Implementation Barriers and Enablers for Preventing Domestic Violence against Women in Northwestern Ethiopia: A Qualitative Implementation Research

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Abstract

Background: Ethiopia is signatory to various international and regional conventions, agreements and protocols related to violence against women, yet the many women suffer violence. To date, very little is known about how these conventions and protocols are implemented, and the barriers associated with implementation. Our study explored the barriers to implementation of domestic violence against women prevention policies and enablers in the Northwestern Ethiopia.

Methods: We conducted in-depth interviews, key informant interviews and focus group discussions among a total of 43 participants purposefully selected from different sectors and communities. Data were transcribed, coded and thematically analyzed using NVivo 11 software.

Results: Community-traditional gender-norms, budget constraints, poor planning and non-adherence to planned activities, lack of commitment, poor integration and inter-sectoral collaboration served as barriers to implementation of policies aimed at preventing domestic violence in Ethiopia. However, enablers of domestic implementation of violence prevention programs include community health extension program, women development 'army', policy frameworks, government's political willingness, presence of school-based gender clubs.

Conclusions: The implementation of existing evidence and policies was still poor at the community level due to lack of inter-sectoral collaboration, poor integration and stakeholders with competing priorities among others. Future intervention programs that would sustain and synergized domestic violence prevention, should integrate intersectoral collaboration and service within existing program.

Background

Globally, one in three women experience at least one form of violence against women (VAW) in their lifetime (1–3). Domestic VAW results in relationship break down, morbidity, murder and death, and women lose healthy years. This can be a huge threat and an unmanageable burden to public health (4). Nevertheless, in many societies, domestic VAW is considered a minor, socially tricky and private matter (4–6), despite the serious implications it has on victims, their families' and the societies' health care cost and productivity (7, 8).

Domestic VAW is a manifestation of inequality and power imbalance in relationship (9). In addition, studies report that domestic VAW is associated with poor reproductive health outcomes, such as, low skilled birth attendance, reduced antenatal care, high unintended pregnancy and unsafe abortion (1, 4, 5, 10–18). To offset the debilitating consequences of domestic VAW, the United Nations (UN) is aiming at creating an enabling environment for women's right, political, economic empowerment and legal protection by 2035 (19, 20). However, program integration, ownership and scaling up processes are very limited. Almost all of the gender transformative health programs have relied on nongovernmental organizations (NGOs) in low- and middle-income countries (LMIC) (21).

In Ethiopia, domestic VAW is very high, and it ranges from 19–78% (13). Women continue to suffer from violence and abuse in spite of local and international human right laws such as the Universal Declaration of the Human Rights (22). Anecdotal evidence from Ethiopia suggests that community-based domestic VAW preventive programs are limited. The few domestic violence preventive interventions are poorly implemented. Identify and understanding the barriers and enablers of implementation of domestic violence preventive programs and policies in Awi zone, Northwestern Ethiopia will foster program success and impacts.

Methods

A qualitative study was conducted as part of a community-based quasi-experimental pilot study in Awi zone, Northwestern Ethiopia from November 15, 2017 to November 15, 2018 (23). The study was guided by the Consolidated Framework for Implementation Research (CFIR), which used the assessment of intervention barriers to and enablers based on five established domains; namely evidence-based intervention, inner setting, outer setting, individual behavior setting and process of implementation setting. Damschroder and colleagues through a systematic review synthesized and documented evidence of 19 theoretical frameworks and developed the CFIR for program and policy implementation (24). Also, the CFIR has looked at evidence gaps, which shows that many theories have focused on understating individual behavior changes. Nevertheless, little research has been done to understand the dynamic interrelationship between individual and settings, organization, workplace, individuals' behavior). Furthermore, frequently cited theories (social cognitive theory and theory of planned behavior) are relied on intention and behavior of individuals. The WHO special program of tropical disease research (TDR) program (25), adapt and recommends the application of the CFIR. The CFIR is therefore a pragmatic meta-theoretical framework which can be used to complement these theories. This includes its comprehensive classification of key constructs related to the intervention characteristics, inner and outer settings, individual characteristics (behavior) and implementation process (24, 25). Domestic VAW is a common phenomenon in the community (26, 27).

