Evaluating the Knowledge and Awareness of Women's about the Nexus between Reproductive Health Problems and Gender Based Violence in North Western Ethiopia

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Abstract

Background: Sexual and reproductive health is the base of peoples living. **However,** many reproductive health questions are left unanswered. Hence, this study intends to assess women's awareness and knowledge of reproductive health problems as a result of violence in North Western Ethiopia.

Methods: To attain the objective of this study, mixed research approach with cross sectional concurrent research design was employed. Survey questionnaires, interviewees, focus group discussion and document reviews were the data collection instruments used. The collected data was analyzed by descriptive statistics. The target of this study was ten (10) randomly selected districts with 415 women (women in reproductive age) being the unit of analysis.

Results: The result demonstrated that, 40% of respondents have an awareness of GBV and its effects on reproductive health, while 60 % are unaware of the importance of the relationship. It also show (55.9 %) of the respondents reported they are aware RH problem can be due to violence, while 44.1 % of as they were unaware. Concerning this awareness, (40.5%) are aware of the problem of headaches, whereas (29.6%) are aware of functional limitation and disability. Considering, psychological/mental health problems, 39 % are aware of the problem of depression and anxiety, while 35.7 % of the respondents reported awareness about post-traumatic stress disorder. Regarding awareness and perception of the sexual and RH problems, (36.1 %) of the respondents reported they have awareness about STI and HIV/AIDS, while 19.8 % have no awareness. The study also showed that unwanted pregnancy, fetal injuries and cervical cancer problems reported by 31.3%, 25.5% and 25.3% respondents respectively. From the study findings, a significant number of respondents are aware of physical health problems rather than psychological and sexual RH problems. This implies even though women are aware of RH problems, they have little awareness that GBV causes RH problems.

Conclusion: The findings inferred a majority of the respondents reported no awareness about the types of gender based violence which leads to reproductive health problems. Therefore, the health care sector needs to make significant impact by publicizing and addressing violence against women to reduce RH problems.

Background

Reproductive health is a universal concern especially for women particularly during the reproductive years. Reproductive health is a fundamental component of an individual's overall health status and a central determinant of quality of life. However, many reproductive health questions are still unanswered [1; 2]. As the study elaborates, many reproductive health questions are still unanswered; a solid foundation of biological reproductive health knowledge must be understood before attempting to investigate more complex reproductive health problems [1]. A study showed that even though sexual and reproductive health is important to us all, at all stages of our lives, far too many people are denied their

right to sexual and reproductive health [3]. The vast majority are poor women, men and young people in developing countries [4].

In many developing countries, most reproductive decisions are made by the men although it is as well the concern of women. Accordingly, about 45% and 35% of the respondents of the research done by [5] reported their husbands dominate the contraceptive use and maternal health service utilization decision-making. This indicates that reproductive decision-making is strongly affected by gender power relations. Yet little attention has been paid to the serious health consequences of abuse and the health needs of abused women and girls. Women who have experienced violence suffer from a range of reproductive health problems, often in silence. In a Mexican society, the forms of violence have impact negatively on women's reproductive health, yet a culture of silence as well as the lesser inclusion of indigenous groups in implementation and enforcement of public policies has caused an imbalance [6; 7].

The women's understanding of good reproductive health included three major themes which were expressed differently in the three communities. Their understanding included good physical and mental health, and underscored the need for activities promoting health. Their ability to reproduce and raise children, practice family planning and birth spacing, and go through pregnancy and motherhood safely were central to their reproductive duties and their social status. Finally, they saw reproductive health within the context of economic status, good marital relations and strength to cope with their lives. These findings point to the need to situate interventions in the life course of women, their health and that of their husbands and families; the importance of reproduction not only from a health services point of view, but also as regards women's roles and responsibilities within marriage and their families; and taking account of the harsh socio-economic conditions in their communities [8].

In Africa, where a large proportion of the world's forcibly displaced populations are found, the total disease burden due to reproductive morbidity is 44.5 per cent. Poor reproductive health related to sex and reproduction is due to key causal factors found within risky sexual behaviors, pregnancy, abortion and childbirth [9]. The low status of women in Ethiopia underpins, and often directly undermines each of the negatives. Most Ethiopian women lack the reproductive and social self-determination needed to exercise their reproductive rights a condition that in turn, perpetuates their low reproductive health and social status. Ethiopia's rates of maternal and newborn morbidity and mortality are among the highest in the world. Women traditionally enjoy little independent decision making on most individual and family issues, including the option to choose whether to give birth in a health facility or seek the assistance of a trained provider [10]. Lack of clear understanding and misperceptions about SRH combined with unsupportive cultural expectations about sexual life remain important constraints to young people's efforts of seeking such services. Absence of confidentiality, lack of privacy, feeling of shame, being identified by parents and other people, and health system factors such as lack of SRH services plus long waiting time were also important barriers to using SRH. Thus, SRHS programs for young people must address psycho-social, sociocultural and health service factors through culturally sensitive SRH education and service delivery approaches. Furthermore, an inclusive approach which involves parents is recommended in SRH education program [11].

