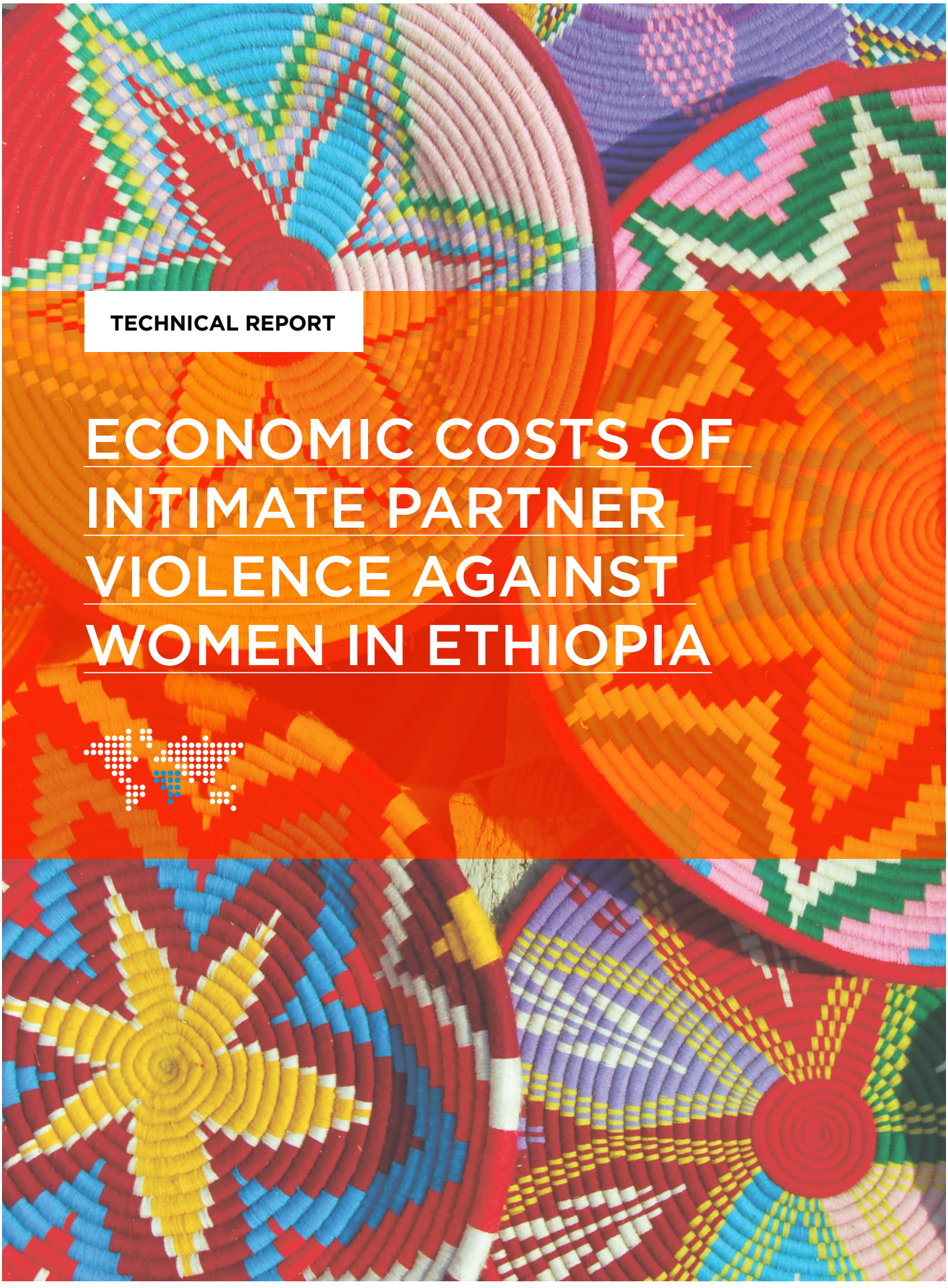


TECHNICAL REPORT

ECONOMIC COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN ETHIOPIA

Federal Democratic Republic of Ethiopia
Ministry of Women and Social Affairs

FRONTIERi

NUI Galway
OÉ Gaillimh

UN WOMEN

Disclaimer

This publication of *Economic Costs of Intimate Partner Violence against Women in Ethiopia: Summary Report* was first published in 2022 by UN Women in collaboration with the Ministry of Women and Social Affairs. The views expressed in this publication are those of the authors and do not necessarily represent the views of UN Women or the Ministry of Women and Social Affairs.