Setting

Our study was conducted in Awi zone, which is one of the zonal administrations in Amhara regional state. Enjibara town is the administrative center, located 447km from Addis Ababa in Northwestern parts of Ethiopia. According to the Zonal Health Department, Awi Zone has a population of 1,285,242, in 2018, of which 50.9% are women (28). Evidence from the national census of Ethiopia conducted by the Central Statistical Agency (CSA) indicates that 87% of the population live in rural areas. Awi zone has a total of 215,564 households with an average of 5 persons per household. About 93.5% of the population are Ethiopian Orthodox Christians, and 5.4% are Muslims (29).

Participant recruitment

Forty-three (43) participants were recruited purposively from diverse groups in different communities for in-depth interviews (IDIs), key-informant interviews (KIIs) and focus group discussions (FGDs). We selected interviewee based on their unique and key position held in the Zonal Offices and in the community. Participants for IDIs comprised women, men, leaders/local politicians, religious leaders, and community elders. Key informants on the other hand were recruited from both Departments of Women and Child Affairs and Health Offices, as well as Judicial, Police and Security Officials. Lastly, focus group discussants were men and women from different sectors, and community's representatives. Participants were selected in collaboration with Police Officer, a local leader and Health Extension Workers. A special case was made to also purposively recruit Gender Officers as key informants because of their position in the community.

Data Collection

Investigators and trained interviewers collected data on IDIs, KIIs, and FGDs including policy document reviews to explore the existing policy implementation to prevent domestic VAW. We used semi-structured interview guides to moderate the interviews. While IDIs explored individual perception about VAW, gender equality and accepting

attitudes towards justified wife-beating. KII delved into the overall situation of VAW and gender equality in the locality, as well as the prevention measures, policy implementation barriers and enablers. The KII also explored availability of collaborators, communities' attitude towards domestic violence and gender equality. Both IDIs and KIIs lasted 30–45 minutes.

In addition, FGDs made up of 8–10 discussants each were conducted using a guide to assess the general community attitudes, perception towards domestic VAW, level of implementation of preventive measures, and implementation bottlenecks. Separate FGDs were conducted for two women's and two men's groups and were facilitated by three members of the research team (moderator and two note takers). Discussion were audio-recorded while note takers captured nonverbal communication cues (physical gestures) during the discussion. The FGDs lasted between 60–90 minutes.

Furthermore, we systematically reviewed policy documents covering women-related issues. The policy documents included Ethiopian Constitution, The Criminal Codes, Family Law, Population and Women's Policy, Gender Training Manuals, Standard Operating Procedures and other regional or international human rights and gender discrimination documents ratified by Ethiopia. These policy document were reviewed to figure out the presence of gender context in the framework, and its use as a guide and legal framework for implementation.

Data analysis

Data were transcribed and translated verbatim from the local language (Amharic) into English by playing and re-playing the audio tapes, and also referring to the summary notes taken during interviews or discussions. The issue of languages translation in public health research was handled according to the research evidence recommendation (30, 31). The study participants' socio-demographic data were entered into SPSS (version 23.0) for the descriptive analysis (Table 1). The overall qualitative data management were employed based on thematic analysis approach (30). The transcribed data were imported into Nvivo 11 for windows (32) for coding and prepared for further analysis. The transcribed data from interviews and FGDs were arranged into thematic areas. Similar ideas were read and re-read for better understanding of the transcribed data. Coding of the transcribed text was performed, and emerging themes and sub-themes were identified accordingly. The participants' narrative quotes were presented using participants' anonymous codes. Corresponding to the themes and sub-themes, parent and child nodes were constructed according to the flow of interviews and FGDs as well as the relationship between participants' perspectives. Nvivo 11 for Windows version software was used to carry out these thematic arrangements. The thematic analysis was guided by the consolidated framework model for implementation research (24, 25).

Table 1
Background characteristics of the qualitative study participants

Variables	Categories	n = 43	%
Age (years)	Mean ($\pm$ SD)	37.5 ($\pm$ 8.6)	
	≤ 36	22	51.2
	> 36	21	48.8
Sex	Female	25	58.1
	Male	18	41.9
Occupational status	Housewife	8	18.6
	Farmer	6	14
	Merchant	3	7.0
	Government employee	24	55.8
	Others	2	4.6
Educational status	Illiterate	2	4.7
	Able to read and write	2	4.7
	1–6 Grades	4	9.3
	7–12 Grades	11	25.6
	12+	24	55.8
Organization represented	Women and Child Affairs Department	7	16.3
	Police and Security Department	6	14.0
	Health Department	16	37.2
	General Community Representatives	13	30.2
	Justice Department	1	2.3
Residence	Urban	23	53.5
	Rural	20	46.5

Results

A total of 43 participants were included in the study. Of these, 34 participants were involved in four FGDs that comprised eight to ten discussants. In addition, five KIIs, and four IDIs were conducted (Table 1).