Methods

Study Site

Ethiopia is situated in the Horn of Africa, it has nine regional states and two chartered city administrations. The Amhara region is one of the regional states in the Federal Democratic Republic of Ethiopia, located in north-west between 9°20' and 14°20' North latitude and 36° 20' and 40° 20' East longitude. Its land area is estimated at about 170,000 square kilometers. The Amhara Region borders Tigray in the North, Afar in the East, Oromiya in the South, Benishangul-Gumuz in the South-west and the country of Sudan in the west. Amhara is divided into 11 zones and 140 districts with about 3429 kebeles (the smallest administrative units). Decision-making power has recently been decentralized to districts and thus the districts are responsible for all development activities in their areas. The 11 administrative zones are: North Gondar, South Gondar, West Gojjam, East Gojjam, Awie, Wag Hemra, North Wollo, South Wollo, Oromia, North Shewa and Bahir Dar City special zone [12].

Study Population

Based on the 2007 census conducted by the Central Statistical Agency of Ethiopia (CSA), the Amhara Region has a population of 17,221,976. Of which, 8,641,580 were men and 8,580,396 women; urban inhabitants' number 2,112,595 or 12.27% of the population. Amhara region has an estimated density of 108.2 people per square kilometer. For the entire Region 3, 983,768 households were counted resulting in an average for the Region of 4.3 persons to a household, with urban households averaging 3.3 and rural households 4.5 people [13]. The results of the 2007 Population and Housing Census of CSA [14] showed the total population of Amhara region at 17.2 million. The size of the population increased by 25 % from 1994 - 2007 representing an annual growth rate of 1.7 percent. The total fertility rate (TFR) of the region declined from 5.1 children per woman in 2005 to 4.2 in 2011[15]. However, currently the projected population of the study area as of 2017 was estimated 21,134,988[16].

Research Method and Design

The study employed mixed research method, consisting of both quantitative and qualitative research methods in order to avoid the drawbacks of each method. Where, quantitative methods fail to capture respondents' in-depth understanding in discussion. The data collection involves gathering both numeric information (questionnaire) as well as text information (interviews) so the final database represents both quantitative and qualitative information. In mixed research, the qualitative and quantitative parts of a study can be conducted concurrently (conducting both parts at roughly the same time) or sequentially (conducting one part first and then the second) to address a research question or a set of related questions [17]. Then, taking this into account and considering the nature of the project, concurrent parallel research design was applied for the purpose of addressing different research questions and for the sake of complementarily sets of quantitative and qualitative data.

Data Sources and Data Types

For this study both primary and secondary sources were employed to obtain necessary information and required data. Hence, primary sources included survey respondents, interviewees, key informants and focus group discussion participants to obtain primary data. While, secondary sources such as books, journals and annual reports relating to with the research problem or in direct relation to the study are included to obtain secondary data.

Data Collection Methods /Instruments

Survey questionnaires, interview, key informant interviews and FGDs were the data collection instruments used to gather primary data as shown here under:

Survey Questionnaires: These composed of both closed and open-ended questions. It was prepared in English and translated into Amharic, the respondents' local language. Before the questionnaire was administered, the draft was evaluated and unnecessary details and vague questions removed. A pretest was conducted to detect any weakness in design and instruments, and to provide alternative data from sample respondents as well as to ensure the items questionnaires bear the same meaning to all respondents and to assess the average time required administering an instrument. Hence, a pilot test was carried out on randomly selected respondents.

Interview: Semi- structured interviews were employed to obtain the qualitative data about the factors that determine the reproductive health in Amhara Region. The interviewees were selected from women between the ages of (15-49), the reproductive age group in the study area. With the consent of the participants, they were recorded through note taking and tape recording. The time for each interview was determined based on the data saturation for the required information regarding the issues raised.

Focus Group Discussions (FGD): A focus group discussion was carried out in each of the selected zones of Amhara region involving seven to twelve participants. Issues addressed in the focus group discussions for triangulation purposes were obtained from household survey and interviews. The group discussions were conducted via Amharic language, the medium of communication in the area with an assistant active note taker trained in proper orientation on how to organize research notes. The researchers acted as moderators during the discussions. Notes were taken from group discussions were summarized and any key and important issues arising in one group discussion used for further discussion in the following group discussions of study area.

Key Informant Interviews: These attempts to explore facts on the grounds of a rational approach to include key informant interviews by involving selected groups of individuals likely to provide needed information, ideas and insights on the proposed research. The informants were selected based on the position they have as woreda health office officials, zonal health department officials, regional health bureau officials, health extension workers from selected zones, regional bureau of women and children affairs officials, zonal women and children affairs department officials and woreda office of women and children affairs officials. The time and place for key informant interview' was decided by the key informants themselves and the majority of interviews were held in the place they selected.

