relationship with others I would be blamed for the abuse.	6(2.7%)	49(22.2%)	8(3.6%)	59(26.7%)	84(38%)	15(6.8%)
I hid the abuse from others because I was afraid, they would tell me what to do.	6(2.7%)	62(28.1%)	16(7.2%)	56(25.3%)	62(28.1%)	19(8.6%)

People supported me when I told them about the abuse. (Reversed)	10(4.5%)	47(21.3%)	65(29.4%)	9(4.1%)	53(24%)	37(16.7%)
People in my community encourage me to talk about my abusive experience. (Reversed)	10(4.5%)	11(5%)	41(18.6%)	35(15.8%)	103(46.6%)	21(9.5%)
Perpetrator (72.9%)						
My abuser convinced me that there was something wrong with me.	53(24%)	123(55.7%)	26(11.8%)	11(5%)	6(2.7%)	2(0.9%)
My abuser blamed me.	3(1.4%)	11(5%)	2(0.9%)	16(7.2%)	102(46.2%)	87(39.4%)
My abuser isolated me from family and friends.	3(1.45%)	16(7.2%)	5(2.3%)	61(27.6%)	79(35.7%)	57(25.8%)
My abuser made me feel inferior	2(0.9%)	18(8.1%)	8(3.6%)	57(25.8%)	77(34.8%)	59(26.7%)
My abuser monitored my activities.	1(0.5%)	12(5.4%)	5(2.3%)	39(17.6%)	75(33.9%)	89(40.3%)

When the scores are seen by type of stigma, the IPV survivors rated their exposure to Perpetrator stigma high (4.3) and Anticipated stigma low (3.5) on the same scale. As illustrated in Figure 1, Isolated stigma and Internalized stigma got rates in between (4.13, and 3.62 respectively).

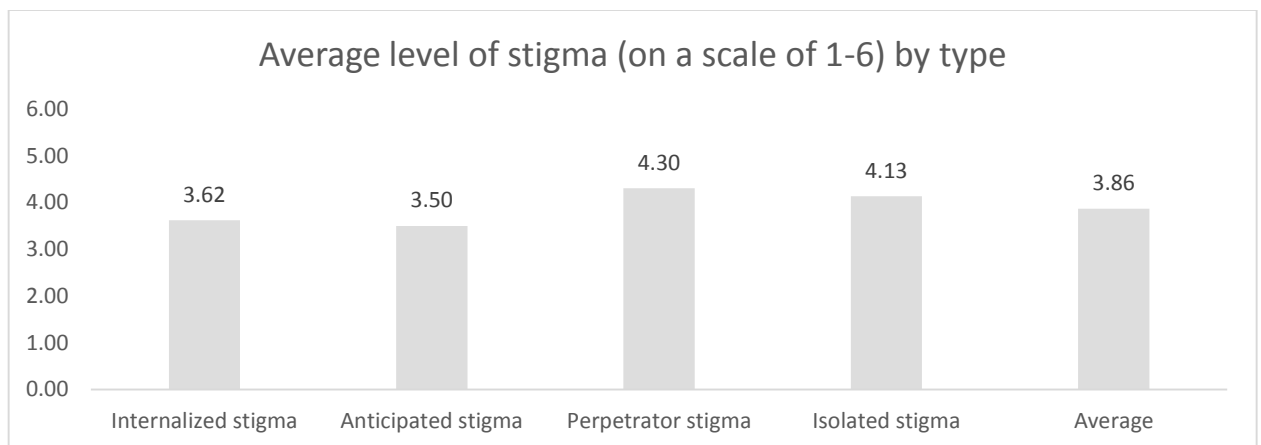


Figure 3: Average level of stigma (on a scale of 1-6) by type

In order to check the proportion of IPV survivors across the types of stigmas, those who agree (4 to 6 on the Likert scale) to the specific exposure (Figure 2) were counted. On average, 44.3% of the survivors rated the level of stigma 4 and above on a 1-6 scale of IPVSS. The most common type of stigma is perpetrator stigma (72.9%), followed by isolated stigma (62.4%). On

the other hand, a smaller proportion of survivors (29.9%) reported their exposure to anticipated stigma.

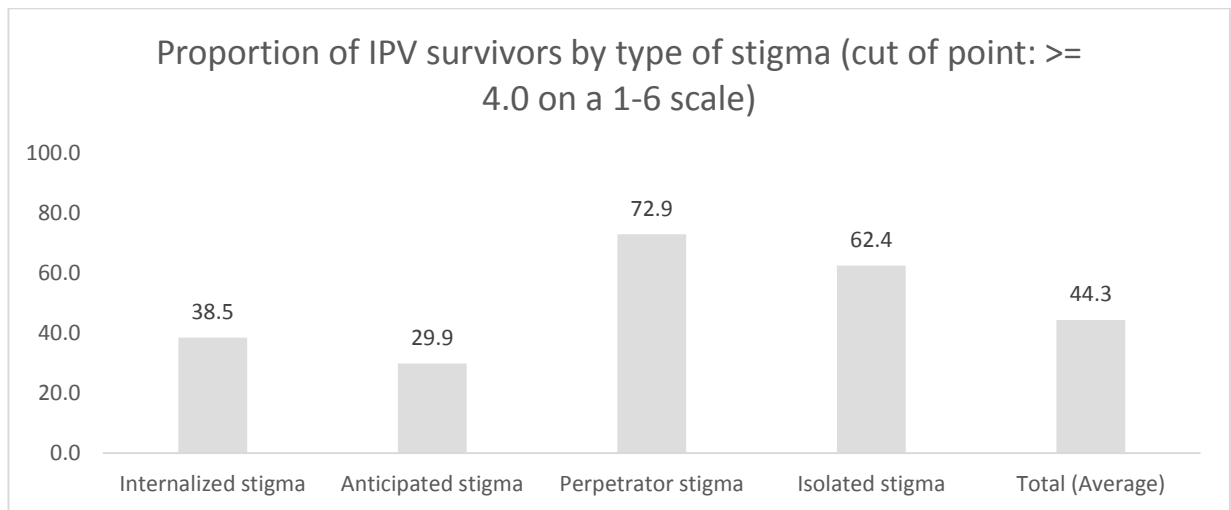


Figure 4: Proportion of IPV survivors by type of stigma (cut of point: ≥ 4.0 on a 1-6 scale)

When the categories of stigma are further explored, there are specific stigma experiences which got high scores on the Likert scale. Among the internalized stigma scales, the survivors rated “I knew the abuse was my fault” and “People blamed me for staying in the relationship despite the abuse I experienced” had high scores (4.57 and 4.19, respectively). All the experiences under anticipated stigma are lower than 4.0 on the same scale.

On the other hand, the main contributors for the high score of perpetrator stigma are “My abuser blamed me”; “My abuser isolated me from family and friends”; “My abuser made me feel inferior”; and “My abuser monitored my activity” where the survivors gave an average score of 5.10, 4.67, 4.66 and 5.00, respectively. In addition, “I wasn’t allowed to do anything by my abuser” and “My abuser told me not to tell others how he treated me” are the experiences that got high score under the isolated stigma.

Table 4: Specific Type of Stigma by Category

Type of Stigma	Stigma	Average on Scale of 1 -6
Internalized stigma	People blamed me for staying in the relationship despite the abuse I experienced	4.19
	I felt that the abuse was my fault	2.92
	People say the abuse was my fault	3.79
	I knew the abuse was my fault	4.57
	I felt like i deserved it	2.37
	People viewed me as damaged	3.88
Anticipated stigma	If I told people about the abuse, I worried that they would think I asked for it	3.75
	I believed that if I shared details about my relationship, I would be blamed for the abuse	3.95
	People don't support me when I tell them about the abuse	3.28
	I hide the abuse from others because they would tell me what to do	3.74
	People in my community don't encourage me to talk about my experience	2.76
Perpetrator stigma	My abuser convinced me that something is wrong with me	2.10
	My abuser blamed me	5.10
	My abuser isolated me from family and friends	4.67
	My abuser made me feel inferior	4.66
	My abuser monitored my activity	5.00
Isolation stigma	I wasn't allowed to do anything by my abuser	4.56
	I didn't know whom I could tell about the abuse without being used against me	3.87
	My abuser told me not to tell others how he treated me	4.39
	I didn't tell others because am ashamed of the abuse	3.70

KII findings from service providers have shown that there is a high prevalence of IPV-related stigma that is affecting IPV survivors' recovery and their ability to seek help. According to their response, not only from professional helpers, IPV survivors also experienced stigma from the

informal support system such as religious leaders, family members and elders as the following quote describe:

“IPV survivors come to us after passing through many procedures of traditional way of dispute resolution “Shimgilina” where they often faced pressured to be patient and maintain the marriage especially when they have dependent children. The usual way shimagles suggestion to maintain the marital integrity is “ለልጅ ስትይ አንገት ድፈ!”

Female Gender Inclusion and Women Empowerment Officer at Sub city Women and
Social Affairs Office (Age 34)

In response to the question regarding the evaluation of professional helpers’ attitudes within the organizations, nearly half (6) of the KII respondents indicated that they have assessed their colleagues as having willing and supportive attitudes towards IPV survivors. Conversely, the remaining half reported difficulties in meeting the needs of IPV survivors due to the necessity of collaboration with law enforcement authorities, health professionals, and organizations such as AWSAD that provide temporary shelters. They emphasized that the prolonged justice system hinders survivors’ recovery and ability to start an abuse-free life, compounded by the frequent requirement for police witness statements to provide necessary support. The following quote describes:

“The One Stop Centers within health facilities demonstrate a strong willingness to cooperate and assist IPV survivors. In contrast, police and justice offices often seek justification to support survivors, treating IPV as a private matter and frequently referring them back to traditional dispute resolution mechanisms such as “shimgilina.” Given that IPV typically occurs behind closed doors and late at night, often without witnesses, it is challenging for survivors to secure the necessary legal services.”

Male Gender Inclusion and Women Empowerment Officer at Sub city Women and Social Affairs Office (Age 41)

A judge from the Federal First Instance Primary Court explained that “we adhere to the principle of treating everyone as innocent until proven guilty. Consequently, when following these standard procedures, survivors may feel offended or perceive that their cases are being denied or dismissed. Additionally, some judges may hold judgmental attitudes influenced by their cultural context or social norms.

Female Judge, First Instance Primary Court (Age 40)

Regarding the type of stigma prevalent among IPV survivors, service providers highlighted that self-stigma and perpetrator stigma played a vital role in developing anticipated stigma which in return resulted with isolation stigma as a coping mechanism.

In response to the consequences or impact of the IPV stigma experience, 26 (11.8%) of IPV survivors said they left their jobs; 98 (44.3%) reported they were sick or stayed depressed; about 88 (40%) of them changed their place of residence or run away to some other places; 85 (38.5%) of them divorced or broke the relationship as a result of the abusive experience related stigma they faced. The responses for the impact of IPV stigma are not exclusive to one option. This study finding is in line with a systematic review conducted from low- and middle-income countries that has shown women who experienced IPV stigma choose not to work and face challenges in securing or maintaining employment. Adopting avoidance coping strategies, experiencing depression, needing to relocate or leave school, developing internalized stigma, facing an escalation of violence and withdrawing cases after they reached court were mentioned as consequences of public stigma towards IPV survivors (Murvartian et al., 2023).

In addition, 72 (32.6%) of respondents stayed isolated or hid themselves as the following quote describes:

“I used to hide myself by staying at home. I avoided any social gatherings as I used to think people are talking about my abusive events, I was afraid that they will disrespect me as a result of my abuse.”

“ከቤት ውስጥ ራሴን ደብቄ ነበር ሰርግም እድርም ለቅሶም አልሄድምነበር። ሰዎች ሲሰበሰቡ ስለኔ ጥቃት ሚያወሩ ስለሚመስለኝ። በደረሰብኝ ጥቃት ምክንያት እንዳይንቁኝ ወይም እንዳያንቁሽኝ እፈራ ነበር።”

(IPV survivor, woreda 06, Age 32)

Stayed sick or depressed was the most common discussed effect of IPV stigma as 44.3% of IPV survivor women reported, followed by 40% who were forced to change their places of residence as a result of possible stigma experience related to IPV.

IPV and subsequent stigma also resulted in leaving their job for 26 (11.8%) of IPV survivors and 40 (18.1%) of them reported that they faced negative economic consequences as they had to follow-up the prolonged legal procedures which shifted their attention from their job.