Existing policies implementation status

The assessment of the implementation status was aimed at identifying implementation bottlenecks and enabling conditions in preventing domestic VAW. Through the narratives of participants, the details of these barriers and enablers are described as follows.

Barriers of community-based intervention implementation

The operationalization of existing policy documents and research evidence recommendations to prevent domestic VAW have been affected by various factors. Participants mentioned various types of barriers at different levels. Some of the major barriers include financial constraints, lack of commitment from local politicians, lack of awareness of existing programs, poor planning, poor implementation limited collaborations, poor integration, entrenched and skewed community traditional gender-norms, and competing priorities of local politicians and other key stakeholders.

Financial constraints: Financial constraints was one of the most frequently cited barriers to policy implementation. Participants explained that the government has a budgetary policy that mandates every sector to allocate two percent of their annual budget for gender related activities, but this is hardly followed, as the allotted budget is not used for the intended purposes.

One female discussant in the FGDs said:

"...no special budget is allocated for gender equality or domestic violence prevention in our setting...During annual budget allocation in our administration, they address the issue of women and child affairs later after other sectors' budget allocation..." (F, 38 years, FGD_{p1})

Another barrier to intervention implementation was lack of commitment from local politicians. Participants indicated that domestic VAW prevention issues are only documented in policy documents, but very limited practical attentions is given to it in most settings. Practical intervention to address domestic VAW issues are not implemented. Additionally, participants were of the view that gender mainstreaming has not been actively implemented because of the apparent indifference of many stakeholders, lack of commitment and attention from local politicians, and poor involvement of the implementers, and lack of full engagement within the community are some of the barriers that affect implementation of existing policy.

One male FGD participant remarked:

"...To ensure gender equality, politicians should teach and serve as role models. They should start from their offices and homes. Sadly, they are not good role models. They are not also working but talking and giving only paper value. Generally, implementation is so poor ..." (M, 49 years, FGD_{p1}).

The lack of political will and commitment also manifest in apathy among officialdom to consciously develop appropriate and well-targeted panning for domestic violence prevention activities. One female FGD participant commented, thus;

"...they (top officials) do not consider gender equality and domestic violence against women during planning. So, we do not have a plan to do this type of trainings to reduce domestic violence against women, and also we did not do anything based on plan ahead." (F, 30 years, FGD_{p 6})

Poor implementation collaboration and integration with existing program

Evidence from participants indicated that existing policies and evidence-based interventions on domestic VAW prevention could not be implemented due to lack of collaboration among sectors.

A male FGD participant mentioned:

"...if we work in collaboration with health extension programs, implementation of violence against women prevention will be an easy task. It will not be an extra burden for us, and it will bring about the needed change..." (M, 55 years, FGD_{adv1})

In addition to poor collaboration, other participants mentioned poor integration of domestic violence prevention activities with existing programs, such as health extension and others. The following quotes illustrate poor collaboration and integration:

"...no one has been supporting us so far...We could not find any sector working on violence against women to collaborate with, or integrate our plan with...everybody speaks about program integration...but there is very little practical implementation to prevent domestic violence against women. Everything is pushed on the health extension workers without adequate support..." (F, 33 years, FGD_{p6})

"... there is a huge gap integrating efforts to prevent violence against women. Perhaps, one sector may take the responsibility of leading a particular initiative, but may not be well integrated with other sectors to address violence against women at the grass root level..." (M, 53 years, KI₀₀₁)

Traditional gender-norms: Almost all participants agreed that the prevailing attitude on traditional gender-norms in the community serves as a major barrier to implementing existing policies and interventions to promote gender equality and prevention of domestic VAW. The community has an ingrained culture that supports traditional gender-norms, for instance, there is lack of positive attitude towards gender equality, and absence of male involvement on domestic violence prevention activities. It was evident that community members and other stakeholders, such as politicians, local leaders, religious leaders, elders, and others, all lack information and understanding of the negative effect of domestic VAW and gender inequality norms. For instance, most people in the community as well as stakeholders perceive wife-beating as a normal practice. One of a male FGD participant remarked:

"...to ensure gender equality, politicians should be taught to be role models. They should start from their office and homes. But they have not been a good example for others. They have not also been working as talking, only 'paper value'..." (M, 55 years, FGD_{adv1})

Competing priority and poor coordination mechanism

Most of the study participants agreed that stakeholders focus on competing priorities to the detriment of domestic violence prevention programs. In addition, there exists several committees with many tasks, making it difficult to implement domestic violence prevention programs. Participants also mentioned that lack of independent responsible body affects the awareness creation and undermines serious preventive efforts.