While reasonable efforts have been made to ensure that the contents of this publication are factually correct and properly referenced, neither UN Women nor the Ministry of Women and Social Affairs accept responsibility for any loss or damage that may be occasioned directly or indirectly through the use of, or reliance on, the content of this report, including its translation into languages other than English.

All rights reserved. Printed in Ethiopia.

TECHNICAL REPORT

ECONOMIC COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN ETHIOPIA

Federal Democratic Republic of Ethiopia
Ministry of Women and Social Affairs

FRONTIERi

NUI Galway
OÉ Gaillimh

UN WOMEN

LIST OF ACRONYMS

ATET	Average Treatment Effect on the Treated
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
EWLA	Ethiopia Women Lawyers Association
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender Based Violence
IDI	Individual In-depth Interview
IPV	Intimate Partner Violence
KII	Key Informant Interview
MoH	Ministry of Health
MoJ	Ministry of Justice
MoWSA	Ministry of Women and Social Affairs
OOP	Out-of-pocket
OSC	One-Stop Center
PSM	Propensity Score Matching
RCC	Revised Criminal Code
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SPSS	Statistical Package for Social Sciences
UN	United Nations
USD	United States Dollar
VAWG	Violence against Women and Girls
WHO	World Health Organization

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES/FIGURES

LIST OF TABLES/FIGURES

PREFACE

Violence Against Women and Girls (VAWG) has been recognized as a human rights violation and public health problem globally. In Ethiopia, VAWG in general and intimate partner violence in particular continues to be a major challenge and a threat to women's empowerment. According to the Ethiopian Demographic and Health Survey 2016, 1 out of 3 (34%) ever-married women aged 15-49 ever experienced spousal violence in the form of emotional, physical and/or sexual violence by their current/most recent husband/partner. More specifically, 24% of ever-married women experienced emotional violence, 24% experienced physical violence, and 10% experienced sexual violence.

More recently, there has been a growing concern about the significant economic costs of violence against women and girls for individuals and families, as well as for the national economy. In 2013, the 57th session of the Commission on the Status of Women (CSW57) noted the economic and social harm caused by such violence (para 11.) and urged all governments to carry out continued multidisciplinary research and analysis on the structural and underlying causes of, cost and risk factors for, violence against women and girls and its types and prevalence.

Measuring the costs of violence against women will determine how violence affects women, households and the State. Such analysis of the cost enables governments to understand the magnitude of the challenge and to make an informed decision about how public resources should be allocated. Furthermore, estimating the full cost of VAWG will in turn enable governments to understand the benefits of prevention and/or management of VAWG.

On behalf of UN Women, I would like to commend the government of Ethiopia under the leadership of the Ministry of Women and Social Affairs for its high commitment and leadership in the undertaking of this important study in Ethiopia . Partnering with the National University of Ireland, Galway brought so much insight as the University has years of experience in the subject matter, including the capacity and commitment to thoroughly assess the economic cost of intimate partner violence. Moreover, the engagement of local level researchers to work closely with the University was also necessary to ensure knowledge transfer and ownership of the study.

I look forward to further interpretation of the results as they shape up decision making whilst influencing policy making and evidence-based programming.

Schadrack Dusabe
Representative to UN Women Ethiopia, OIC

ACKNOWLEDGEMENTS

This report has been supported by UN Women Ethiopia and the Ministry of Women and Social Affairs (MoWSA). However, the views expressed, and the information contained, in this report are not necessarily those of, or endorsed by, UN Women Ethiopia or MoWSA, which can accept no responsibility for such views or information, or for any reliance placed upon them.

The authors acknowledge the valuable input received from UN Women Ethiopia, MoWSA, and other key national stakeholders. The report would not have been possible without the invaluable generosity of women and service providers in the communities in Ethiopia who participated in this research. The authors equally express their gratitude to the key agencies who provide critical services for women survivors of intimate partner violence, including the Ministries of Health, Justice, MoWSA and NGOs such as the Ethiopian Women Lawyers Association (EWLA).