4.4. Contributing factors for stigma experience of IPV survivors

An attempt has been also made to compare the level of stigma across different demographic characteristics such as marital status, employment status, age category, level of education, age at first marriage, duration of abusive relationship, frequency of abuse, last time abuse experienced and type of abuse in the following way. Level of stigma disaggregated by each categories of age of a woman, education level, last time abuse, frequency of abuse, duration of abusive relationship and age at the first marriage are analyzed and compared in Table 5.

Table 5: One-Way ANOVA Analysis

One-Way ANOVA		Average Stigma Score				
		N	Mean	SE	F (Between groups)	P-Value
Age of a woman	15-19	9	4.29	0.17	2.283	0.029
	20-24	30	4.15	0.08		
	25-29	46	3.83	0.08		
	30-34	34	3.84	0.07		
	35-39	45	3.83	0.08		
	40-44	30	3.83	0.11		
	45-49	19	3.78	0.10		
	50+	8	3.80	0.23		
Education level	Unable to read and write	49	3.86	0.07	2.265	0.049
	Primary education	34	3.98	0.08		
	Secondary education	81	3.95	0.06		
	College diploma	31	3.65	0.09		
	Bachelor degree	20	3.99	0.11		
	Masters degree	6	3.63	0.19		
Last time Abuse	In 1 month	23	4.20	0.10	3.059	0.011
	In 2 - 3 months	24	3.90	0.09		
	In 4 - 6 months	40	3.82	0.09		
	In 7 - 12 months	46	3.98	0.09		
	In 1 - 2 year	55	3.84	0.07		
	Before 2 years	33	3.70	0.08		
Frequency of abuse	1-5 times/month	77	3.95	0.05	2.258	0.05
	6-10 times/month	74	3.77	0.06		
	11-15 times/month	33	4.03	0.10		
	16-20 times/month	14	4.01	0.15		
	21-25 time/month	5	3.50	0.09		
	26-30 times/month	18	3.86	0.13		
Duration of abusive relationship	1-2 years	94	3.88	0.06	2.456	0.047
	3-4 years	45	3.81	0.08		
	5-10 years	68	3.86	0.06		
	11-15 years	7	4.41	0.18		
	16-26 years	7	4.13	0.18		
Age at marriage	10-15	9	3.77	0.48	1.486	0.196
	16-18	69	3.93	0.52		
	19-21	36	3.74	0.51		
	22-25	53	3.75	0.51		
	26-29	13	4.02	0.51		
	30-32	4	3.73	0.53		

Marital status	Never Married	37	4.15	0.50	4.469	<0.001
	Married/Monogamous	44	3.80	0.48		
	Married/ polygamous	43	4.03	0.51		
	Divorced	46	3.87	0.50		
	Separated	29	3.76	0.46		
	Widowed	13	3.55	0.50		
	Living Together	9	3.53	0.69		

Bivariate analysis was conducted using One-Way ANOVA to examine average stigma scores across various groups, as shown in Table 5. The results indicated significant variations in average stigma scores related to demographic and social factors, including a woman's age, education level, last time a woman encountered abuse, frequency of abuse, duration of the abusive relationship, and marital status. However, the age of a woman at her first marriage did not show a significant difference in average stigma scores across categories.

The analysis showed that age of women influenced stigma score, with a p-value of 0.029. Specifically, the 15-19 age group had the highest mean stigma score (4.29), while the 45-49 age group had the lowest (3.78). Another important factor that influenced stigma score in this research was education level. Women with a Bachelor's degree reported the highest mean stigma score (3.99), compared to those with a Master's degree, who had the lowest mean score (3.63). Last time a woman encountered abuse showed significant differences, with a p-value of 0.011. Women who experienced abuse in the last month had the highest mean stigma score (4.20), while those who had not faced abuse in over two years had the lowest score (3.70).

Frequency of abuse per month indicated significant differences as well, with a p-value of 0.05. Women who experienced abuse 11-15 times in a month reported the highest mean stigma score (4.03), compared to those who faced it 21-25 times per month, who had the lowest mean score (3.50). The duration of an abusive relationship also has significant difference on average

stigma scores, yielding a p-value of 0.047. Women in abusive relationships lasting 11-15 years had the highest mean stigma score (4.41), while those in relationships lasting 3-4 years had the lowest score (3.81). In addition, marital status significantly influenced stigma scores, with a p-value of 0.001. Women who had never married reported the highest mean stigma score (4.15), whereas those living together had the lowest average stigma score (3.53). In contrast, the age of a woman at her first marriage did not significantly affect average stigma scores, with a p-value of 0.196.

An attempt was also made using T-Test to check the difference on average stigma scores across different groups of income in the last 12 months, employment status and type of abuse a woman experienced as illustrated in the table below.

Table 6: T-Test Analysis

T-Test Tables		Average Stigma Score				
		N	Mean	SE	t	One side p-value
Income in the last 12 months	No	116	3.94	0.05	1.680	0.047
	Yes	105	3.83	0.05		
Employment status	Employed	111	3.82	0.49	-1.92	0.028
	Unemployed	110	3.96	0.50		
Physical abuse	Yes	170	3.95	0.04	3.322	0.001
	No	51	3.68	0.07		
Psychological abuse	Yes	219	3.89	0.03	-0.033	0.487
	No	2	3.90	0.00		
Mixed abuse	Yes	168	3.95	0.04	3.268	<0.001
	No	53	3.69	0.06		

Table 6 illustrates that IPV survivor women without income had a slightly higher average stigma score (3.94) compared to those with income (3.83). The difference is statistically significant ($p = 0.047$). Unemployed women had a higher average stigma score (3.96) than employed individuals (3.82). This difference is also statistically significant ($p = 0.028$). Individuals who experienced physical abuse had a higher average stigma score (3.95) compared to those who did not (3.68). This difference is highly significant ($p = 0.001$). However, there is no significant

difference in stigma scores between those who experienced psychological abuse (3.89) and those who did not (3.90), with a p-value of 0.487. Those who experienced mixed abuse had a higher average stigma score (3.95) compared to those who did not (3.69). This difference is highly significant ($p < 0.001$).

From the factors with significant difference in the bivariate analysis using One-Way ANOVA and T- test, multivariate regression analysis was done to check the effect of different predictors such as marital status, education level, physical abuse, duration of abuse, employment status, time of last abuse encountered category and age categories of IPV survivor women.

Table 7: Multiple Regression Analysis

Model		Sum of Squares	df	Mean Square	F	Sig.	
1	Regression	9.951	7	1.422	5.983	<.001 ^b	
	Residual	50.606	213	0.238			
	Total	60.557	220				

a. Dependent Variable: Average_Stigma_Score
b. Predictors: (Constant), Marital_Status, Education by level, Physical Abuse, Duration_Abuse_Cat, Employ_Status, Last_Abuse_Cat, age_cat

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.		
	B	Std. Error				Lower Bound	Upper Bound
1	(Constant)	4.020	0.161	24.999	0.000	3.703	4.337
	Employment status	-0.065	0.070	-0.062	-0.930	0.354	0.073
	Physical Abuse	0.249	0.079	0.200	3.135	0.002	0.405
	Age	-0.063	0.026	-0.215	-2.399	0.017	-0.115
	Education by level	-0.020	0.027	-0.052	-0.769	0.443	0.032
	Lat abuse time	-0.008	0.026	-0.022	-0.292	0.771	0.043
	Duration in abusive relation	0.109	0.042	0.224	2.619	0.009	0.192
	Marital status	-0.054	0.022	-0.170	-2.451	0.015	-0.098

The model used average stigma score as dependent variable, the intercept 4.020 as constant indicating the baseline level of stigma score when all predictors are zero, and employment status, physical abuse, age of a woman, education level, last time abuse encountered, duration of abuse and marital status as predictors of average stigma scores.

Table 7 summarizes the results of a multiple regression analysis aimed at predicting the average stigma score based on several independent variables as listed below: Experiencing physical abuse increases the stigma score by 0.249 units.

Regression Statistics

The regression analysis revealed several key statistics. The Sum of Squares (Regression) was 9.951, which indicates the variability explained by the model. The degrees of freedom (df) for regression was 7, suggesting there are 7 predictors. The Mean Square (Regression) was calculated as 1.422, derived from the sum of squares divided by its degrees of freedom. The F-value was 5.983, which tests the overall significance of the model; a higher value indicates a better model fit. The Significance (p-value) was <0.001 , indicating that the regression model is statistically significant. The Residual sum of squares was 50.606 with 213 degrees of freedom, representing the variability not explained by the model. The Total Sum of Squares was 60.557, representing the total variability in the dependent variable. The coefficients table provides details on each predictor's impact on the average stigma score and a Constant: 4.020 ($p < 0.001$) indicates the average stigma score when all predictors are zero.

Significant Predictors:

Physical Abuse: Coefficient = 0.249 ($p = 0.002$). This suggests that experiencing physical abuse is associated with higher stigma scores or experiencing physical abuse increases the stigma score by 0.249 units.

Age Category: Coefficient = -0.063 (p = 0.017). This indicates that as age increases, stigma scores tend to decrease. Older age categories are associated with a decrease in stigma score by 0.063 units.

Duration of Abuse Category: Coefficient = 0.109 (p = 0.009). Longer durations of abuse correlate with higher stigma scores. Longer duration of abuse increases the stigma score by 0.109 units.

Marital Status: Coefficient = -0.054 (p = 0.015). Different marital statuses have a negative association with stigma scores. Being married or in a relationship decreases the stigma score by 0.054 units.

In contrast, Employment status, education level, and last time abuse category were among non-significant predictors according to the multiple regression analysis result. Employment Status: Coefficient = -0.065 (p = 0.354), Education Level: Coefficient = -0.020 (p = 0.443), Last Time Abuse Category: Coefficient = -0.008 (p = 0.771) do not significantly affect the average stigma score.

On the other hand, a thematic analysis was also done from service providers responses based on the causes/contributing factors of stigma towards IPV survivor women, structured into themes that highlight social, institutional, and cultural factors:

Theme 1. Social Norms and Cultural Expectations

This theme focuses on the deep-rooted societal and cultural values that shape stigmatizing attitudes towards IPV survivors. The factors discussed under this theme includes: Social norms and patriarchy which include cultural beliefs that reinforce male dominance and female subservience, leading to victim-blaming and judgment. Gender norms, which encompasses expectations on how women should behave in relationships and marriage, leading to blame when those expectations are violated. Comparing former mother's experience, which involves cultural or generational

comparisons that create a standard for endurance in abusive relationships. Unintended marriage, which refers to cultural disapproval of women who experience unintended or unconventional marriages especially when the marriage is self-arranged or did not get family approval. Having children, which involves societal expectations that women should stay in abusive relationships "for the sake of children," stigmatizes those who choose to leave.

Theme 2. Lack of Awareness and Education

This theme captures the impact of limited knowledge and awareness about IPV and its effects, contributing to stigma and judgment. Lack of awareness about IPV, its causes, and its consequences leads to misunderstandings and the perpetuation of harmful stereotypes. Additionally, the presence of false narratives and misinformation about IPV cases contribute to develop negative attitudes toward survivors among service providers.

Theme 3. Institutional Barriers and Failures

This theme highlights the shortcomings of law enforcement and the justice system in dealing with IPV, which both reflects and reinforces stigma against survivors. The key factors discussed here are: Law enforcement bodies' need to justify denial/dismissal: Police may dismiss or deny IPV cases due to entrenched biases, minimizing the seriousness of abuse. Law enforcement's stereotypes and assumptions about IPV survivors often lead to doubting the credibility of women reporting abuse. Overburden of cases (In Police office) where the high volume of cases may lead to inadequate attention or minimal resources being devoted to IPV cases, reinforcing stigma. Minimal or no legal action from authorities, discouraging survivors from seeking justice which often leads survivors to fear retaliation by their abusers. Institutional incompetence in properly addressing and managing IPV cases, leading to neglect or poor treatment of survivors, which may heighten survivors' stigma experiences.

Theme 4. Judgment and Blame

This theme reflects the individual and societal attitudes that place the blame on survivors rather than holding abusers accountable, perpetuating stigma. Among the key factors discussed here, having judgmental attitudes: where society tends to judge and criticize women for experiencing or disclosing abuse, victim blaming which involves blaming the survivor for the abuse they endured, often due to beliefs that they provoked or deserved it and broader societal and institutional assumptions about the survivor's role in the abuse often lead to questioning their credibility.

Theme 5. Socioeconomic Factors and Power Dynamics

This theme explores how survivors' socioeconomic status and the power dynamics within abusive relationships contribute to their stigmatization. Economic dependency and the role of power dynamics within abusive relationships add to the marginalization of survivors. Low socioeconomic status (SES) where survivors from lower economic backgrounds may face additional stigma due to class-based assumptions and biases. In addition, dependency on abusers which comprises economic or emotional dependency on the abuser may lead society to stigmatize survivors, questioning why they don't simply leave.