One of the female discussants in an FGD said:

"...overly busy schedules, lack of independent responsible body (institution) to coordinate this (domestic violence prevention issue) is a problem, because Women and Children Affairs Office is almost not functioning well, they are only implementing politics, very superficially. No-one is asking the women their life experiences at their home..." (F, 31 years, FGD_{p3}).

In addition, one of the key informants indicated: “... *Women’s and Child Affairs Offices has no structure at the bottom (Kebele level) to engage the community very well...*” (F, 35 years, KI₀₀₂)

Enabling conditions for community-based interventions

Participants commented that implementers have not taken advantage of the enabling conditions to operationalize existing policies into interventions to prevent domestic VAW and promote gender equality norms in real life settings. The enabling factors include existing policy frameworks, existing Women Development ‘Army’ (WDA), health extension program, social organization (Equib), Women and Child Affairs Office, School Gender-Clubs and Women Leadership are reported in the KIIs, IDIs and FGDs. The existing enabling environment can be facilitated through integration, collaboration and engaging communities in the implementation program. The potentially enabling and favorable contexts are further explained below:

Availability of policy framework and government willingness: Existing policy documents related to violence against women

Some supportive policy documents include internationally ratified convention and government policies related to domestic VAW. The Government of Ethiopia is a signatory to various international and regional conventions, charters and protocols. Some of the relevant conventions include: the Universal Declaration of Human Rights (1948) (22); Conventions on the Elimination of all Forms of Discrimination Against Women, Article 1 (33); the African Charter on Human and Peoples Rights, Article 3 (1–2) (34); Beijing Platform for Action (1995); Committed to Safe guarding Women’s Rights (35), and Maputo Plan of Action (2016–2030), which gives due attention to the implementation of international, regional and national legislations in order to create a conducive environment for getting reproductive health care to prevent domestic VAW (20). To fulfil the ratified international conventions’ requirements, the government of Ethiopia has incorporated women’s issue into different policy documents. The National Population Policy (1993) has stipulated the minimum legal age for marriage for both sex as 18 years, aimed at improving women’s lives (36). Again, the Constitution (1994) has clearly addressed the protection of human rights from its Article 14–18 (the right to life, security and prohibition against inhuman treatments). Other articles in the Constitution, Article 25 states: “that all person are equal before the law”, Article 35 (1–9) states: “women have equal rights with men”, and Article 34 (1–5) talks about marital, personal and family rights (37).

Moreover, Article 4 of the Criminal Code of Ethiopia under Proclamation No. 414/2004, emphasizes equality before the law. Article 561 criminalizes any injuries and sufferings caused to women (38). Furthermore, conditions of marriage, and equal rights of access to- and control over resource is clearly stated in the revised family laws of Ethiopia (39). The government of Ethiopia launched a gender mainstreaming program in different sectors with guiding mainstreaming manual to serve as an implementation guide or enforce the existing policies (40). In addition, the Ministry of Health has developed the standard operating procedures to respond to and prevent sexual violence. Though all these laws are in place, the public awareness is very poor including poor implementation (41), and this can be rectified by trainers’ and participants’ modules for future awareness creations (42).

Governmental structure and progressive willingness

The Ethiopian government has placed due attention and commitment on the affairs of women. For this reason, a Ministry of Women and Child Affairs has been established with accompanying sectors on District levels. It is mandated to safeguard and address issues of women and children. This government commitment contributes to women rights protection, follow-up of vulnerable women, and application of necessary measures on gender

equality and preventing VAW. The government of Ethiopia has been giving several opportunities progressively, and top political positions to women in the country. Therefore, working in collaboration with the Women and Child Affairs Office can be strategic to sustain the intervention.