The authors also wish to acknowledge the technical input and feedback provided by Addisalem Befekadu, Seid Ail and Mahider Mulugeta and thank them for their steadfast support over the life of the project.

Nata Duvvury
Principal Investigator

Authors:

Frontieri Team:
Dereje Kifle
Jema Haji
Azeb Adefrsew
Medhane Zekarias
Dube Jara

NUI Galway Team:
Nata Duvvury
Caroline Forde
Mrinal Chadha

Suggested Citation:
Economic Costs of Intimate Partner Violence against Women in Ethiopia: Technical Report. Addis Ababa: UN Women Ethiopia

EXECUTIVE SUMMARY

Violence against women and girls (VAWG) is a pervasive social, economic and public health problem worldwide. A commonly accepted estimate provided by the World Health Organization (WHO) suggests that approximately one in three ever-partnered women have experienced either sexual and/or physical violence perpetrated by an intimate partner worldwide[1]. As such, the eradication of this pervasive societal issue is prioritised in Sustainable Development Goal (SDG) 5. Expanding our knowledge on the nature and multifaceted impact of VAWG, research on its wider social and economic costs is growing, enabling an understanding that can readily inform budgetary allocations for addressing this problem.

In Ethiopia, the 2016 Demographic and Health Survey (EDHS) estimated that 34% of ever partnered women aged 15 to 49 experienced physical, sexual and/or emotional violence by their current/recent partner. The seriousness of the issue has been recognized by the Ethiopian government and legislation, such as the Revised Family Code (2000) and Revised Criminal Code (2005), which criminalise most forms of VAWG, including intimate partner violence (IPV) in the context of marriage or irregular union which leads to grave injury or mental health problems. Elimination of VAWG is further prioritised in the 2017 Women's Development and Change Strategy, the GTP II and the second National Human Rights Action Plan 2016-2020. However, to date, the wider social and economic costs of VAWG, and particularly the costs of IPV, in the country were unknown.

This study has been conducted to develop the evidence base on the economic impacts of VAW more broadly through estimating these impacts with a focus on IPV. We have employed a mixed methods approach to estimate the wider economic costs of IPV for women/households and the economy, as well as the costs of providing services to survivors of IPV. Focusing primarily on tangible monetary costs, estimates of out-of-pocket costs, foregone income and productivity loss due to violence have been produced. In addition, we provide an estimate of the various costs associated with providing violence services.

To gather information relating to individual experiences of women, structured interviews (surveys) were undertaken with 2,095 women, aged 18 to 59, in the four areas of Ethiopia that represent more than 80% of the national population - Addis Ababa City administration, Amhara region, Oromia region and the Southern Nations, Nationalities, and Peoples' Region (SNNPR). In-depth qualitative interviews were also conducted with 20 women in shelters/rehabilitation centers across the three regions and one city administration. These interviews enabled a better understanding of the impacts of violence on women, as well as their help-seeking behaviors and recovery processes.

To establish the costs of service provision, key informant interviews were undertaken with 87 service providers across the health, criminal justice, civil legal services and social services sectors. Care was taken to collect data from representatives in the four sectors across the different administrative levels of the country (ie., federal, regional, zonal and woreda levels). With the support of UN Women, we recruited representatives from Women, Children and Youth Affairs offices; Police Commissions/Stations (particularly women and children protection units); Federal and regional attorney general offices/Ministry of Justice bureaus (focusing on the women and children coordination offices at the head office level and the Special Investigation and Prosecution Units at the sub-city/woreda levels); Ethiopia Women Lawyers Associations (EWLAs); hotline services and organizations providing shelter/rehabilitation services; Federal and Regional Supreme Courts, First Instance Courts, Specialized courts; health centers and Hospitals (providing support services to victims of IPV at federal, regional and district levels), including women-friendly spaces. These spaces, also known as 'one-stop centers', provide a holistic multi-sectoral response across sexual and reproductive health and IPV through legal, clinical and psychosocial service provision.