Theme 6. Overburdened and Under-resourced Systems

This theme addresses the systemic issues that prevent adequate institutional responses to IPV, contributing to the marginalization and stigmatization of survivors. Law enforcement agencies may lack the resources and time to adequately investigate IPV cases, leading to neglect and reinforcing stigma and authorities sometimes fail to take responsibility for protecting survivors or addressing IPV cases, perpetuating cycles of neglect fuels the experiences of self-stigma by IPV survivors.

4.5. Coping Mechanisms

Study participants reported different strategies to cope with their stigma experience. Over three fourth, 168 (76%) of participants said they have sought support or shared their stigma experience and they also reported that it was helpful for them or they have got information where to go for further support. The remaining 53 (24%) said they didn't share the stigma experience related to their abusive relationship to anyone else around either hoping for the situation to be changed or trying to tolerate the stigma in their own way.

For those who shared experience of stigma and sought help, 168 (76%), they were asked where they have sought help or to whom they shared their stigma experience. Their responses were thematized in to three themes (help seeking from formal support sources, help seeking from informal support sources and others coping mechanisms).

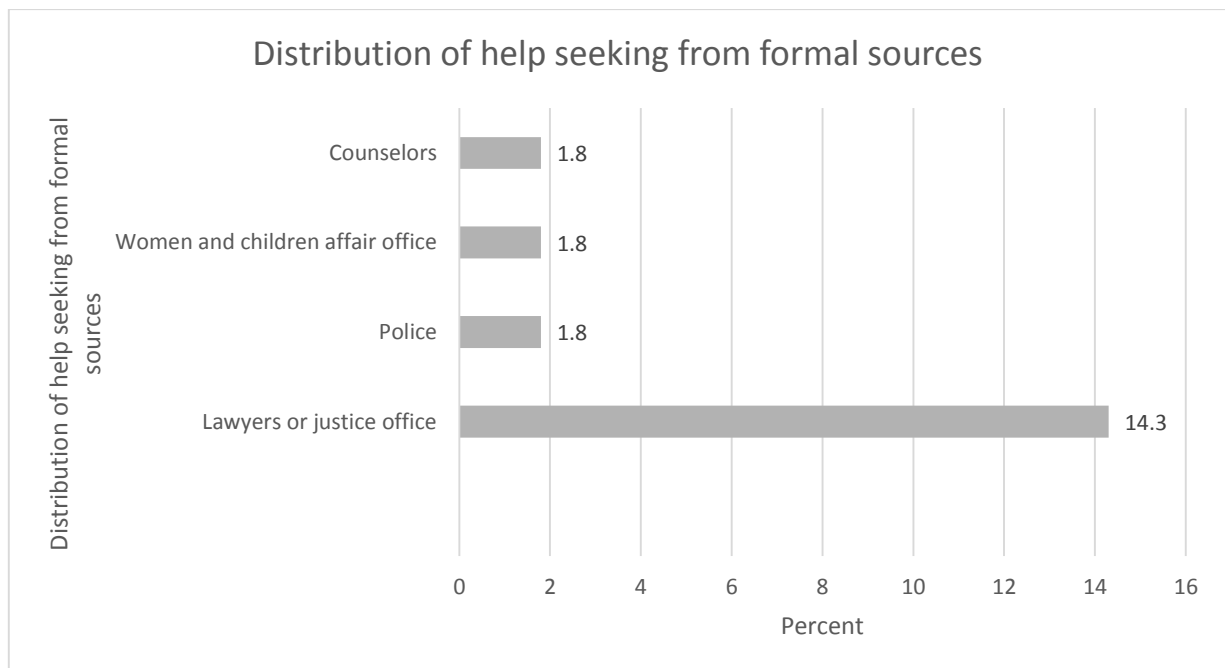


Figure 5: Distribution of help seeking from formal sources

Help seeking (from both formal and informal support sources) was the most prominent coping mechanisms among study participants. However, the majority of them 89 (53%), sought help from informal sources like family members, close friends, religious leaders and elders as

shown in figure 5 below compared to 33 (19.6%) who sought help from professional sources. (See fig. 4 & 5).

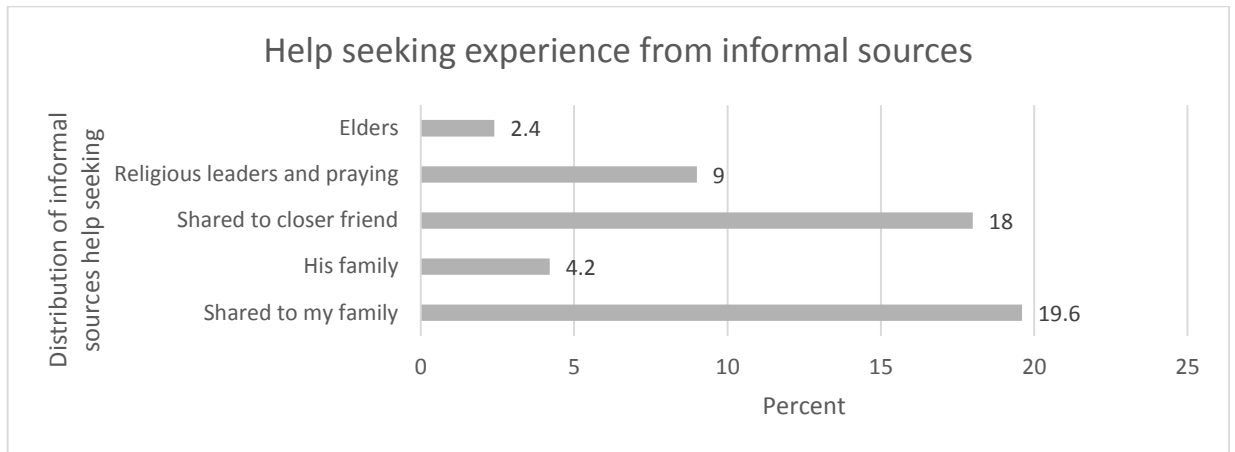


Figure 6: Help seeking experience from informal sources

In addition, majority of IPV survivors, 91 (54.2%) used different coping mechanisms to deal with their abuse and stigma experience by their own like temporary disappearance from home “h-1111” in 18.5% of them, change place of living or working (10.1%), isolation and hiding from others (staying alone) in 8.3%, trying to tolerate the feeling (9%), crying or writing their feelings on the paper to get relief (3.2%), avoidance of loneliness (2.3%), stop talking with him and discussion with the abuser (0.5% for each) as illustrated in figure 6 below. (Please note that the responses for coping mechanisms of IPV stigma are not exclusive).

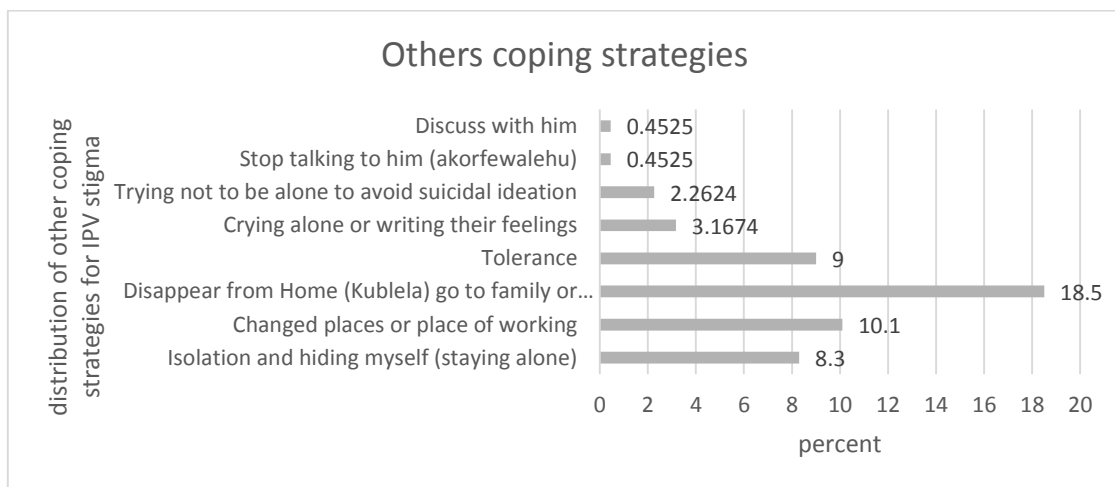


Figure 7: Others coping strategies

These coping strategies were used by IPV survivors both before they went out seeking help or after they have reached the formal sectors to seek help. Some of IPV survivors indicated that they are not interested to go to the formal support system as stated in the sample quotations below.

“They didn’t know what steps we have passed through till we get there. But they advise us to tolerate and sent us back to mediators to solve our issues. I would have rather stayed on the street than to be back with him if I don’t have children ልጆች ባይኖሩኝ እሱ ጋር ከምመለስ ጎዳና ላይ ብቆይ እመርጥ ነበር።”

Psychological and physical IPV survivor women (Age 36)

“I just went to get their help in leaving my abusive marriage. I didn’t ask them to decide what is better for me. The suggestion with the word “ተስማም” (get along) was really hurting!”

Physical IPV survivor women (Age 33)

“I went to the police station seeking their protection from further abuse by my partner, they told me this is a common issue (family issues should be dealt at home) and when I insisted their help, they ordered me to bring a divorce certificate so that they will be involved. I wonder if they don’t know how long it will take us to get the divorce.”

Psychological and physical IPV survivor women (Age 29)

Lack of social support was mentioned as a predictor of IPV and its stigma severity as narrated in the following quotes:

“It seems like I have made him powerful and have given him all my life so that he thinks I have nowhere to go.”

Psychological IPV survivor women (Age 33)

“He repeatedly told me that he has made a favor for me besides he was beating and disrespecting me even in front of others, because he knows I have no one on my side to share and discuss my situation. If I decide to leave, I only have relatives where I have experienced rape during my childhood.”

Psychological and physical IPV survivor women (Age 29)

Depending on their experience, 94.1% of IPV survivors suggested for other IPV survivors to seek professional help including legal support though it still needs improvement, 17.1% of them

suggested to seek support from family, friends, neighbors and religious leaders, whereas nearly 10% of study participants said they can handle by self-measures like changing places, fighting back, regular praying and the likes.

On the other hand, a thematic analysis was done from the service providers (KII participants) responses, for the reasons why IPV survivor women, hesitate to disclose their abuse or to seek help. Five overarching themes have emerged. Each theme represents a cluster of related factors that contribute to the barriers faced by IPV survivors to seek help.

Theme 1. Economic Constraints

This theme reflects the financial barriers that make survivors dependent on their abusers, reducing their ability to seek help or leave abusive situations. Under this theme, there are factors such as economic dependency of a woman, having dependent children and being dependent on the abuser that make IPV survivor women not to seek help. Financial dependence on the abuser, lack of independence, and concerns about children create significant barriers to leaving abusive relationships.

Theme 2. Social Stigma and Cultural Norms

This theme captures how societal attitudes, cultural expectations, and community reactions affect survivors' decisions to stay silent. Social norms surrounding marriage, divorce, and gender roles play a significant role. Under this theme, different factors such as fear of stigma, victim blaming, perpetrator stigma, not to be labeled divorced, family and religious leaders' influence were discussed as barriers for IPV survivors to not disclose their abuse experience. The presence of cultural expectation where social norms emphasize the importance of family unity, and women often encouraged to stay in marriages for the sake of kids reinforces women should sacrifice their wellbeing to maintain ideal family structure, including enduring violence. IPV survivors usually

face judgment and pressure from societal expectations, making it harder to break free due to fear of social consequences like divorce, stigma or community disapproval.

A legal advisor from Ethiopian Women Lawyers Association (EWLA) explained that:

“The cultural expectations that women should sacrifice for the family integration is common among all religions where mainly the women are pressured to tolerate and endure any violence from her partner which contribute for accepting violence as a norm. If she breaks this norm, she will face rejection by religious leaders and the community as well.”

Theme 3. Concerns for Children

This theme focuses on how the well-being of children can influence a survivor’s decision to remain in or disclose an abusive relationship. Usually having the desire to protect children significantly impact women’s decision to remain in abusive relationship or delay disclosing abuse. Children’s wellbeing and having dependent children are factors discussed under this theme. Worries about children’s well-being, either emotionally or financially, often discourage survivors from taking steps to leave abusive situations.