Document Review: These were used as a data collection method for evaluation and analysis of policy and strategies, case reports and legal instruments. Therefore, document reviews were also an important secondary data gathering tools. Giving due emphasis to assess the legal instruments, policies and strategies, programs about sexual and reproductive health, and gender issues in health in Amhara region and in Ethiopia in general as well as supplementing the statistical results in particular.

Sampling Techniques and Sampling Procedures

As the study targets both quantitative and qualitative methodologies, probability and non-probability sampling techniques employed to select the respondents/participants. The researchers were employed multi-stage sampling techniques. In the first stage, random sampling selected zones in Amhara region. Hence, North Gondar, East Gojjam, West Gondar zone, North Wollo and Awi special zone were selected. In similar ways, woredas from selected zones were selected randomly. So, a total of 10 woredas, two from North Gondar zone, three from East Gojjam zone, two from South Gondar zone, two from North Wollo zone, and one woreda from Awi special zone were selected represent zones on the basis of size of woredas' in each zone.

In the second stage, stratified random sampling was employed to select kebeles (small administration unit); because the woredas' of Amhara region categorized into three agro- ecological zones of Woyina-Dega, Dega and Kolla. From these, sample kebeles were selected randomly by taken agro- ecology into account. In the third stage, stratified random sampling was employed to select male and female-headed households from each kebele. Proportional stratified random sampling was employed in accordance with the size of the kebele, then, each kebele's list of male and female-headed households were used as a sample frame. Finally, systematic random sampling technique was applied to select sample respondents from each kebele based on the lists obtained from the respective kebele's administration office.

Sample Size Determination

There are a number of strategies in determining a sample size, here; the researchers used formula based on the real context of the study. As the exact number of the study population is not clearly known, the researchers obtained to apply the precision of estimation of an unknown population for sample size determination. As quoted by [18;19] suggested the most commonly used formula for a questionnaire survey studies sample size determination when the population is large, indefinite and the needed representative sample is to analyze proportion. (see Formula 1 in the Supplementary Files)

Where, n_0 = the required numbers of sample

z = the value of the desired confidence level or confidence interval (95%=1.96)

e = the desired level of margin error or precision

p = estimated variability or proportion of an attribute in the population (50%=0.5)

$$q = 1-p$$

Accordingly, the researchers used 95% confidence level ($z=1.96$), the maximum variability among the population (50%), and 5 % margin of error/precision by looking at the expected criteria. When we apply the formula, (see Formula 2 in the Supplementary Files)

The researchers expected a 10% non-response rate for this study. 38 respondents were included. The required sample sizes of this study were 422 women. However, seven questionnaires were not returned for further analysis. 415 questionnaires were used in the analysis.

Data Analysis

Both quantitative and qualitative data analysis techniques were employed. For quantitative method, upon completion of the data collection, the data is coded, edited and entered into the SPSS (Statistical Package for Social Science) version 20 and then the data analyzed through descriptive statistics(frequency and percentage) and inferential statistics(regression model analysis). A Chi-square test was also used to examine the association of variables and the qualitative data collected through key informant's interviews, focus group discussions and interview was analyzed textually to complement the statistical results. In other words, the qualitative data was analyzed by identifying key themes after transcribed, translated and coded raw data.

Issues of Reliability, Validity and Trustworthiness of the Study

The researchers conducted a pre-test among 30 respondents from selected study area before the execution of actual study to assure the reliability of the study. A Chronbach alpha was also employed to measure the internal consistency of the instrument or to test the reliability of the study. Therefore, the reliability of test statistics to all questions was checked using Chronbach Alpha with in the value of $\alpha > 0.75$: i.e. 0.801. The researchers employed multiple source of information, established a chain of evidence, and had key informants' review reports for assuring the validity of the study. A copy of the questionnaires was peer reviewed to examine the items, and number of questions and measure the concept or construct of interest (content validity). Experts added some constructive ideas to improve the structured questionnaires and discussion guides, thus, some useless, repeated or redundant and ambiguous items were omitted. In addition, to achieve the trustworthiness of the study, the investigators employed triangulation via data sources, and description to convey finding and to complement statistical results with the qualitative part of the study. The findings and results of the study were interpreted in relation to the review of the literature and previous study for the purpose of analytical generalization.

Ethical Considerations

The issue of ethics is a critical concern in research. Different ethical principles were considered throughout data collection procedures. Firstly, the investigators took permission letters from the University of Gondar research and community service affairs vice president office, regional health bureau and zone department, bureau of women and children's' affairs, the authority of administrators in each

district and health office. Secondly, consent was ensured with the participants and respondents to gain permission in order to conduct discussions and complete questionnaires ethically via describing the objective of the study and using the Amharic language enabling every participant and respondent to understand and be aware that all data collected from them was used only for academic purposes. In addition, ethical clearance was attached corresponding with the cover page of the questionnaire to clarify the purpose of the study and data were handled confidentially. Participants/respondents were also informed that the identity of the participants should not be written in the study document. Suitable places and times were chosen according to their suggestions. The researchers gave guarantees of the right to participate voluntarily and withdraw at any time during discussions. Furthermore, the key informants have been contacted by the letter of cooperation written by the authority and institution. The researchers properly paraphrased all literature and acknowledged all those consulted in this study.