Survey data was analysed in STATA and SPSS. Quantitative modelling, including propensity score matching (PSM), was undertaken to establish the implications of IPV for the overall economy. These methodologies provide, for example, estimates of the out-of-pocket expenses associated with IPV, the number of work and care workdays lost per incident of IPV and loss of household income due to IPV. Qualitative data was analysed using thematic content analysis, supported by ATLAS.ti version 8 software. Retrospective data was collected regarding the individual, household and community experiences of violence and to establish some economic and social implications.

Key Findings

Women who participated in this study have a mean age of 34.5 years, have some education, though mostly to primary level, and are predominantly based in rural areas. Nearly 70% of these women are of the Oromo or Amhara ethnicity and the majority are currently married. In addition, approximately 46% of women reported being engaged in economic activity.

[1] World Health Organization [WHO]. (2021). *Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women.* Geneva: World Health Organization.

Overall, 36% of women surveyed report ever experiencing physical, sexual, psychological and economic IPV, with 21% of women reporting IPV in the last 12 months. Just over a quarter of women (25.8 %) reported 'ever' experience of physical and sexual violence, while 13% of women reported such violence in the last 12months. An important insight of this study is that a majority of the incidents of IPV involve a combination of multiple behaviors that are physical, sexual, economic and psychological in nature. For costing, it is important to consider the totality of violence experienced, rather than specific types of violence.

The study broadly confirms the standard factors that are often considered to increase the risk of partner violence - younger age, lack of education, husband's drinking and substance abuse, low household wealth, and childhood experience of violence. Interestingly, employment emerged as a positive risk factor, rather than a protective factor, for women.

The aggregate cost of IPV in Ethiopia, including costs for women and households, as well as the potential cost of service provision, comes to 68,154,357,585 Birr (USD 1,312,652,927). In sum, this cost of IPV is equivalent to 1.21% of 2020 GDP. It demonstrates in clear terms the significant economic drain that IPV places on the economy, thus affecting the economic security and well-being of women and households.

Costs for Women and Households

A major cost women survivors of IPV incur is out-of-pocket costs (OOP) for seeking services such as medical treatment and legal support, and for repairing/replacing damaged property. On average, violence survivors spent 2,394 Birr in the last 12 months due to violence experienced in the past year, or roughly about 10% of an IPV survivor's annual income. The national estimate of OOP comes to 5.2 billion Birr (USD 100 million).

Loss of care work due to violence was another important cost for women and their households. Women survivors of IPV in the last year lost approximately 19 days of care work and their husbands missed about 11 days. This is quite close to the care workdays lost estimated in other studies and demonstrates the impact of IPV on the well-being of children and household members[2]. The monetary loss for care workdays comes to 2.1 billion Birr (USD 40 million).

IPV impacts women's productivity and income over the long-term. The current study estimated the productivity loss for working women due to 'ever' experience of violence, amounting to an average of 16.67 days in a year, which is significant. The monetary value is thus high, equating to about 5.3 billion Birr (USD 102 million).

Not unsurprisingly, and consistent with other costing studies[3], working women experiencing 'ever' IPV have a lower monthly income than working women who have not been subjected to IPV, by about 372.82 Birr. The total loss of women's income for all survivors amounts to 18.6 billion Birr (USD 358 million). If we consider the overall household, the loss of household income amounts to a monthly loss of 929.90 Birr. At the national level, this translates to an income loss of 31 billion Birr (USD 596 million).

Additionally, households experiencing IPV are found to have a lower monthly household expenditure than those not affected by IPV, by about 392 Birr. This translates to a national loss for households of 8.9 billion Birr (USD 171 million).

As is evidenced, the loss for Ethiopian households as a result of IPV is immense. Together, these losses (excluding women's income loss, which is captured in household income loss) amount to 52 billion Birr (USD 1 billion). This is the unrecognized loss for women and their households in Ethiopia due to IPV. The loss is, in fact, equivalent to 0.93% of 2020 GDP .

Costs of Service Provision

Next, we examine the costs of IPV service provision. The national potential cost of service provision across all sectors comes to 15.75 billion Birr (USD 303.3 million). This potential cost is based on the assumption that 22.5% of survivors seek help for services, as indicated in the 2019 EDHS[5].