The following quotes describe these concerns of IPV survivor women towards their children safety and financial security:

“When they decide to leave the abusive marriage, mostly husbands do not offer the necessary expenses of the kids and husbands often don’t visit their kids regularly even after they choose to keep the kids with their mother. Sometimes they offer the amount decided in the court during separation, which can’t cover the necessary living cost in the current market. As a result, IPV survivor women decide to choose returning with their abusers for the sake of kids.”

Female Gender Inclusion and Women Empowerment officer Woreda 7 (Age-32)

Theme 4. Fear and Psychological Impact

This theme includes emotional and psychological barriers that cause survivors to hesitate in seeking help. Fear of the abuser, potential retaliation, fear of divorce, lack of psychological support and internalized blame are key factors discussed here. The internalization of blame and normalization of abuse worsen these psychological barriers for women to seek help.

Theme 5. Lack of Support Systems

This theme reflects the absence of strong social networks or institutional support to protect IPV survivors. It includes barriers related to law enforcement, social services, and family structures. Absence of social support, inability to return to their family, lack of family support, absence of law enforcement and lack of trust in justice systems are key factors discussed as a barrier to seeking help. Inadequate law enforcement and justice system responses make survivors feel unsafe and unsupported when seeking justice or protection. Survivors fear retaliation due to the legal shortcomings. The following quotes describe how the stigma from service providers affect IPV survivors to seek help:

“IPV survivors tend to hide themselves especially when the abuse is in public space. Moreover, when they felt stigmatized while trying to seek help. While majority of IPV incidents are occurring behind closed doors or in the absence of others, the law enforcement bodies look for justification even if they came up with visible physical injuries.”

Female Legal Advisor, EWLA (Age-38)

“The main reason why we stayed in abusive relationship is because we don’t trust the formal support and protection system which sometimes cause to a further extensive violence including death. As a result, we better survive for our kids and keep ourselves silent. We have seen many women injured after their abusers are released with bail “ቢታሰርግ” በዋስ ይፈታል!”

Physical Violence Survivor, AWSAD (Age-29)

The thematic analysis of the recommendations provided by service providers to overcome stigma and support IPV survivors reveals several recurring themes as presented below.

Theme 1. Awareness and Education

Raising awareness is emphasized as a key approach to reduce the stigma surrounding IPV. Educating the public, survivors, and service providers is central to changing societal perceptions. Engaging influential community and religious figures in spreading knowledge about IPV and dismantling cultural attitudes that support violence is also crucial. Encouraging survivors to seek help and share their stories is a form of peer-based awareness creation that empowers survivors and breaks the silence around IPV.

Theme 2. Service Access and Legal Support

Increasing service access that involves expanding shelters, legal aid, and psychosocial services to ensure that IPV survivors have the support they need to leave abusive environments. Offering immediate and comprehensive legal services to survivors ensures they are protected by the justice system, fostering an active court process. The provision of emotional and psychological recovery through specialized centers helps survivors rebuild their lives post-abuse.

Theme 3. Strengthening Legal Frameworks

Strengthening the role of law enforcement and courts to handle IPV cases quickly and effectively shows a firm stance against violence. Revising legal frameworks to improve survivor protections and make it easier for survivors to leave abusive relationships is crucial. Continuous improvement of policies based on research and real-world effectiveness is necessary to better serve survivors.

Theme 4. Prevention and Empowerment

IPV prevention focuses on addressing the root causes of IPV through various preventative measures, including education, public campaigns, and efforts to change societal norms that foster

violence. Empowering women both socially and economically is crucial for enabling them to escape abusive situations, thereby reducing their dependence on abusers. Additionally, teaching couples communication and conflict resolution skills through marriage counseling can help prevent IPV by addressing issues before they escalate into violence.

Theme 5. Survivor Autonomy and Well-Being

Respecting and supporting survivors' autonomy in deciding when to leave abusive relationships is a fundamental principle of the recommendations. Custody assessments should prioritize the children's best interests, recognizing that their well-being is closely tied to the well-being of the survivor. Additionally, ensuring that both parents share responsibility for their children after separation helps maintain the children's emotional stability and prevents the economic burden from falling solely on the survivor.

Theme 6. Community and Professional Involvement

Involving the community and religious leaders can provide survivors with more support networks, helping to break isolation and reduce stigma. Training service providers to offer unbiased, non-judgmental support is essential to ensure that survivors feel safe and respected when seeking help. Additionally, mediation services should be survivor-centered, avoiding any pressure on survivors to reconcile with abusers, and recognizing the potential risks involved.

Theme 7. Training and Professional Development

Law enforcing bodies require specialized training to handle IPV cases with the necessary care and understanding of the complex dynamics involved. Additionally, it is crucial to ensure that all professionals involved in service provision are properly trained to avoid being judgmental and to handle IPV cases with compassion.

Theme 8. Systemic Improvement and Policy Development

Continuous improvements in the delivery of justice and services to survivors can lead to more effective outcomes. Basing policies on research ensures that they are grounded in data and real-world effectiveness, resulting in better protections and services for survivors.

These recommendations form a multifaceted, survivor-centered approach that integrates awareness, legal and service accessibility, prevention, and empowerment. It involves both immediate responses (e.g., legal aid, psychosocial support) and long-term strategies (e.g., policy revision, education) to foster a supportive environment for IPV survivors while combating stigma.

The next chapter will be Discussion where efforts will be made to interpret the above findings with respect to the research objectives, and the relations to the literature reviewed earlier.

CHAPTER FIVE

DISCUSSION

In this chapter, interpretation and drawing meaning from the major findings of this study based on the main themes of the research objectives and the existing body of literature will be made. The levels of IPV stigma and its contributing factors then, the relationship between IPV stigma and type of abuse (Physical or psychological) and duration of abusive relationships, and the effect of demographic variables such as marital status, age, age at marriage, employment status and education level will be discussed.

5.1. Stigma Experience and its Effects

The first research objective of this study was an investigation of the experience of IPV stigma among IPV survivors in Kolfe Keranio Addis Ababa. Based on the above findings, the prevalence of IPV stigma was 44.3%, Internalized IPV stigma was 38.5%, Anticipated stigma was 29.9%, Perpetrator stigma was 72.9% and Isolation was 62.4%. This means that in Ethiopia, Addis Ababa KK sub city, IPV survivors had highly experienced IPV related stigma. In consistent with other studies, the present study also revealed that blame is one component of the stigma process for IPV experiencing women (Murray et al., 2018; Overstreet & Quinn, 2013). The present study revealed that 85% of IPV survivors responded agree and strongly agree for the stigma scale “My abuser blamed me” among the perpetrator stigma has got the highest response with scale (see Table 3). In addition, nearly half (48.7%) of IPV survivors agreed and strongly agreed for the scale “People blamed me for staying in the relationship despite the abuse I experienced” which may have resulted with internalized stigma.

The study has shown us perpetrator stigma is a significant aspect of the challenges faced by survivors of IPV. It encompasses the negative messages and psychological abuse from the perpetrator, contributing to internalized stigma, isolation and devaluation of survivors. Perpetrator

stigma was also highlighted by service providers as a barrier to seek help and heighten internalized stigma of IPV survivors. This form of stigma can have profound effects on survivors, affecting their self-esteem and hindering their recovery and help-seeking behaviors. As a result, service providers should assess IPV survivors' stigma experience to understand and address perpetrator stigma as it is crucial in supporting IPV survivors and facilitating their journey towards healing and establishing violence free life. This finding was supported by different studies conducted to understand how IPV stigma affects their help seeking experiences and recovery process (Murray, Crowe, & Brinkley, 2015; Murray et al., 2018).

Isolation stigma was the next most prevalent type of stigma (62.4%) experienced by IPV survivors in the present study. Isolation was used as a coping mechanism for internalized and anticipated stigma. This finding was in consistence with a literature review conducted to check the Role of Stigma and Stigmatization among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence. The review has shown that stigmatization was associated with different coping behaviors such as avoidance, lack of disclosure and isolation (Kennedy & Prock, 2018).

KII from service providers in this study findings has also shown that a significant number of survivors IPV-related stigma that is affecting IPV survivors' recovery and their ability to seek help. They also highlighted that stigma come from not only from professional helpers, but it comes from the informal support system such as religious leaders, family members and friends while ideally were supposed to be their assistance. This is in line with studies conducted to check components of and sources of IPV-related stigma experienced by IPV survivors (Crowe & Murray, 2015; Murray, Crowe, & Brinkley, 2015).

Regarding the consequences or effect of the IPV stigma experience, the present study revealed that majority of IPV survivors, 98 (44.3%) reported they were sick or stayed depressed;

about 88 (40%) of them changed their place of residence or run away to some other places (without being divorced or break the relationship); 85 (38.5%) of them divorced or broke the relationship and 26 (11.8%) of respondents said they left their jobs as a result of the abusive experience related stigma they faced. In addition, 72 (32.6%) of them stayed isolated or hid themselves. The responses for the impact of IPV stigma are not exclusive to one option. This finding suggested that IPV survivors faced additional life challenges due to the effect of IPV-related stigma that hinders their recovery and might affect in return their decision to leave abusive relationship. This finding was inconsistent with different studies which revealed that IPV stigma was among the major barriers to disclose their abusive relationship and to seek help from different sources (McCleary-Sills et al., 2016; Murvartian et al., 2023). In other words, they stayed isolated, sick or depressed suffering to deal by their own both the abuse and the stigma experiences they faced. Another study also has shown the same effects of IPV stigma in that negative attitude from closest people, family disapproval and humiliating stigma ascribed to those who tried to break away or leave the relationship resulted in deep regret feelings among IPV survivors (Yekoyesew et al., 2019).

5.2. **Contributing factors for IPV stigma**

The study tried to compare if the level of IPV stigma disaggregated across different demographic characteristics such as marital status, age category, employment status, level of education, age at first marriage, and abuse characteristics such as duration of abusive relationship, last time abuse encountered, frequency of abuse per month and type of abuse using One-Way Anova and T-test.

As presented in the findings part, marital status (never married, married (monogamous), married (polygamous), divorced, separated, widow or widower, living together) are analyzed and compared in Table 5. Stigma scores vary significantly by marital status categories, with the highest

mean scores of 4.15 for never-married women and the lowest mean score of 3.53 for women living together. The differences are statistically significant ($F = 4.469$, $p < 0.001$). Marital Status also found to be a significant predictor of IPV-related stigma in the regression analysis with Coefficient = -0.054 ($p = 0.015$). Different marital statuses have a negative association with stigma scores. Being married or in a relationship decreases the stigma score by 0.054 units. This finding was supported by a study conducted to check the effects of domestic violence myths, victim's relationship with her abuser, and the decision to return to her abuser that has shown dating relationship was more subjected to IPV-related stigma than married ones (Yamawaki et al., 2012). This could be explained in that dating relationship has less acceptance than marital ones in the community and might be assumed that the never married group are supposed to leave their relationship easily as they don't have legal recognition.

In a similar way, this study revealed that ages of women have a significant difference in the mean of stigma score across their categories. As shown in Table 7, the highest mean score (4.29) for the level of sigma was observed in the 15-19 age category and the lowest mean score of 3.78 for women aged 45-49. The differences are statistically significant ($F = 2.283$, $p = 0.029$). It was also among significant predictors of IPV-related stigma in the multiple regression analysis (Age Category: Coefficient = -0.063 ($p = 0.017$)), suggesting that individuals in the younger age group are more likely to experience stigma compared to those in later age groups. This could be due to the presence of societal expectations and vulnerability in younger women might exacerbate their experiences of stigma or older women might feel less stigmatized, potentially because of their life experiences or lower societal expectations. This finding is inconsistent with a study that indicated IPV was more prevalent among younger women of reproductive age which may lead to increased stigma as younger women are more likely to be judged for their experience of abuse (Curry et al., 2018).

Among the demographic factors, Age at first marriage did not show significance difference on the mean of stigma scores across categories during the bivariate analysis with One-Way Anova. This finding is in contrast to the different reports in Ethiopia and a multi country study findings that highlighted the highest rates of child marriage that has increased the vulnerability of young girls to IPV, leading to isolation, violence and lack of decision making power in their marriage (CSA & ICF, 2016; Gunarathne et al., 2023; Kidman, 2017; UNICEF, 2018; Wodon et al., 2017). This could be due to the presence of various cultural norms and societal structures which may influence how stigma is perceived and reported or could be due to insufficient sample size which might have difference statistical significance in larger samples.