Results

The result and discussion part of this research deals with women's awareness and knowledge of the nexus between violence and reproductive health problems, and awareness about the types of gender based violence which leads to reproductive health problems in the study area. It also included the demographic, individual, relational, community and society characteristics of the respondents in the study area. The awareness and perception of respondents towards the nexus between genders based violence and a reproductive health problem was also discussed through frequency and percentage. To know the categorical explanatory variables (demographic, individual, relation, community and society factors) to dependent variable (reproductive health problem due to violence), a Chi-square test was employed.

Demographic Characteristics of the Respondents in the Study Area

Age, Age of first marriage, Duration in Marriage, Number of desired Children and Actual number of Children of Respondents

Regarding the age of the respondents, the minimum age lies at 19 and the maximum at 45. While the range of the age 26 with the standard deviation of 9.514. The data revealed the age of the respondents was concentrated in the adult age group (26). The study also shows the respondent's age of first marriage with a mean of 18.96 years old and the maximum of 40. Implying that, most respondents were first married at an average of 18 years old. In the case of duration of marriage, respondents reported a minimum of 1 year and maximum of 40 years of marriage. The study also showed respondents were willing to have children at the maximum of 15 and an average or mean age of 5.57. Similarly, respondents responded their actual number of children with the mean of 3 and maximum of 12 children in the study area (See Table.1). These findings infer that respondents were at least 18 years of age, with a mean age of 18 for their first marriage, an actual number of children with mean of 3 and are willing to have a large number of children.

Table.1 Respondents response to their age, age of first marriage, duration in marriage, desired number of children and actual number of children of respondents(N=415)

S/n	Options	Minimum	Maximum	Mean	Range	Std. Deviation
1	Age	19	45	26.7446	26	9.51466
2	Age of First marriage	22	40	18.9639	18	4.79544
3	Duration in marriage	1.00	40	13.6627	39	10.12325
4	The number of children for future	0.00	15	5.5732	15	2.27364
5	Number of children	0.00	12	3.2120	12	2.10551

Source: Obtained from survey data, 2019

Residences of the Respondents in the Study Area

Considering the place of respondents', 59 % of the respondents live in rural areas, while 41 % live in urban areas. This infers the majorities of the respondents were concentrated and reside in rural parts of the area (See Table, 2). However, the remaining less than half reside in urban sites. The place of residence may influence the reproductive health of the women. The chi-square test also showed there was a statistically significant association between a women's place of living or residence and their reproductive health with alpha value of 0.006, which is significant at $P < 0.05$.

Table .2 Respondents residence or place of living (N=415)

Options	Frequency	Percentage	
Rural	245	59	.006
Urban	170	41	

Source: Obtained from survey data, 2019

Religious status of the Respondents in the Study Area

As Table.3 shows, a significant number of respondents (89.6%) were orthodox, with few (0.7) being protestant. 9.4 % Muslim and 0.2 % catholic. This showed a majority of orthodox believers, which may have an influence on their reproductive health. This is due to the religion affiliation possibly hindering or improving the reproductive health aspects of women in the study area. But, the chi-square test showed no statistically significant association between women's religious affiliations and their reproductive health with alpha value of 0.572, which is insignificant at $P < 0.05$.

Table.3 Respondents religious affiliations (N=415)

Options	Frequency	Percentage	
Orthodox	372	89.6	.572
Protestant	3	0.7	
Catholic	1	0.2	
Muslim	39	9.4	

Source: Obtained from the survey data, 2019

Educational Status of the Respondents in the Study Area

As can be seen in Figure.1, the majority of the respondents (38.5%) were not illiterate, while 23.61 % of the respondents are able to read and write. The study also revealed that 17.3 % of respondents have had a primary education and 5% a secondary education. In a similar manner, the findings pointed out that 12.2 % diploma, and 6.7 % have a degree and above. This infers a significant number of respondents were not literate which hinders the improvement of reproductive health conditions as there is not adequate knowledge to keep and protect their physical, psychological and social aspects of reproductive health in a well manner. Women who have a diploma and degree or above are more likely protect their reproductive health than women who have no formal education. The absence of education hinders the improvement of reproductive health (physical, sexual, mental and psychological and social health) of women in the study area. In order to see whether there is an association between women's educational status and their reproductive health issues, chi-square test was employed. The result showed a significant association ($\chi^2=13.721$, $df=5$, $p=0.017$, $p<0.05$).