More specifically, the service provision costs for the organizations that participated in our research amount to 580,011,217 Birr (USD 11,171,016) across the sectors. The largest costs among these participating organizations are in the health sector - 360,943,906 Birr (USD 6,951,780), followed by 104,211,937 Birr (USD 2,007,122) for criminal justice, 83,240,390 Birr (USD 1,603,210) for civil legal services and 31,614,984 Birr (USD 608,905) for social services.

---

[2] Asante, F., Fenny, A., Dzidzor, M., Chadha, M., Scriver, S., Ballantine, C., & Duvvury, N. (2019). *Economic and Social Costs of Violence Against Women and Girls in Ghana: Country Technical Report*. Retrieved from https://www.whatworks.co.za/documents/publications/302-10079-ghana-technical-report-final-web-file/file

[3] Morrison, A.R. and Orlando M.B. (2004). The Costs and Impacts of Gender-Based Violence in Developing Countries: Methodological Considerations and New Evidence. World Bank Discussion Paper.
And Duvvury, N. Minh, N. and Carney, P. (2012) *Estimating the Costs of Domestic Violence against Women in Vietnam* Hanoi: Govt. of Vietnam.

[4] At the time of writing, the official 2021 GDP was not available.

[5] Ethiopian Public Health Institute - EPHI, Federal Ministry of Health - FMoH, and ICF. 2021. *Ethiopia Mini Demographic and Health Survey 2019*. Addis Ababa, Ethiopia: EPHI/FMoH/ICF. Available at https://www.dhsprogram.com/pubs/pdf/FR363/FR363.pdf.

That the health sector incurs the largest costs for violence service provision echoes literature highlighting healthcare as a pivotal point of service delivery for survivors[6]. IPV is a direct and indirect risk factor for a variety of health problems frequently seen in healthcare settings. According to a variety of studies, women and girls experiencing violence access health services more frequently, including the emergency department, outpatient care, primary care services, and counselling services[7]. They are also more likely to report a worse health status and quality of life than those who do not experience violence[8].

The unit cost for the health sector in the current study is 25,868 Birr. This is substantially higher than the unit cost of 223 Birr for out-patient department (OPD) visits in primary hospitals as reported in a 2013/14 costing study in Ethiopia focused on the general costs of primary health care services provided at government primary hospitals and health centers[9]. However, our unit cost includes administrative costs and personnel training. As such, it is not comparable to the 2013/14 study unit cost. Taking the basic average unit cost for providing a health service, such as an exam, from the current study, we see that this cost is a little higher than that for general healthcare (300 Birr v 223 Birr). The findings highlight the significant drain IPV poses for healthcare service provision, nonetheless. Comprehensive prevention of VAW would enable such expenditure to be reallocated to other vital services.

Expenditure for the criminal justice (104,211,937), social services 31,614,984 Birr (USD 608,905) and civil legal (83,240,390) sectors is also substantial. Indeed, the social services cost is significantly less than the resources needed, a finding reflected in the service provider narratives in section 6.4 focusing on the challenges faced by organizations providing IPV services.

An important finding that also emerged from the KIIs involves the difficulty faced by participants when trying to distinguish between costs for GBV/VAW and costs for IPV. It Is evident that there are no specific services In Ethiopia for IPV and that specialized training for IPV is lacking. Given that IPV is the most prevalent form of VAW, in addition to the fact that the needs of IPV survivors are unique and extensive, this is a situation in need of remedy. Specific budgets for specialized service provision by comprehensively trained service providers across the relevant sectors must be allocated by the government.

The aggregate cost of IPV in Ethiopia, including costs for women and households, as well as the potential cost of service provision, comes to 68,154,357,585 Birr (USD 1,312,652,927). In sum, this cost of IPV is equivalent to 1.21% of 2020 GDP. It demonstrates in clear terms the significant economic drain that IPV places on the economy, thus affecting the economic security and well-being of women and households.