However, this study regression analysis also revealed that Education level and Employment status categories did not show any significant difference on the average stigma scores with a p value of > 0.05 indicating they are among non-significant predictors of IPV-related stigma. This finding is in contrast with many studies conducted in different places shown the strong association between education and employment status of women as a protective factors (Abramsky et al., 2011; Ashenafi et al., 2020; Ellsberg et al., 2015; Gunarathne et al., 2023; Liyew et al., 2022; Maher & Hayes, 2023; Ogum Alangea et al., 2018; Sabri et al., 2014; Stöckl et al., 2021). This could be due to the contextual differences where studies were conducted, the difference among sample characteristics across studies or sample size differences. In addition, it could be because once women experience IPV, they may experience effects of IPV such as stigma, more or less in a similar way as they shared a common stigmatized identity “being IPV survivor”. However, this finding could be difficult to generalize for overall IPV survivors in Ethiopia as it might be different when the data become nationally representative.

Among the violent characteristics, experiencing Physical Abuse with a Coefficient = 0.249 ($p = 0.002$) and Duration of Abuse Category with a Coefficient = 0.109 ($p = 0.009$) have shown

significant difference across their categories. This suggests that experiencing physical abuse is associated with higher stigma scores and having longer duration of abuse is predicting higher stigma score than those who stayed for a short period. This could be when there is physical injury as a result of physical abuse, IPV survivors might be forced to present their situation to seek help. This finding was in line with a study conducted by Eckstein (2016) who has shown that Female IPV survivors with physical abuse experienced higher level of IPV stigma than their counterparts. In addition, the longer duration of abusive relationship causes the highest level of stigma among IPV survivors which could be due to survivors may begin to internalize the negative messages and blame from their abusers, leading to feelings of shame and self-blame or could be due to society may blame them for staying in abusive relationships. The longer a survivor remains in the relationship, the more they may feel judged by others, increasing their sense of stigma. Conversely, Last time abuse categories did not show any significant difference on the average stigma scores with a p value of > 0.05 indicating it is among non-significant predictors of IPV-related stigma.

The present study also revealed that the presence of co-occurrence of physical and psychological abuse in more than three fourth (76%) of study participants. This finding was supported by a qualitative study done to assess the coping strategy among physical abuse IPV survivors that have shown almost all in depth interview participants stated that they had experienced psychological abuse too such as felt disrespect, humiliation, depression, low self-esteem, suicidal temptation, regret, worry and desperation (Yekoyesew et al., 2019).

From the thematic analysis of service providers KII responses, institutional and social norms, judgment and victim-blaming, socio-economic and power dynamics, and over-burdened and under-resourced systems were identified as predictors of IPV related stigma.

The thematic analysis uncovers the deep-rooted influence of social norms, cultural expectations, and institutional failures in reinforcing IPV-related stigma. Patriarchal norms, which

promote male dominance and female subservience, play a central role in perpetuating stigma, as women are often blamed for their victimization or pressured to remain in abusive marriages for the sake of family integrity. This is particularly evident in traditional dispute resolution mechanisms like "Shimgilina," where community leaders may encourage women to endure abuse for the benefit of their children. The study also highlights the failure of law enforcement and the justice system in addressing IPV, as cases are frequently dismissed or minimized, leaving survivors to feel unsupported and stigmatized. This institutional neglect reinforces the survivors' experiences of isolation and self-blame. This finding was in line with other studies conducted among IPV survivors (Eckstein, 2016; Gunarathne et al., 2023; McCleary-Sills et al., 2016; Murvartian et al., 2023).

Judgment and victim-blaming attitudes, both from society and institutional actors, further compound the stigma experienced by IPV survivors. Societal attitudes that question the credibility of survivors or place the blame on them for not leaving abusive relationships contribute to the internalization of stigma. The study's finding that survivors frequently encounter judgment from law enforcement and social service providers illustrates the systemic barriers they face in seeking justice and support, fueling feeling of stigma. This finding is also inconsistent with other studies that has shown how judgment and victim-blaming attitudes from both society and institutional actors contribute to the stigma experience of IPV survivors (Crowe & Murray, 2022; Meyer, 2015; Overstreet & Quinn, 2013).

In contrast to the quantitative findings of this study, the role of socioeconomic status and power dynamics within abusive relationships is highlighted as a significant contributor to stigma in the KII responses. Survivors from lower socioeconomic backgrounds are more likely to face class-based stigma, as their economic dependence on their abusers is often viewed as a weakness or failure. This dynamic is exacerbated by the power imbalance in abusive relationships, where

abusers may control not only the survivor's finances but also their social interactions and mobility, further isolating them and heightening their vulnerability to stigma. This contradiction could be due to quantitative method might not fully capture the extent to which abusers control various aspects of survivors' lives, and KIIs often provide deeper, more nuanced insights into personal experiences and social dynamics that quantitative methods might overlook.

The systemic inadequacies in law enforcement and justice systems are critical in understanding the stigma experiences of IPV survivors. Over-burdened police and judicial systems often fail to provide timely or adequate responses to IPV cases, leading to prolonged suffering for survivors. The lack of proper resources and training for handling IPV cases not only discourages survivors from seeking help but also perpetuates the cycle of abuse and stigma. This institutional failure, coupled with societal judgment, leaves survivors feeling unsupported and marginalized, further isolating them from potential sources of help.

In conclusion, the findings from the study emphasize that stigma experience of IPV survivors is deeply intertwined with demographic factors, abuse characteristics, and systemic shortcomings.

5.3. **Coping Mechanisms to IPV Stigma**

In the present study, IPV survivors used different strategies to cope with their stigma experience. Over three fourth, 168 (76%) of participants said they have sought support or shared their stigma experience to both formal and informal sources of help. However, they used multiple coping strategy concurrently or sequentially. This finding was supported by other researchers conducted to explore the coping mechanisms among IPV survivors which revealed help-and support-seeking coping was among the main coping strategies they used to overcome IPV and its related stress (Crowe & Murray, 2015; Sere et al., 2021). Even though all study participants in the present study had sought help from either police or women affair office for their IPV incidents,

about a quarter, 53 (24%) said they didn't share the stigma experience related to their abusive relationship to anyone else around. It could be due to either hoping for the situation to be changed or trying to tolerate the stigma in their own way.

In Ethiopia, beside the low prevalence of help seeking among IPV victims (19.8% with 95% CI: 15.9–24.3%) as shown in the study conducted using national EDHS data by Muluneh and colleagues (2021), only few (9.2%) of them sought help from a formal source (such as police, lawyer or doctor) while the remaining sought help from informal sources such as neighbors, family and friends. In line with this, the present study finding also revealed that the majority of IPV survivors, 89 (53%), sought help coping stigma experiences from informal sources like family members, close friends, religious leaders and elders compared to 33 (19.6%) who sought help from professional sources. This finding is also supported by different empirical literatures done in different contexts. For instance, a qualitative study done by Rizo (2015) showed that all study participants discussed help-seeking as an important coping strategy used by survivors. In addition, the majority of IPV survivors cited they tend to engage in the informal help-seeking such as seeking information, resources, and support from family (their own or their partner's), friends, neighbors, teachers, new partners, and members of their faith community.

From the informal potential support sources, family and friends were the most common sources mentioned by IPV survivors to seek help in the present study. In line with the study above that revealed family and friends as the most common sources of informal support, the present study also shown us about 42% of those who sought help mentioned they sought help from friends and family members and the remaining 11.3% from religious leaders and elders. Similar findings also observed in another study conducted in Tanzania using demographic and health data of 2015-2016, only half of IPV survivors had sought help and from their own family being the highest followed by from perpetrator's family. The formal sector was used when the injury is severe and they are

afraid of further abuse (Mahenge & Stöckl, 2021). A systematic review done on help seeking of IPV survivors done in Europe, also revealed that the formal support source was usually used as a coping when the violence is severe (Lelaurain et al., 2017). In a similar manner, a study conducted among IPV survivors to review their help seeking behaviors and factors associated with the decision to seek help in the United States showed that majority of IPV survivors seek help from the informal support system (Gover et al., 2012). This means seeking help from the informal support system is more common even in the developed world.

Among the KII participants, a service provider discussed the absence of comprehensive response at the woreda and sub city level which might contribute to low level of help seeking from the formal support source as illustrated in the following quote:

“There is no legal unit here in the woreda and sub city women and social affairs office to assist them in facilitating prosecution of perpetrator so that justice will be served to the victims. As a result, we refer them to the police office and the court which may increase the duration of their waiting time till their needs are properly addressed.

Female gender-based violence expert, KK sub city women and social affairs office (age 29)

Almost all key informants who participated in this study discussed that lack of awareness in IPV case management has contributed for experiencing stigma from the service providers. In line with the findings of other studies, this study has shown victims were blamed when they seek support from both the formal and informal support sources. The victim blaming attitude is mostly as a result of the lacking the necessary understanding of the complex nature of IPV that resulted service providers and informal support sources to develop a stereotypical attitude towards IPV victims (Meyer, 2012, 2015).

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

The experience of stigma among IPV survivors is found to be widely prevalent (44.3%). Even though all the study participants in this study had sought help for their IPV experience from the formal sources (police and women affair office), about one fourth (24%) of them did not seek help to cope their stigma experience related to IPV. Perpetrator stigma was the most common one followed by Isolation which in return affected the level of internalized and anticipated stigma among IPV survivors.

Being in a younger age group and in never married intimate relationship were among the main contributing factors to experience higher level of stigma compared to those in later age groups and married ones. Moreover, experiencing physical abuse and having longer duration of abusive relationship also contributed to experience higher level of average stigma scores than their counterparts. On the other hand, institutional and social norms, judgment and victim-blaming attitudes, socio-economic and power dynamics, and over-burdened and under-resourced systems were identified as predictors of IPV related stigma.

As many other studies also showed, help and support seeking was found to be the most common coping mechanisms to IPV and its consequences like stigma. However, the majority of them tend to engage in the informal potential support system than the formal sectors. Economic dependency was the most common cited reason discussed by service providers that prevents IPV survivors to leave their abusive relationship.

6.2. Recommendations

The researcher made the following recommendations according to the major findings discussed above and conclusions made from the findings. As stigma is a serious challenge experienced by majority of IPV survivors and has many consequences that hinder the help seeking

and recovery of IPV victims, efforts to minimize IPV and related stigma should be strengthened by the following recommended strategies. Relevant sectors such as government offices, Non-Governmental Organizations (NGOs), civil society organizations, women rights advocates, health program managers, as well as community structures that intervene to end VAW (IPV) and stigma surrounding IPV, and the community at large should address IPV and its stigma predictors to foster a more supportive environment for IPV survivors, reducing stigma and enabling them to rebuild their lives:

Efforts on prevention of IPV and response (including law enforcement) by different actors should be strengthened to decrease IPV incidents to the possible lowest level and to minimize its related impacts and consequences.

Education in general and awareness raising (anti-stigma campaign) in the community need to be considered, challenging the patriarchal and cultural norms that perpetuate victim-blaming.

Strengthening the formal support sectors through capacity building training and capacitating them with necessary support material to increase the responsiveness of law enforcement and social services.

Provision of economic empowerment opportunities for IPV survivors.

Empowering IPV survivor women and girls through service provision that prioritize their needs, preferences and rights will help to facilitate their recovery.

Why do IPV survivors tend to seek help from informal support sources than the formal ones need to be studied further,

The effect of employment status, education level and age at marriage on the level of IPV stigma experience need to be studied with a better national representative data.

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ANNEXES

Annex A1: English Version of the Data Collection Tools

Stigma on Intimate Partner Violence Survivors in KK sub city, AA, Ethiopia Consent and Information Sheet

Hello, my name is Birtukan Seid

I am studying for MA degree in Social Psychology at Addis Ababa University. I am conducting a study in Kolfe Keraniyo sub city to learn about the nature and level of Stigma on Intimate Partner Violence among survivor women. This study is being conducted as part of a partial fulfillment of MA in Social Psychology.

You have been chosen by chance to participate in this study among IPV survivors. I want to assure you that all of your answers will be kept strictly in a private way. I do not keep a record of your name or address. You also have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There is no right or wrong answers for the questions listed here. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk. Your participation is completely voluntary, but your experiences could be very helpful to other women in Ethiopia.

Do you have any questions?

The interview takes approximately 30 minutes to complete.

Do you agree to be interviewed?

Does not agree to be interviewed. Thank the participant for her time and end interaction.

Agrees to be interviewed. Is now appropriate time to talk?

It's very important that we talk in private. Is this a right place to take the interview, or is there somewhere else that you would like to go for taking the interview?

I certify that above consent has been read by interviewer and I am willing to participate in the study.