Existing Women Development 'Army' (WDA): The government has designed a policy and small functional units, called One to Five (1:5) WDA groups, for both females and males. Each WDA group could be made up of 30 to 40 members. Almost all the participants suggested that these two existing groups (women and men development 'army' groups) offer good opportunities for the implementation of interventions with an optimal cost and as a culturally compatible approach. The WDA group being the most active group, can be an important entry point for community-based action, easy access to the women, encourage active participation and enable close follow-ups to be led by the health extension workers. One of the key informants commented:

"...women gather in one house every month to have various discussions on their issues, some of which include savings (Equib) and small income generating activities. This committee fights for women's rights and also plays a crucial role in the prevention of domestic violence. The women development 'army' are working in collaboration with the health sector, mainly health extension program..." (F, 35 years, KII₀₀₂)

Health Extension Program: This is an existing program under the health sector which staffed with only female health extension workers. These women are taken through intensive training on several community health packages of services which equips them, to organize culturally appropriate sessions for women at the household level to improve women's and children's health in the community. This has enhanced the health sector's implementation of their program to improve maternal and child health, and also prevent domestic violence. A key informant mentioned:

"...although we have not been working that much with good collaboration, the health sector has a community-based health education program, which has been delivered by health extension workers. If sectors could integrate it would not be difficult to tackle domestic violence. The HEP, itself is a good enabler if we use it for the future. The health sector is an important implementer better than other sectors. The HEWs are the leader of the women development 'army'..." (F, 35 years, KII₀₀₂ & F, 26 years, KII₀₀₉)

Social organization (Equib): Equib is an informal local savings and loans scheme, which is led by a community appointed committee. It also functions as a social gathering that holds discussion sessions on social issues. This scheme supports members of the community and also serves as an avenue for effective conflict resolution within the community. It is bound by the community traditional governance culture that can be used as an enabling condition to implement domestic VAW prevention interventions.

Work in collaboration with School Clubs: The school gender-clubs work in collaboration with school teachers and directors to prevent child marriage. They identify potential child marriage victims whose family might have made such arrangements and report to the justice office for them to take necessary actions. For instance two key informants mentioned:

"... schools have committees to prevent harmful traditional practices and early marriages...have been doing a good job...playing a pivotal role in preventing early marriages. This method can be adopted...it will have a great role to play in preventing domestic violence against women in the community..." (F, 35 years, KII₀₀₂ & M, 53 years, KII₀₀₁)

The assessment of barriers to and enablers of the implementation were guided by the CFIR (25), which is described in detail in the method section. The summary of findings is illustrated in the framework (Fig. 1).

Discussion

This study explored the existing policy implementation status aimed at preventing domestic VAW and its barriers and enablers in the Northwestern Ethiopia. Poor implementation of existing policies related to gender equality and domestic VAW at community level is linked to budget constraints, lack of commitment, poor integration and collaborative works, deep-rooted inequity-norms, and stakeholders having competing priorities. Meanwhile the existing policies such as community health extension program, WDA, political will, existing policy frameworks, and school-based clubs are some of the enabling conditions for future sustainable implementation and scale-up of the domestic VAW prevention programs.

Implementation of existing government policies or sanctions is crucial to respond to and prevent domestic VAW. This study found that there is a gap in implementation of existing policies in relation to gender equality and prohibition of domestic VAW. This study's finding is consistent with the WHO (43) recommendation to achieve the five years strategic plan of responding HIV /AIDS through promoting gender equality and equity. To respond to this, necessary, legal, regulatory and policy reforms must be made and implemented to strengthen service integration and linkages to improve the impact and efficiency of community-based interventions. Furthermore, this study explored the implementation of existing policies in real setting. It was found that the translation of research evidence into routine practice was hindered by a lack of commitment from local politicians, financial constraints, poor integration of service and collaboration with other sectors, poor planning and non-adherence to the plan, lack of awareness about domestic VAW among politicians consideration of these as part of their norm, poor implementation alliance (poor engagement of stakeholders), and competing priorities. This finding is similar to existing research evidence from a systematic review from epidemiological studies to improve implementation of policies to prevent domestic violence (44).

In addition, this qualitative study identified implementation barriers consistent with review evidence that has revealed that government needs to address the political, social, and economic structures that subordinate women. Implementing national plans and making budget commitments to investing in actions by multiple sectors, community and group interventions involving women and men can shift discriminatory social norms. Likewise, education and empowerment of women are fundamental. Furthermore, training of health workers to identify and support survivors are strategies to prevent and respond to violence (45). A weak health system has been a challenge given that the health systems have a crucial role in the multisectoral response to domestic VAW. Substantial system and behavioral barriers exist, especially in Ethiopia. The research evidence has suggested that domestic VAW has been identified as a health priority. Strengthening the role of the health system in addressing domestic VAW and girls (46, 47) needs a comprehensive health-system approach that helps health-care providers to identify and support women subjected to domestic VAW through capacity building, effective coordination between stakeholders.