Working Conditions of Respondents in the Study Area

As can be seen in Table 4, nearly half the respondents (46.5%) were farmers, 14 % were government employment. The study also showed that 3.6 %, 3.6 % and 5.8 % were private employees, housewives and daily laborers respectively. 10.4 % and 16.1% were traders and employed in other tasks. From the above findings, it can be inferred the majority were working as farmers. However, few respondents were employed as housewives and daily laborers. The chi-square test also showed a statistically significant association between current working status type and reproductive health with alpha value of 0.041, which is significant at $P<0.05$.

Table.4 Respondents current working status (N=415)

Options	Frequency	Percentage (%)	
Farmer	193	46.5	.041
Government employment	58	14.0	
Private employment	15	3.6	
House wife	15	3.6	
Daily laborer	24	5.8	
Trade	43	10.4	
Others	67	16.1	

Source: Obtained from survey data, 2019

Regarding the availability of their own work, the majority of the respondents (54.5%) had their own work, while 45.5% worked for other people (See Table,5). Showing that for a significant number of the respondents their own work is the means of sustaining their daily life and income generation for family consumption in a given period of time. The chi-square test showed no statistically significant association between women's working for themselves and their reproductive health with alpha value of 0.163, which is insignificant at $P < 0.05$.

Table.5 Respondents working for themselves (N=415)

Options		Frequency	Percentage (%)	
Do you have your own work at time?	Yes	226	54.5	0.163
	No	189	45.5	

Source: Obtained from survey data, 2019

Awareness and Knowledge of Women of the Nexus between Genders based Violence and Reproductive Health Problems in the Study Area-*Amhara Region*

Awareness about GBV types and its effects on Reproductive Health in the Study Area

As Table.6 shows, 40% of the respondents reported they have an awareness regarding gender based violence and its effects on reproductive health, the study also shows 60 % of the respondents have no awareness about the relationship. This indicates the need for further work about the causes, forms and consequences of gender based violence for the community to address the problems of GBV that lead to serious reproductive health problems especially in the study area-*Amhara Region*.

Table.6 Respondents for awareness about GBV types and its problems for Reproductive Health in the study area (N=415)

Variables	Options	Frequency	Percentage (%)
Do you know GBV types that lead to RH problem in your community?	Yes	166	40.0
	No	249	60.0

An Awareness and Perception about Reproductive Health Problems due to GBV in the Study Area

Regarding the awareness of the reproductive health problems due to gender based violence, 55.9 % of the respondents reported an awareness of the relationship, while 44.1 % of the respondents responded no awareness of it (See Table, 7). From this finding, one can understand that women are aware of the nexus between RH problems and gender based violence in the study area.

Table.7 Respondents awareness on reproductive health problems which comes due to violence in the study area (N=415)

Variables	Options	Frequency	Percentage (%)
Do you know the reproductive health problems due to violence in your community?	Yes	232	55.9
	No	183	44.1

Source: Obtained from survey data, 2019

Awareness of Physical Reproductive Health Problems due to GBV in the Study Area

Concerning their awareness of the issue, a significant number of respondents (40.5%) are aware headaches can be significant of GBV, (29.6%) of the respondents are aware of functional limitation and disability due generally to gender based violence in the study area (See Table.8). The study also shows that gastrointestinal disorders and premature mortality are reported by 28.2% and 27.2% of the respondents respectively. In a similar manner, 26.5%, and 25.8% of the respondents reported they aware concerning the problem of fatigue and immediate physical injuries (to head, ear, teeth, lacerations, burns, fractures, homicides...) in the study area. However, 15.4 %, 26.3 %, 28.7 %, and 30.1 % of the respondents have no awareness of the problems of headache, functional limitation and disability, premature mortality and immediate physical injuries (to head, ear, teeth, lacerations, burns, fractures, homicides...) respectively. All this shows a majority of the respondents are aware of the problems of headaches, functional limitations and disability, and gastro intestinal disorder, while a significant number of respondents have no awareness of the problem of premature mortality and immediate physical injuries.

Table.8 Respondents awareness of physical reproductive health problems due to GBV in the study area (N=232)

Physical Reproductive health problems due to GBV	Options	Frequency	Percentage (%)
Immediate injuries to (head, ear, teeth, lacerations, burns, fractures, homicides...)	Yes	107	25.8
	No	125	30.1
Headache	Yes	168	40.5
	No	64	15.4
Fatigue	Yes	110	26.5
	No	122	29.4
Functional limitation and disability	Yes	123	29.6
	No	119	26.3
Gastrointestinal disorders	Yes	117	28.2
	No	115	27.7
Premature Mortality	Yes	113	27.2
	No	119	28.7

Source: Obtained from survey data, 2019

N:B:_The multiple responses were recorded among the respondents who know the reproductive health problems that comes due to violence (N=232)

Awareness and Perception on Psychological/Mental Health Problems due to GBV

As can be seen in Table.9, 39 % of the respondents are aware of the problem of depression and anxiety, while 35.7 % of the respondents reported awareness about post-traumatic stress disorder in the study area. The study also shows 34.9 %, and 28.9% of the respondents have an awareness about the problem of low self-esteem, and eating and sleeping disorders. Additionally, among psychological and mental health problems, 22.2 %, 20.7 %, 16.4 %, and 14.2 % of the respondents reported being aware of the problem of alcohol and substance abuse, obesity or anorexia, sexual risk taking and unsafe sexual behavior, aggression and violence due to gender based violence in the study area respectively. However, 41.7 %, 39.5 %, 35.2 %, 32.7 % of respondents said they have no awareness regarding the problems occurred as a result of gender based violence.