Signed: _____ Date: _____

Name of data collector _____ Woreda Name _____

I. Demographics and basic Socio-economic Information

SN	Question	Response	Skip
ID001	Serial Number		
ID002	Age of woman (in completed years)		
ID003	Have you ever attended school (formal education)	1. Yes 2. No	Skip to ID005, if “No”
ID004	If yes, what is the highest grade you completed? If attended college/university add the number of years at school and number of years at college. E.g., If a woman attended two years of TVET after grade 10, write 12.	_____	
ID005	What is your marital status?	1. Never Married 2. Married - Monogamous 3. Married - Polygamous 4. Divorced 5. Separated 6. Widow or Widower 7. Living Together	
ID006	What was your age by the time you got married for the first time?	_____ years	
ID007	What is your role in the household?	1. Head of the household 2. Spouse 3. Daughter 4. House maid	

SN	Question	Response	Skip
		5. Other (specify) _____	
ID008	Religion	1. Orthodox 2. Islam 3. Catholic 4. Protestant 5. Waqi-Feta 6. Traditional 7. Other	
ID009	During the last 12 months, did you earn any income?	1. Yes 2. No	
ID010	If yes, how much is your average monthly income?	_____ ETB	
ID011	Are you employed?	1. Yes, self-employment 2. Yes, wage-based employment 3. No	

II. Experience of Violence or abuse

Instruction: Here below are questions asking you about abuses you have encountered. There is also a list of behaviors that many women report as have been used by their partners or former partners. I would also like you to estimate how often these behaviors occurred for you during the last abusive relationship. Remember, your answers are strictly confidential.

SN	Question	Response	Skip
SA001	Have you ever encountered any form of abuse?	1. Yes 2. No	

SN	Question	Response	Skip
SA002	If yes, when was the last abuse encounter you had?	_____	
SA003	How often did any of the abuse/s happened to you in a month?	_____	
SA004	How long have you been in abusive relationship?	_____ Years	
SA005	Which type of abuse have you encountered? (Multiple answers is possible)	<ol style="list-style-type: none"> 1. Called you a name and/or criticized you 2. Tried to keep you from doing something you wanted to do (example: going out with friends, going to meetings) 3. Gave you angry stares or looks 4. Prevented you from having money for your own use 5. Ended a discussion with you and made the decision himself 6. Threatened to hit or throw something at you 7. Pushed, grabbed, or shoved you 8. Put down your family and friends 9. Accused you of paying too much attention to someone or something else 10. Put you on an allowance 11. Said things to scare you (examples: told you something “bad” would 	

SN	Question	Response	Skip
		<p>happen, threatened to commit suicide)</p> <p>12. Slapped, hit, or punched you</p> <p>13. Made you do something humiliating or degrading (example: begging for forgiveness, having to ask his permission to do something)</p> <p>14. Checked up on you (examples: checked your phone, called you repeatedly at school or work)</p> <p>15. Pressured you to have sex in a way that you didn't like or want</p> <p>16. Threatened you with a knife, gun, or other weapon</p> <p>17. Spanked you</p> <p>18. Told you that you were a bad person</p> <p>19. Stopped you or tried to stop you from going to work or school</p> <p>20. Threw, hit, kicked, or smashed something</p> <p>21. Kicked you</p> <p>22. Physically forced you to have sex</p> <p>23. Threw you around</p> <p>24. Physically attacked the sexual parts of your body</p> <p>25. Choked or strangled you</p> <p>26. Used a knife, gun, or other weapon against you</p>	

III. Level of stigma and IPV

Instruction: In the next section I will be asking you about your feelings on the abusive relationship you had. While answering, you are expected to tell me whether you agree on the statement or not and the degree of agreement you have on the idea. The degree of agreements ranges from strongly disagree to strongly agree (Strongly Disagree/Disagree/Somewhat disagree/Somewhat Agree/Agree/Strongly Agree)

SN	Question	Response	Skip
1	If I told people about the abuse, I worried that they would think I “asked for it.”	<i>Strongly Disagree/Disagree/Somewhat disagree/Somewhat Agree/Agree/Strongly Agree</i>	
2	People blamed me for staying in the relationship despite the abuse I experienced.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
3	I felt that the abuse was my fault.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
4	My abuser convinced me that there was something wrong with me.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
5	I believed that if I shared details about my relationship with others I would be blamed for the abuse.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
6	People said the abuse was my fault.	<i>Strongly Disagree/Disagree/Somewhat</i>	

		<i>Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
7	I knew the abuse was not my fault.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
8	My abuser blamed me.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
9	People supported me when I told them about the abuse.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
10	I felt like I deserved it.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
11	My abuser isolated me from family and friends.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
12	I wasn't allowed to go anywhere or do anything by my abuser.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
13	I didn't know whom I could tell about the abuse without it being used against me.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	

14	People viewed me as damaged once I shared my experience with the abuse.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
15	My abuser told me not to tell others how he treated me.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
16	I hid the abuse from others because I was afraid, they would tell me what to do.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
17	People in my community encourage me to talk about my experiences.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
18	I didn't tell others about the abusive relationship because I felt ashamed of the abuse.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
19	My abuser made me feel inferior	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	
20	My abuser monitored my activities.	<i>Strongly Disagree/Disagree/Somewhat Disagree/Somewhat Agree/Agree/Strongly Agree</i>	

IV. Effects, Coping to IPV Stigma and Help Seeking Experiences

1. If the stigma experience is positive, what did you do when you felt stigmatized? (Your coping mechanism)
2. Did you share to anyone else to seek help your experience of stigma?
3. If yes, to whom you shared your experience.
(Friends, my families, his families, mental health professionals, elders, religious leaders, others.....)
4. Were they supportive enough for your problem? Did they tell you where to get additional support for your problem?
5. What impact did it bring in your social, economic and other community level participation?(more than one answer is possible)
I left my job Stay depressed/sick Run away to other places
(changed place of residence).....

Stayed isolated..... break the relationship.....
Others.....
6. What do you suggest to overcome the impact of stigma to others who have the experience of IPV related Stigma?(more than one answer is possible)

To seek professional help (including legal support).....
To tell the families or friends (seek informal support).....
Others.....

Annex A2: Amharic Version of the Data Collection Tools

Stigma on Intimate Partner Violence Survivors in KK sub city, AA, Ethiopia

ስምምነት እና የመረጃ መስጫ ቅጽ

ሰላም ብርቱካን ሰኢድ እባላለሁ።

በአዲስ አበባ ዩኒቨርሲቲ በሶሻል ሳይኮሎጂ የማስተርስ ዲግሪ እየተማርኩ ነው። በኮልጌ ቀራኒዮ ክ/ከተማ የቅርብ አጋር ጥቃት ደርሶባቸው በሕይወት የተረፉ ሴቶች ላይ ስላለው በደረሰባቸው ጥቃት ምክንያት መገለል ምንነት እና ደረጃ ለማወቅ ጥናት እያካሄድኩ ነው። ይህ ጥናት በማህበራዊ ሳይኮሎጂ ውስጥ (MA) ክፍል አካል ሆኖ እየተካሄደ ነው።

በዚህ ጥናት ከቅርብ አጋር ጥቃት የደረሰባቸው ሴቶች መካከል ለመሳተፍ በአጋጣሚ ተመርጠዋል። ሁሉም መልሶችም በጥብቅ ሚስጥራዊ መንገድ እንደሚቀመጡ ላረጋግጥልዎ እፈልጋለሁ። ስምዎትን ወይም አድራሻዎትን አልመዘግብም። እንዲሁም በማንኛውም ጊዜ ቃለ መጠይቁን የማቆም ወይም መመለስ የማትፈልጉትን ማንኛውንም ጥያቄ የመዘለል ሙሉ መብት አለዎት። እዚህ ለተዘረዘሩት ጥያቄዎች ትክክለኛ ወይም የተሳሳቱ መልሶች የሉም። አንዳንዶቹን ርዕሰ-ጉዳዮች ለመወያየት አስቸጋሪ ሊሆኑ ይችላሉ ነገር ግን ብዙ ሴቶች የመናገር እድል ማግኘታቸው ጠቃሚ ሆኖ አግኝተውታል።

የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ነው፤ ነገር ግን ያጋጠማችሁ ተሞክሮ ለሌሎች የኢትዮጵያ ሴቶች ጠቃሚ ሊሆን ይችላል። ማንኛውም ጥያቄ አለዎት? ቃለ ምልልሱን ለማጠናቀቅ 30 ደቂቃ ያህል ይወስዳል።

ቃለመጠይቅ ለማድረግ ተስማምተዋል?

[] ቃለመጠይቅ ለማድረግ አልተስማሙም። ተሳታፊውን ለጊዜዎት አመሰግናለሁ ብለው ይሰናበቱ።

[] ቃለመጠይቅ ለማድረግ ተስማምተዋል። ለመነጋገር ጊዜው አሁን ነው?

በግል መነጋገር በጣም አስፈላጊ ነው። ይህ ቃለመጠይቁን ለመውሰድ ትክክለኛው ቦታነው ወይስ ሌላ ቦታ ለቃለመጠይቁ መሄድ የሚፈልጉት ቦታ አለ?

ከዚህ በላይ ያለው ፈቃድ በቃለመጠይቅ ጠያቂ መነበቡን አረጋግጣለሁ እና በጥናቱ ለመሳተፍ ፈቃደኛ ነኝ፡፡ ፊርማ _____ ቀን፡ _____

l. የስነ-ሕዝብ እና መሰረታዊ ማህበራዊ-ኢኮኖሚያዊ መረጃ

ተ.ቁ	ጥያቄ	ምላሽ	ዝለል
ID0 01	ተራ ቁጥር		

ተ.ቁ	ጥያቄ	ምላሽ	ዝላል
ID0 02	የሴት-የዋ ዕድሜ (በተጠናቀቁ ዓመታት)		
ID0 03	ትምህርት ቤት ገብተው ያውቃሉ (መደበኛ ትምህርት)	1. አዎ 2. አልገባሁም (ማንበብ እና መጻፍ እችላለሁ)	Skip to ID005, if “No”
ID0 04	አዎከሆነ፣ ያጠናቀቁት ክፍተኛው ክፍል ስንት ነው? ኮሌጅ/ዩኒቨርሲቲ ከተማሩ በትምህርት ቤት የዓመታት ብዛት እና በኮሌጅ የዓመታት ብዛት ይደምሩ። ለምሳሌ፣ አንዲት ሴት ከ10ኛ ክፍል በኋላ የሁለት ዓመት የቴክኒክና ሙያ ትምህርትና ሥልጠና ከተከታተለች፣ 12 ጻፍ።	_____	
ID0 05	የጋብቻ ሁኔታዎ ምን ያህል ነው?	1. በጭራ ሽላግግሁም 2. ያገባች - ሞኖጋሞስ 3. ያገባች - ከአንድ በላይ ማግባት ውስጥ ያለች 4. የተፋታች 5. ተለያይታለች 6. ባልቴት ወይም ባልየሞተባት 7. አብሮ መኖር	
ID0 06	ለመጀመሪያ ጊዜ ስታገቢ ዕድሜሽ ስንት ነበር?	_____ አመታት	
ID0 07	በቤተሰብ ውስጥ የእርስዎ ሚና ምንድን ነው?	1. የቤተሰብ አስተዳዳሪ 2. የትዳር ጓደኛ	

ተ.ቁ	ጥያቄ	ምላሽ	ዝለል
		3. ሴት ልጅ 4. የቤት ሰራተኛ 5.ሌላ	
ID0 08	ሃይማኖት	1. ኦርቶዶክስ 2. ኦስልምና 3. ካቶሊክ 4. ፕሮቴስታንት 5. ዋቁ-ፈታ 6. ባህላዊ 7. ሌላ	
ID0 09	ባለፉት 12 ወራት ምንም አይነት ገቢ አግኝተዋል?	1. አዎ 2. አይ	
ID0 10	አዎ ከሆነ፣ አማካይ ወርሃዊ ገቢዎ ስንት ነው?	_____ ብር	
ID0 11	ስራ ተቀጥረዋል?	1. አዎን, የራስ ሥራ 2.አዎ፣ ደመወዝ ላይ የተመሠረተ ሥራ 3.አይ ስራ የለኝም	

I. የጥቃት ወይም የመበደል ልምድ

መመሪያ፡ከዚህ በታች ስላጋጠሙሽ በደል የሚጠይቁ ጥያቄዎች አሉ።ብዙ ሴቶች በቅርብ አጋሮቻቸው (በትዳር ግዋደኛ/በፍቅረኛ ወይም በቀድሞ የህይወት አጋሮቻቸው የደረሱባቸውን በደሎች የሚዘግቡባቸው የባህሪዎች ዝርዝርም አሉ።እንዲሁም ባለፉት ቅርብ ጊዜያት ውስጥ እነዚህ ባህሪዎች ምን ያህል ጊዜ ለእርስዎ እንደተከሰቱ እንድትገምቱልኝ እፈልጋለሁ።ያስታውሱ፤የእርስዎ መልሶች በጥብቅ ሚስጥራዊ በሆነ መንገድ ሚያዙ ናቸው።

ተ.ቁ	ጥያቄ	መልስ	ዝለል
SA001	በቅርብ የህይወት አጋርዎ ማንኛውም አይነት በደል/ጥቃት አጋጥሞዎት ያውቃል?	1. አዎ 2. አይ	
SA002	አዎ ከሆነ፤ያጋጠመዎት የመጨረሻ በደል/ጥቃት መቼ ነበር? በወር ይገለጽ	_____	
SA003	በወር ውስጥ በቅርብ አጋርዎ የትኛው በደል/ጥቃት ደረሰብሽ? ምን ያህል ጊዜ ስደርሱብሻል?	_____	
SA004	በበደል/ጥቃት ግንኙነት ውስጥ ምን ያህል ጊዜ ኖረዎል?	_____ አመታት	
SA005	የትኛው አይነት በደል/ጥቃት አጋጥሞሻል? (ብዙ መልስ ማግኘት ይቻላል)	1. በማትፈልገው ስም ጠራሽ እና/ወይ ነቅፎሻል? 2. ማድረግ የምትፈልገውን ነገር እንዳትሠራ ለማድረግ ሞክሯል (ለምሳሌ፡ከጓደኞች ጋር መውጣት፤ ስብሰባ መሄድ) 3. በቁጣ አስተያየት አይቶሻል ወይም ገላምጦሻል?	