Evidence has shown that community behavior and norms towards domestic violence has been improving through contextual health service delivery strategies. To bring impactful changes on individuals and society at large, local resources, health service and public health schemes and communities should be mobilized. Inter-sectoral collaboration and integration are crucial to address the root-cause of domestic violence, which is a global public health epidemic (48). The presence of appropriate community structures, community health care, social

organizations (Idir and Equib), government positive political will, school-based gender clubs and nongovernmental organizations working on the related issues, and welcoming reception of the community members are some of the great enabling opportunities that can facilitate the implementation of programs in promoting gender equality and preventing domestic VAW. Intersectoral collaboration has to be improved as strategies across the social ecology (interacting, social, institutional, cultural, and political contexts) to achieve meaningful changes within the existing social and political structures.

It is important to develop program components that are comprehensive and mutually reinforcing through collaboration and coordination instead of stand-alone interventions. In a multisectoral approach, as shown by this study outcomes, changes in attitudes and behaviors may not need a generation, but can be achieved within shorter timeframes if intervention models adhere to key principles for effective prevention of domestic VAW and girls. Women's movements have led advocacy and action against domestic VAW, and remain central in the design and implementation of high-quality programs to prevent domestic VAW. Based on evidence and promising practical models, greater investments are needed in programmatic innovations, research-activist collaborations, and health sector-leadership to build even greater momentum for primary prevention of domestic VAW and girls (47).

Strength And Weakness Of The Study

Community-based research is very crucial to identify problems in real settings and for the appropriate generalization of the finding for better insight to inform policy. This study used a mixed qualitative methods to explore implementation barriers and enabling conditions. Applied mixed methods of qualitative data collection that, is recommended for the findings' transferability. In addition, it has been conducted for a year to highlight the bottlenecks as a part of a pilot interventional study. However, it does not mean this study was free from any weakness. The individuals experience or victims' life story was not explored due to sensitive nature of VAW, and perpetrators intention was also not assessed. So future studies can focus to address these limitations.

Conclusions

The existing policy framework is a good reflection of the government's commitment and willingness to safeguard the rights of women and girls against domestic violence. Nevertheless, poor implementation of existing policy related to gender equality and domestic VAW at community level was linked with budgetary constraints, lack of commitment, poor integration and collaborative works, deep-rooted inequity-norms, and stakeholders having competing priorities. Integration of domestic violence prevention with existing programs and applying within the existing policy frameworks such as standard operating procedure, manuals and others legal sanctions into routine services is relatively poor. The community health extension program, WDA structure, government's political willingness and existing policy frameworks towards promoting the rights of the women/girls and gender-equity behaviors, school-based clubs and others are some of the enabling factors for future implementation and sustainable domestic VAW prevention programs. Therefore, community-based intervention is one of the most acceptable and proven ways to prevent domestic VAW. Sectors should collaborate to implement corrective measures to transform community's old-fashioned gender-norm to prevent domestic VAW.

Acronyms

CSA: Central Statistical Agency

FGD: Focus group discussion

IDI: In-depth Interview

KII: Key Informant Interview

VAW: Violence against women

WDA: Women Development 'Army'

Declarations

Ethics approval and consent to participate: The protocol was reviewed and approved by the Institutional Health Research Ethical Review Committee (IHERC) of College of Health and Medical Sciences at Haramaya University (Ref. No. IHERC/146/2017). The study was conducted in accordance with the declaration of Helsinki's. **Informed verbal and written consent** was obtained from participants involved in the current study, and the ethics committee approved this procedure. Informed consent was obtained from the legal guardian of illiterate participants for study participation. Confidentiality of the information was kept and maintained by avoiding personal identifiers and password locking in computer with stored data.

Consent for publication: Not applicable.

Availability of data and materials: The data that support the review findings of this study are available upon submitting a reasonable request to the principal author, and the institutional health research ethics review committee.

Competing Interests: The authors declared that they have no competing interests.

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Authors' Contributions: AS, KT, AM, NA and AA conceived and designed the study. AS carried out activities from inception to the draft of the manuscript. KT, AM, NA, NA and AA rigorously reviewed the manuscript for intellectual content. All authors read and approved the final version of the manuscript.

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Figures

Figure 1

Qualitative findings filled on consolidated framework for Implementation Research model