Similarly, 27 %, 21 %, 20.2 % and 16 .9 % of the respondents reported no awareness of the problem of eating and sleeping disorders, low self-esteem, and post-traumatic stress disorder due to violence in the study area respectively. From the above result, it can be deduced the majority of the respondents have awareness about the problems of depression, anxiety, and post traumatic disorder, while a significant number have no awareness of these problems in the study area.

Table.9 Respondents awareness on psychological and/mental health problems due to GBV in the study area (N=232)

Psychological/mental health problems due to GBV	Options	Frequency	Percentage (%)
Depression and Anxiety	Yes	162	39.0
	No	70	16.9
Eating and sleeping disorders	Yes	120	28.9
	No	112	27.0
Post-Traumatic Stress Disorder	Yes	148	35.7
	No	84	20.2
Low self esteem	Yes	145	34.9
	No	87	21.0
Alcoholic and Substance abuse	Yes	92	22.2
	No	140	32.7
Obesity or Anorexia	Yes	86	20.7
	No	146	35.2
Aggression & Violence	Yes	59	14.2
	No	173	41.7
Sexual risk taking and unsafe sexual behavior	Yes	68	16.4
	No	164	39.5

Source: Obtained from survey data, 2019

An Awareness and Perception on the Sexual and Reproductive Health Problems due to Violence in the Study Area

Table.10 demonstrates that 36.1 % of the respondents reported awareness about STI (Sexual Transmitted Diseases) and HIV/AIDS (Human Immune Virus Acquired Immune Deficiency Syndrome), while 19.8 % of the respondents reported no awareness of STI/AIDS from violence. The study also shows that unwanted pregnancy, fetal injuries and cervical cancer issues reported by 31.3%, 25.5% and 25.3% respondents due to their awareness of these issues, while 24.6 %, 30.4 %, 30.6 % of the respondents reported no awareness of them.

27.2%, 26.9 % and 23.6% of the respondents reported an awareness of the problems of maternal, neonatal and infant mortality, abortions (safe and unsafe), and others problem apart from sexual health problems that might be occurred due to gender based violence in the study area. However, 28.7%, 29%, and 32.3 % of the respondents reported no awareness about these issues. From the study's results, it can be understood that most of the respondents are aware of STI/ AIDS, and unwanted pregnancy problems, on the other hand they are not aware of the problems of cervical cancer, fetal injuries, maternal, neo natal and child mortality, and abortions apart from sexual health problems possibly due to violence against women in the study area.

Table.10 Respondents awareness on sexual and reproductive health problems due to Violence against women in the study area (N=232)

Sexual and reproductive health problems due to GBV	Options	Frequency	Percentage (%)
Fetal Injuries	Yes	106	25.5
	No	126	30.4
STI/ HIV/AIDS	Yes	150	36.1
	No	82	19.8
Cervical Cancer	Yes	105	25.3
	No	127	30.6
Unwanted pregnancy	Yes	130	31.3
	No	102	24.6
Abortions (safe and unsafe)	Yes	114	26.9
	No	118	29
Maternal, neonatal & infant mortality	Yes	113	27.2
	No	119	28.7
Others	Yes	98	23.6
	No	134	32.3

Source: Obtained from survey data, 2019

Discussion

As finding of this study demonstrated, 40% of the respondents reported they have awareness regarding gender based violence and its effects on reproductive health, while 60 % have no awareness about the relationship. On the level of understanding on the issue of gender-based violence, most of the students who are understood about gender-based violence will aware on the problem. In other hand, if such problem occurs, they know what should be done to handle the situation. The number of cases of the occurrence of gender-based violence also contributed to the awareness on gender-based violence. Nowadays, there are increase numbers of cases on gender-based violence reported in mass media that lead students aware about the cases. Indirectly, when there is increasing number of cases so they will try to take care of themselves especially when they are going for outing [20]

In the findings reported by [21] the improvement was largely due to a change among young men, from 48% having a high level of attitudinal support for violence in 2009 to 38% in 2013. The Government of Sweden noted that GBV is more prevalent in patriarchal societies with rigid notions of manhood, weak institutions, poor access to information and poor reinforcement of human rights; societies where violence is socially accepted as a means to settle inter-personal disputes[22]. A study conducted on reproductive health among women in three communities around Beirut, Lebanon, as part of the reproductive health component of a larger Urban Health Study. The women's understanding of good reproductive health included three major themes, which were expressed differently in the three communities. Their understanding included good physical and mental health, and underscored the need for activities promoting health. Their ability to reproduce and raise children, practice family planning and birth spacing, and go through pregnancy and motherhood safely were central to their reproductive duties and their social status. Finally, they saw reproductive health within the context of economic status, good marital relations and strength to cope with their lives [23].