ተ.ቁ	ጥያቄ	መልስ	ዝላል
		<p>4. ለራስሽ ምትጠቀሚበት ገንዘብ እንዳትይዥክ ክልክሎሻል?</p> <p>5. ክእርስዎ ጋር ውይይት አብቅቶ ውሳኔውን ራሱ ወስኗል?</p> <p>6. በሆነ ነገር ሊመታሽ ወረወረብሽ? ዝቶብሻል? አስፈራርቶሻል?</p> <p>7. ገፋሽ፣ጭምቅ አድርጎ ያዘሽ ወይም ወዘወዘሽ?</p> <p>8. ቤተሰብሽን እና ጓደኞቻሽን አዋረደብሽ?</p> <p>9. ለአንድ ሰው ወይም ለሌላ ነገር ክልክ በላይ ትኩረት በመስጠት ክሶሻል?</p> <p>10. በሱ ላይ በገንዘብ ጥገኛ አድርጎሻል?</p> <p>11. የሚያስፈራዎትን ነገር ተናግሯል? (ለምሳሌ፡- አንድነገር “መጥፎ” እንደ ሚሆን ነግሮሻል? እራስን ለማጥፋት ዛቻ)</p> <p>12. በጥሬ መታሽ ወይም ደበደበሽ?</p> <p>13. አዋራጅ ወይም አዋራጅ ነገር እንድትሰሪ አድርጎሻል? (ለምሳሌ፡ ይቅርታ እንዲያደርግልሽ እንድትለምኛው፣ የሆነ ነገር ለማድረግ ፈቃዱን እንድትጠይቁ አስገድዶሻል?)</p> <p>14. ተፈትሽሻል? (ለምሳሌ፡ስልክሽን ፈትሷል? በትምህርት ቤት ወይም በሥራ ቦታ እያለሽ ደጋግሞ ይደውላል?)</p> <p>15. በማትፈልገው ወይም በማትወጅው መንገድ የግብረሥጋግንኙነት እንድትፈጽሚ አስገድዶሻል?</p>	

ተ.ቁ	ጥያቄ	መልስ	ዝላል
		16. በቢላ፣ሽጉጥ ወይም ሌላ መሳሪያ አስፈራርቶሻል? 17. ደበደበሽ? 18. መጥፎ ሰው እንደሆንሽ ነግሮሻል? 19. አስቁሞዎታል ወይም ወደ ሥራ ወይም ትምህርት ቤት እንዳይሄዱ ለመከላከል ሞክሯል? 20. የሆነ ነገር ወረወረ፣መታ፣ረገጠ ወይም ሰባበረ? 21. ረገጠሽ? 22. ወሲብ እንድትፈጽሟ በአካል አስገድዶሻል? 23. በዙሪያው ወረወረሽ? 24. የሰውነትሽን የወሲብ አካል ጉዳት አድርሶበታል? 25. አነቀሽ? 26. በአንቺ ላይ ቢላ፣ሽጉጥ ወይም ሌላ መሳሪያ ተጠቅሟል?	

II. የመገለል ደረጃ

መመሪያ:- በሚቀጥለው ክፍል በነበራችሁ የአስከፊ ግንኙነት ላይ ያለዎትን ስሜት እና የመገለል ተሞክሮ እጠይቅዎታለሁ። መልስ በሚሰጡበት ጊዜ በመግለጫው ላይ መስማማት አለመስማማት እና በሃሳቡ ላይ ያለዎትን የስምምነት መጠን እንድትነግሩኝ ይጠበቃል። የስምምነቱ መጠን ከጠንካራ አለመስማማት እስከ ጠንካራ መስማማት ይደርሳል (በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ)።

ተ.ቁ	ጥያቄ	ምላሽ
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1	ስለ ደረሰብኝ በደል ለሰዎች ብነግራቸው “እኔ የጠየቅኩት ነው” ብለው ያስባሉ ብዬ እጨነቃለሁ።	በጣም አልስማማም /አልስማማም/ በተወሰነ አልስማማም /በተወሰነ ደረጃ እስማማለሁ /እስማማለሁ /በጣም እስማማለሁ
2	ያጋጠመኝ በደል እያለ ሰዎች በግንኙነቴ ውስጥ በመቆየቴ ወቀሱኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ
3	የደረሰብኝ በደል የኔ ጥፋት እንደሆነ ተሰማኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ
4	በዳዩ የሆነ ችግር እንዳለብኝ አሳመነኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ
5	ለሌሎች ያለኝን በዳይ ግንኙነት በዝርዝር ካካፈልኩ ለደረሰብኝ ጥቃት ተጠያቂ አድርገው እንደሚወቅሱኝ አምን ነበር።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ
6	ሰዎች የደረሰብኝ በደል የኔ ጥፋት ነው አሉ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ
7	የደረሰብኝ በደል የኔ ጥፋት እንዳልሆነ አውቃለሁ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ
8	በደል ያደረሰብኝ እኔኑ ወቀሱኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/እስማማለሁ/በጣም እስማማለሁ

9	ስለ ደረሰብኝ በደል ስነግራቸው ሰዎች ደግፈውኛል። አግዘውኛል።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
10	በደሉ ይገባኛል ብዬ ተሰማኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
11	በደል ያደረሰብኝ ከቤተሰብ እና ከንደኞቼ አገለለኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
12	በዳዩ የትም እንድሄድ ወይም ምንም ነገር እንዳደርግ አይፈቅድልኝም።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
13	እኔን ለመውቀስ ጥቅም ላይ ሳይውል በደሌን ለማን እንደምናገረው አላውቅም ነበር።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
14	የበደል ልምዴን ካፈልኩኸቸው በኋላ ሰዎች እንደተጎዳሁ ቆጠሩኝ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
15	በዳዩ እንዴት እንዳደረገኝ ለሌሎች እንዳልናገር ነግሮኛል።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
16	በደሌን ከሌሎች ደብቄው ነበር ምን ማድረግ እንዳለብኝ ይነግሩኛል ብዬ ስለፈራሁ።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
17	በአካባቢዬ ያሉ ሰዎች ስለ ደረሰብኝ በደል እንድናገር ያበረታቱኛል።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ

18	በደረሰብኝ በደል ሀፍረት ስለተሰማኝ ስለ በዳይ ግንኙነቴ ለሌሎች አልተናገርኩም።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
19	በደል ያደረሰብኝ የበታችነት ስሜት እንዲሰማኝ አድርጎኛል።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ
20	በዳዩ እንቅስቃሴዬን ይከታተል ነበር።	በጣም አልስማማም/አልስማማም/በተወሰነ አልስማማም/በተወሰነ ደረጃ እስማማለሁ/አስማማለሁ/በጣም እስማማለሁ

III. ያሳደረው ተጽዕኖ እና መገለልን ለመቋቋም ያደረጉት ሙከራ ላይ ምላሽ

1. የመገለል ልምድ አዎንታዊ ከሆነ፣ መገለል ሲሰማዎት (ሲደርስብዎት) ምን አደረጉ? (የእርስዎን የመቋቋም ዘዴ ይንገሩን)
2. የመገለል ልምድዎን በተመለከተ እርዳታ ለመፈለግ ጉዳዮችን ለሌላ ለማን አጋርተዋል? ስለመገለልዎ ለማን ተናግረዋል?
3. አዎ ከሆነ፣ የእርስዎን ተሞክሮ ለማን ነበር የተናገሩት?
(ለንደኞቹ፣ ቤተሰቦቹ፣ ቤተሰቦቹ፣ የአእምሮ ጤና ባለሙያዎች፣ የሀገር ሽማግሌዎች፣ የሀይማኖት መሪዎች፣ ሌሎች)
4. መልስዎ አዎ ከሆነ በምትፈልጉት ያክል እገዛ አድርገዋል? ተጨማሪ እገዛ ከየት እንደሚያገኙ አመለክተዋል?
5. መገለልዎ በማህበራዊ፣ ኢኮኖሚያዊ እና ሌሎች የማህበረሰብ ደረጃ ተሳትፎ ላይ ምን አይነት ተጽእኖ አመጣ?
ስራዬን ለቅቄያለሁ.....
በጭንቀት ተውጬ ነበር/ ታምሜ ቆይቻለሁ.....
ወደ ሌላ ቦታ ሸሸሁ (የመኖሪያ ቦታ ቀይራያለሁ).....
ተነጥለው መቆየታቸው (ከሰው ተገልጦ ቆየሁ).....
ግንኙነቴን አፈረስኩ (ተፋታሁት).....

ሌሎች

6. ሌሎች ከቅርብ አጋር ጥቃት ጋር የተያያዘ መገለል የደረሰባቸው ሰዎች ላይ የሚደርሰውን መገለል ለማሸነፍ ምን ይጠቁማሉ? ይመክራሉ?

የባለሙያ እርዳታ መጠየቅ አለባቸው (የህግ ድጋፍን ጨምሮ).....

ለቤተሰቦቹ ወይም ለጓደኞቻቸው መንገር (መደበኛ ያልሆነ ድጋፍ ይፈልጉ).....

ሌሎች

Annex B: Interview Guide for Service Providers (Health professionals, Women office, Counsellors, Police officials, Judges and Lawyers)

1. Age _____ Sex _____

level of Education _____ Employment _____

2. How do you feel when you give service for IPV survivors?
3. How do you assess the attitude of professional helpers in your organization towards intimate partner violence survivors?
4. Any suggestion you propose to improve for those with negative attitudes or stigmatizing attitudes for IPV survivors?
5. Is stigma prevalent among IPV survivors?
6. What do you think are the causes of stigma towards intimate partner violence survivor women?
(Ideally supposed to be helped rather than stigmatized)
7. What do you think the most common reason for women who are in abusive relationship hesitate to disclose their abuse experience?
8. What type of stigma is common with your clients during their visit to seek help? (Social stigma like victim blaming, Perpetuator stigma, self-stigma or others)
9. What level of stigma is more pervasive for the survivors related to IPV?
10. What do you suggest be done to overcome stigma towards IPV survivors?

Thank you for the willingness to be interviewed.