Concerning their awareness of the issue, a significant number of respondents (40.5%) are aware headaches can be significant of GBV, (29.6%) of the respondents are aware of functional limitation and disability due generally to gender based violence in Amhara region. They understand on the causes on GBV and have their own perception toward this issue. Gender-based violence is a worldwide problem, but in order to better understands the patterns of violence and its causes and, hence, to eliminate them, the starting point should be knowledge of the particular historical and socio-cultural factors at work in each specific context. The specific nature of gender-based violence in the home is such that other, apparently less serious forms of behavior may also be identified as acts of violence; these types of conduct include verbal and coercion, the infliction of physical injuries not severe enough to constitute serious bodily harm, and sexual abuse that does not constitute rape or ravishment [20].

The findings of this study stipulated that, 27 %, 21 %, 20.2 % and 16 .9 % of the respondents reported no awareness of the problem of eating and sleeping disorders, low self-esteem, and post-traumatic stress disorder due to violence in Amhara region respectively. However, little research is available on women's own perceptions of their mental health or on their health priorities. For women themselves, mental health is critically important. One study reported that women's interest in mental health concerns actually outweighed their interest in reproductive health [24]. Confirming the above findings, the study showed that the result of women's perceptions of intimate partner violence (IPV) as 82.2% of the women were quite aware of IPV and 76.1% were concerned when heard about IPV. However, 78.5% were of the opinion that violence between married, dating or ex-partners is a personal matter between them and no one should interfere or report the violence [25]. A study reported by Central Statistical Agency (CSA) [Ethiopia] and ICF indicated, the information on sexual behavior is important in designing and monitoring intervention programs to control the spread of HIV. It is recognized that some respondents may have been reluctant to provide information on recent sexual behavior [26].

Lack of clear understanding and misperceptions about SRH combined with unsupportive cultural expectations about sexual life remain important constraints to young people's efforts of seeking such services. Absence of confidentiality, lack of privacy, feeling of shame, being identified by parents and health system factors such as lack of SRH services plus long waiting time were also important barriers to using SRH. Thus, SRHS programs for young people must address psycho-social, sociocultural and health service factors through culturally sensitive SRH education and service delivery approaches. So, an inclusive approach which involves parents is recommended in SRH education program [27]. Confirming of this result, a study findings indicates that that if students are aware with gender-based violence including sexual harassment, rape, incest, domestic violence, violence against women, date rape and violence against disable person, the possibilities of this issue might occur in future is lower. It is because, when they alert about the issue they can try as can as possible to avoid becoming a victims by taking necessary steps to safe themselves. In addition, those who really understand about the issues of gender-based violence, it may indirectly reduce the number of cases [20].

The findings point to the need to situate interventions in the life course of women, their health and that of their husbands and families; the importance of reproduction not only from a health services point of view,

but also as regards women's roles and responsibilities within marriage and their families; and taking account of the harsh socio-economic conditions in their communities [23]. The strongest knowledge concerning HIV prevention was found in Namibia and the weakest in Malawi and Mozambique. Knowledge of HIV prevention increased with education Attitudes towards violence against women were tolerant: in Mozambique and Zambia, for example, the majority of women stated that there are reasons that justify a husband hitting or beating his wife. A substantial proportion of women had experienced physical violence after the age of 15. In Zambia, 47% of all women had experienced physical violence and 20% had experienced sexual violence, and more than half of ever-married women reported having experienced emotional, physical or sexual violence at the hands of their partner [28].

Conclusion

An inability to deal with reproductive health problems at any stage in life may set the scene for later health problems. Evidence has shown that at least 60% of women globally are exposed to reproductive health (RH) problems related to gender based violence than their male counter parts. Such exposure to reproductive health problems is contrary to the definition of human rights which stipulates that universal respect for and observance of human rights and the fundamental freedoms for all without discrimination as to race, sex, language, or religion. There is widespread GBV in the world in the form of physical abuse, rape and forced marriages. These forms of violence negatively impact on women's reproductive health, yet a culture of silence (largely precipitated by socio-cultural, economic, religious and policy implementation) encase the subject of GBV. The findings from this research show that different forms of gender based violence committed on women impacts on women's reproductive health. So, the reproductive health of women is the outcomes of different gender based violence. Hence, evaluating the knowledge and awareness on those RH problems due to gender based violence needs an attention especially in Amhara Region. The findings regarding the awareness about GBV types and their impacts on reproductive health in the study area demonstrated that, 40% of the respondents reported an awareness regarding the gender based violence and its impact on reproductive health. The study also demonstrated 60 % of the respondents have no awareness about the relationship between gender based violence and reproductive health problems. Therefore, as a result of this study finding, it can be inferred the majority of the respondents reported no awareness about the types of gender based violence which leads to reproductive health problems in the study area.

However, concerning the awareness about the reproductive health problems due to gender based violence, (55.9 %) of the respondents reported awareness about the reproductive health problems due to violence, while 44.1 % of the respondents responded no awareness of the issues. Concerning awareness to the physical reproductive health problems due to gender based violence, a significant number of respondents (40.5%) are aware of the problems of headaches, (29.6%) of the respondents are aware of functional limitation and disability due to gender based violence in the study area. From the psychological/mental health problems due to GBV, 39 % of respondents reported being aware of the problem of depression and anxiety, while 35.7 % of the respondents reported awareness about post-traumatic stress disorder in the study area.

Regarding an awareness and perception of the sexual and reproductive health problems, (36.1 %) of the respondents reported being aware of STI (Sexual Transmitted Diseases) and HIV/AIDS (Human Immune Virus Acquired Immune Deficiency Syndrome), while 19.8 % of the respondents have no awareness of STI/AIDS from violence. The study also showed that unwanted pregnancy, fetal injuries and cervical cancer problem reported by 31.3%, 25.5% and 25.3% respondents due to their awareness of the relationship. From the study findings, a significant number of respondents have awareness about physical health problems rather than psychological and sexual reproductive health problems. From the above study findings, we can understand that women have awareness about the reproductive health problems, but they have little awareness about gender based violence that causes RH problems in the study area.

Recommendations

The following points were forwarded as the basic elements to address gender-based violence in all sexual and reproductive health situations in the study area for all concerned bodies.

- The health care sector must take a significant impact on publicizing and addressing violence against women, and on reducing the reproductive health problems related to abuse/violence.
- Training and education must be expanded about the types or forms of GBV and its consequences as well as the psychological and sexual reproductive health problems in the study area. With training and support from program managers, health care providers can learn to identify and care for women who have experienced violence. For screening to be useful, providers must be well trained in how to ask about and respond to abuse, and be prepared to help survivors of abuse with treatment and referral. They must learn to work with agencies in other sectors.
- Changing people's behavior and attitudes towards violence requires long-term commitment. Community health care workers and other influential health providers must take the lead in introducing awareness and behavior change in the community. Create a community based response to violence must be created by stimulating discussions, educating community members about the costs and consequences of abuse, and advocating for nonviolent relationships. Exposing violence and enabling vulnerable and marginalized people to receive necessary services will help break the life cycle of violence and promote the rights of women and girls.
- Increasing women's economic empowerment is still crucial for longer term prevention of GBV. Women's economic empowerment interventions which also address gender norms and reach couples and communities can reduce such risks. As influential community leaders, health care professionals—women and men—have important roles to play in promoting violence prevention in the community. They can gain the support of other community leaders.

Abbreviations

GBV: Gender Based Violence; **FGM/C:** Female Genital Mutilation or Cutting; **FGD:** Focus Group Discussion; **GOF:** Goodness of Fitness; **HTP:** Harmful Traditional Practices; **SIDA:** Swedish International

Development Agency; **RC**: Reference Category; **RH**: Reproductive health; WHO: World Health Organizations; **UN**: United Nations; **UNFPA**: United Nations Fund for Population Agency; **UNICEF**: United Nations International Cultural and Educational Fund; **USAID**: United State Agency for International Development;

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from University of Gondar Research and community service affairs V/president and College of Social Science and Humanities Research and community service affairs Committee and informed both oral and written consent was taken from every woman and their parents who participated in the study. Enumerators and invigilators approached well irrespective of ages, religion and ethnicity while conducted this study. The letter of cooperation which was written from University of Gondar, Regional health bureau and each administrative zone were attached in each cover pages of questionnaires where all of the respondents and participants were participated by known the aim of the study. Therefore, all respondents and participates provided their consent without any pressure due to this rationale they were decided to involved after knowing the objective of this study is for academic purpose solely.

Consent for publication

Not Applicable

Availability of data and materials

Data are available from the corresponding authors on reasonable request. Supplementary files also added to the editorial manager website while some of other supplementary documents were not shared to depositor for the sake of maintain confidentiality of our participants. Data supporting findings are available at the hand of Mr. Alemeneh Getaneh, who was coordinator of this study.

Competing of interests

The authors have declared, there is no conflict of interest regarding the concepts and methodological parts of the study.

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Authors Contributions

EK and AG are the major contributor of the proposal development and analysis of the article. EK, SA, and AG facilitated the data collection processes of the manuscript in the study area. All authors conducted the analysis and interpretation of the manuscript. The authors conducted the selection of available studies for systematic review, drafted the first structure of the study, read and wrote based on the guidelines and the standards of the journals. Finally, all procedures and tasks throughout the development of the manuscript have been carried out by the authors' collaboratively.

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Figures

Figure 1

Respondents educational status (N=415) Source: Obtained from survey data, 2019

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