Annex C: Mean Score of IPV Stigma Types per Demographic Characteristics

Demographic characteristics		Type of stigma								Total	
		Internalized		Anticipated		Perpetrator		Isolated		Percent	Mean
		Average	Average	Average	Average	Average	Average				
Percent	Mean	Percent	Mean	Percent	Mean	Percent	Mean	Percent	Mean		
Age group	15-19	4.5	3.98	4.5	3.82	4.2	4.47	4.9	4.94	4.5	4.29
	20-24	13.7	3.65	14.9	3.85	14.5	4.59	15.2	4.62	14.5	4.15
	25-29	20.1	3.50	20.4	3.43	20.9	4.32	20.5	4.07	20.5	3.83
	30-34	15.4	3.62	15.3	3.48	15.2	4.25	14.9	4.00	15.2	3.84
	35-39	20.8	3.70	20.0	3.44	19.7	4.17	19.5	3.97	20.1	3.83
	40-44	13.8	3.67	13.2	3.40	13.3	4.22	13.2	4.02	13.4	3.83
	45-49	8.5	3.60	8.2	3.33	8.4	4.21	8.2	3.96	8.4	3.78
	50+	3.2	3.23	3.6	3.45	3.8	4.48	3.6	4.13	3.5	3.80
Age at first marriage	10-15	5.0	3.69	5.1	3.56	4.1	3.56	5.3	4.33	4.8	3.77
	16-18	38.0	3.65	38.9	3.56	38.2	4.34	39.1	4.21	38.5	3.93
	19-21	18.5	3.41	18.8	3.30	19.6	4.28	19.1	3.94	19.1	3.74
	22-25	28.6	3.58	27.9	3.33	28.5	4.22	27.4	3.83	28.2	3.75
	26-29	7.5	3.81	7.4	3.62	7.3	4.42	7.4	4.21	7.4	4.02
	30-32	2.4	4.00	1.9	3.05	2.2	4.30	1.7	3.19	2.1	3.73
Marital status	Never married	17.2	3.71	18.2	3.81	17.6	4.52	18.8	4.63	17.9	4.15
	Married - monogamous	20.2	3.67	19.6	3.44	19.0	4.11	18.9	3.93	19.5	3.80
	Married - polygamous	20.4	3.80	19.9	3.59	20.3	4.48	20.0	4.24	20.2	4.03
	Divorced	20.3	3.53	21.6	3.63	20.5	4.25	20.7	4.10	20.7	3.87
	Separated	13.1	3.63	12.0	3.20	12.8	4.20	12.6	3.97	12.7	3.76
	Widow or widower	5.1	3.17	4.9	2.91	5.8	4.23	5.7	4.00	5.4	3.55
	Living together	3.6	3.22	3.7	3.20	4.0	4.20	3.4	3.42	3.7	3.53
Religion	Orthodox	36.8	3.46	38.2	3.48	37.4	4.18	37.6	4.04	37.5	3.79
	Islam	48.0	3.73	47.2	3.54	47.8	4.41	47.7	4.23	47.7	3.98
	Protestant	15.2	3.68	14.6	3.42	14.9	4.28	14.7	4.06	14.9	3.87

Role in the household	Head of household	29.4	3.56	28.9	3.38	28.7	4.14	26.9	3.72	28.6	3.72
	Spouse	53.7	3.64	53.1	3.48	53.8	4.33	54.2	4.20	53.7	3.91
	Daughter	2.7	3.64	2.9	3.80	2.9	4.63	3.1	4.75	2.9	4.18
	House maid	7.7	3.62	7.9	3.61	7.9	4.44	8.7	4.68	8.0	4.05
	Other	6.5	3.72	7.1	3.94	6.6	4.51	7.0	4.59	6.8	4.18
Level of education	Unable to read and write	22.1	3.61	21.6	3.41	22.1	4.30	22.1	4.12	22.0	3.86
	Primary education	15.8	3.72	15.8	3.58	15.2	4.26	16.3	4.37	15.8	3.98
	Secondary education	36.5	3.60	38.0	3.62	37.4	4.39	37.6	4.24	37.3	3.95
	College diploma	13.1	3.39	13.0	3.25	13.7	4.19	12.7	3.73	13.2	3.65
	Bachelor degree	9.8	3.92	9.2	3.57	8.9	4.24	9.1	4.16	9.3	3.99
	Masters degree	2.7	3.61	2.4	3.10	2.6	4.20	2.2	3.42	2.5	3.63
Monthly income (in ETB)	<1000	2.9	3.67	2.9	3.47	3.0	4.47	3.0	4.17	2.9	3.93
	1001-2500	22.1	3.68	23.5	3.73	21.8	4.17	24.2	4.36	22.8	3.98
	2501-5000	34.7	3.50	34.6	3.32	35.3	4.09	34.9	3.81	34.9	3.69
	5001-7500	24.8	3.79	23.6	3.44	24.3	4.29	22.8	3.78	23.9	3.84
	7501-10000	7.8	3.71	7.2	3.30	8.1	4.48	7.7	3.97	7.7	3.88
	>10000	7.7	3.69	8.2	3.73	7.5	4.15	7.5	3.91	7.7	3.89
Employment status in the last 12 months	Self employed	18.2	3.65	18.0	3.49	17.5	4.17	17.3	3.94	17.8	3.82
	Wage-based employment	32.2	3.63	32.0	3.48	31.3	4.19	30.7	3.94	31.6	3.82
	Not employed	49.6	3.61	50.0	3.51	51.1	4.42	52.1	4.32	50.6	3.96
Income in the last 12 months	Yes	47.8	3.64	47.1	3.47	46.4	4.20	45.4	3.95	46.8	3.83
	No	52.2	3.60	52.9	3.52	53.6	4.39	54.6	4.30	53.2	3.94
Total (Average)			3.63		3.5		4.3		4.1		3.89

Annex D. Mean Score of IPV Stigma Types per Type of Abuse and its Characteristics

Abuse Characteristics		Type of stigma								Total	
		Internalized Average		Anticipated Average		Perpetrator Average		Isolated Average		Percent	Mean
		Percent	Mean	Percent	Mean	Percent	Mean	Percent	Mean	Percent	Mean
Type of abuse exposed	Physical abuse	77.9	3.67	78.1	3.55	78.0	4.36	78.8	4.23	78.2	3.95
	Psychological abuse	99.0	3.62	98.9	3.49	99.4	4.32	99.1	4.13	99.1	3.89
	Both	76.9	3.66	77.0	3.54	77.4	4.38	77.8	4.23	77.3	3.95
Time of last abuse	In 1 month	12.1	4.21	10.7	3.61	10.8	4.45	11.3	4.50	11.2	4.20
	In 2 - 3 months	10.5	3.51	11.1	3.57	11.0	4.36	11.0	4.20	10.9	3.90
	In 4 - 6 months	17.6	3.53	17.1	3.31	18.0	4.29	18.3	4.18	17.8	3.82
	In 7 - 12 months	20.7	3.60	22.2	3.73	20.9	4.32	21.6	4.29	21.3	3.98
	In 1 - 2 year	25.1	3.65	24.4	3.43	24.7	4.27	23.9	3.97	24.6	3.84
Frequency of abuse in a month	Before 2 years	14.0	3.39	14.4	3.38	14.6	4.21	13.8	3.82	14.2	3.70
	1-5 times/month	34.2	3.55	36.0	3.61	35.4	4.37	36.5	4.33	35.4	3.95
Duration of	6-10 times/month	33.2	3.59	32.1	3.35	32.5	4.17	31.9	3.93	32.4	3.77
	11-15 times/month	15.4	3.73	15.4	3.60	15.6	4.50	15.4	4.27	15.5	4.03
	16-20 times/month	6.6	3.79	6.7	3.70	6.3	4.26	6.6	4.30	6.5	4.01
	21-25 time/month	2.1	3.37	2.0	3.08	2.1	4.04	1.9	3.40	2.0	3.50
	26-30 times/month	8.4	3.75	7.9	3.39	8.2	4.31	7.7	3.90	8.1	3.86
Duration of	1-2 years	41.3	3.52	43.4	3.57	42.1	4.26	43.3	4.20	42.5	3.88
	3-4 years	20.6	3.65	19.2	3.31	20.8	4.39	18.9	3.84	20.0	3.81

abusive	5-10 years	30.7	3.62	30.5	3.46	30.5	4.27	30.7	4.13	30.6	3.86
raltionsh	11-15 years	3.8	4.31	3.6	4.03	3.4	4.66	3.6	4.71	3.6	4.41
ip	16-26 years	3.6	4.12	3.2	3.54	3.2	4.31	3.5	4.54	3.4	4.13
Total (Average)			3.63		3.5		4.3		4.1		3.89

Annex E. Distribution of Type of Abuse per frequency in a month and duration of abusive relationship

Abuse Characteristics		Type of Abuse						Total
		Physical Abuse		Psychological_Abuse		Mixed Abuse		
		Percent	Number	Percent	Number	Percent	Number	
Time of last abuse	In 1 month	10.0	17	10.5	23	10.1	17	40
	In 2 - 3 months	10.6	18	11.0	24	10.7	18	42
	In 4 - 6 months	19.4	33	18.3	40	19.6	33	73
	In 7 - 12 months	20.0	34	20.1	44	19.0	32	78
	In 1 - 2 year	26.5	45	25.1	55	26.8	45	100
	Before 2 years	13.5	23	15.1	33	13.7	23	56
	Frequency of abuse in a month	1-5 times/month	37.6	64	34.2	75	36.9	62
	6-10 times/month	31.8	54	33.8	74	32.1	54	128
	11-15 times/month	13.5	23	15.1	33	13.7	23	56
	16-20 times/month	7.6	13	6.4	14	7.7	13	27
	21-25 time/month	1.8	3	2.3	5	1.8	3	8
	26-30 times/month	7.6	13	8.2	18	7.7	13	31
Duration of abusive relationship	1-2 years	45.9	78	42.0	92	45.2	76	170
	3-4 years	19.4	33	20.5	45	19.6	33	78
	5-10 years	29.4	50	31.1	68	29.8	50	118
	11-15 years	3.5	6	3.2	7	3.6	6	13
	16-26 years	1.8	3	3.2	7	1.8	3	10

Annex F. Type of Abuse per demographic characteristics

Demographic Characteristics		Physical Abuse		Psychological Abuse		Mixed Abuse		Total
		Percent	Number	Percent	Number	Percent	Number	
Age group	15-19	3.5	6	4.1	9	3.6	6	15
	20-24	16.5	28	12.8	28	15.5	26	56
	25-29	22.9	39	21.0	46	23.2	39	85
	30-34	15.9	27	15.5	34	16.1	27	61
	35-39	18.8	32	20.5	45	19.0	32	77
	40-44	12.4	21	13.7	30	12.5	21	51
	45-49	6.5	11	8.7	19	6.5	11	30
	50+	3.5	6	3.7	8	3.6	6	14
Level of education	Unable to read and write	18.2	31	22.4	49	18.5	31	80
	Primary education	18.2	31	14.6	32	17.3	29	63
	Secondary education	36.5	62	37.0	81	36.9	62	143
	College diploma	15.3	26	14.2	31	15.5	26	57
	Bachelor degree	10.0	17	9.1	20	10.1	17	37
	Masters degree	1.8	3	2.7	6	1.8	3	9
	Never married	20.0	34	16.4	36	19.6	33	70
Marital status	Married - monogamous	20.6	35	19.6	43	20.2	34	78
	Married - polygamous	15.3	26	19.6	43	15.5	26	69
	Divorced	22.4	38	21.0	46	22.6	38	84
	Separated	11.8	20	13.2	29	11.9	20	49
	Widow or widower	5.9	10	5.9	13	6.0	10	23
	Living together	4.1	7	4.1	9	4.2	7	16
	Age at first marriage	10-15	3.7	5	4.4	8	3.0	4
16-18		36.0	49	37.7	69	36.3	49	118
19-21		19.9	27	19.7	36	20.0	27	63
22-25		32.4	44	29.0	53	32.6	44	97
26-29		5.9	8	7.1	13	5.9	8	21
30-32		2.2	3	2.2	4	2.2	3	7
Role in the household	Head of household	30.0	51	29.7	65	29.8	50	116
	Spouse	50.0	85	53.4	117	50.0	84	202
	Daughter	3.5	6	2.7	6	3.6	6	12
	House maid	8.8	15	7.8	17	8.9	15	32
	Other	7.6	13	6.4	14	7.7	13	27
Religion	Orthodox	37.1	63	38.4	84	36.9	62	147
	Islam	47.1	80	46.6	102	47.0	79	182
	Protestant	15.9	27	15.1	33	16.1	27	60
Employment status in the	Self employed	15.9	27	18.3	40	16.1	27	67
	Wage-based employment	34.1	58	31.5	69	33.3	56	127

last 12 months	Not employed	50.0	85	50.2	110	50.6	85	195
Income in the last 12 months	Yes	47.1	80	47.0	103	46.4	78	183
	No	52.9	90	53.0	116	53.6	90	206
Monthly income (in ETB)	<1000	2.5	2	2.9	3	2.6	2	5
	1001-2500	25.0	20	20.4	21	23.1	18	41
	2501-5000	40.0	32	36.9	38	41.0	32	70
	5001-7500	13.8	11	24.3	25	14.1	11	36
	7501-10000	10.0	8	7.8	8	10.3	8	16
	>10000	8.8	7	7.8	8	9.0	7	15