Recommendations

Government

- Build GBV prevention and response into national policies and budgets, and scale up current efforts to prevent and address GBV, including by mainstreaming evidence-based violence prevention and response approaches into education, health, social protection and other sectors.
- Invest in improving administrative data management and documenting budget allocation for GBV and IPV.
- Devote special attention to IPV in overall GBV programming and training, as the current response is primarily focused on GBV, and, in particular, sexual assault.
- Establish accountability mechanisms to ensure budget allocation for GBV/IPV.
- Integrate attention to impacts of IPV in macroeconomic and social planning and policies.
- Establish more IPV services, as well as better supports for frontline workers.
- Increase investment in research to establish the predominance and unique nature of IPV to catalyse efforts to legislate for IPV (marital rape etc.) and adequate sentencing for perpetrators.
- Enhance women's rights concerning divorce, particularly with regard to ensuring women obtain their share of the assets, including land.
- Provide economic empowerment and support for women, including enhancement of women's participation in women's issues, such as IPV.
- Multi-sectoral collaboration, including strengthening of the link between legislators and law enforcement agencies.

[6] Forde, C. and Duvvury, N. (2021). *Assessing the Social and Economic Costs of DV: A summary report*. Dublin: Safe Ireland; European Union Agency for Fundamental Rights (2014). *Violence against women: An EU-wide survey*. Luxembourg: Publications Office of the European Union.; Duvvury, Nata, and others (2015). *The Egypt Economic Cost of Gender-based Violence Survey (ECGBVS) 2015*. Cairo: UNFPA.

[7] See, for example: Grisso J.A., Schwarz D.F. et al. (1999). "Violent injuries among women in an urban area". *New England Journal of Medicine*, 341: 1899–1905.; Bonomi, A. E., Thompson, R. S. et al. (2006). "Domestic violence/coercive control and women's physical, mental, and social functioning." *American Journal of Preventive Medicine*, 30(6): 458-466.

[8] Asante, F., Fenny, A., Dzidzor, M., Chadha, M., Scriver, S., Ballantine, C., & Duvvury, N. (2019). *Economic and Social Costs of Violence Against Women and Girls in Ghana: Country Technical Report*. Retrieved from https://www.whatworks.co.za/documents/publications/302-10079-ghana-technical-report-final-web-file/file.

[9] Berman, P. and others (2016). *Costs of Publicly Funded Primary Care Facilities, Departments, and Exempted Services in Ethiopia*. Harvard T.H. Chan School of Public Health; Breakthrough International Consultancy, PLC: Boston, Massachusetts and Addis Ababa, Ethiopia.

Private Sector

- Introduce zero tolerance policies on GBV, including IPV, in the workplace and introduce code of conduct that upholds the right to be free from abuse.
- Introduce workplace policies including domestic violence leave to support survivors of domestic violence, whose productivity loss is a significant cost to business's reputation, profitability and sustainability.
- Establish financial and/or disciplinary sanctions for violations of the GBV, including IPV, code of conduct governing employees. Employers should also work with family members of perpetrators of abuse to identify and address their support needs.
- Liaise with civil society organisations to establish prevention campaigns within the workplace, as well as to establish a system of supports/referrals to meet the needs of both victims and bystander employees.
- Given that differences in economic power are a driver of IPV, businesses to review wage policies to minimize the gender differentiated wage gap, as a key policy to address IPV.

Civil Society

- Multi-sectoral collaboration to prevent and address IPV.
- Develop templates to record budget information for IPV, as well as a module to help build understanding of budgets.
- Advocate for gender-responsive budgeting, including allocation of adequate budgets for GBV/IPV-related interventions.

Donors

- UN organizations to motivate the government to increase their investment in IPV services.
- Bilateral and multilateral donors to coordinate their funding of violence services to ensure a comprehensive response.

Community

- Recognise the importance of families playing the 'biggest role in the community' and lead in implementation of IPV interventions focused on education, awareness raising and prevention.
- Facilitate community and household level dialogues on strengthening interpersonal communication.

1. INTRODUCTION

1.1 Overview of the Study

Violence against women and girls (VAWG) is a significant social, economic and public health problem worldwide, cutting across cultural and religious barriers. Research has found that, globally, approximately one out of every three ever-partnered women have experienced sexual and/or physical violence perpetrated by an intimate partner[10]. Intimate partner violence (IPV) "refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" [11]. The prevalence is even higher in Sub-Saharan Africa (SSA), where approximately 45.6% of women have been subjected to at least one form of IPV in their lifetime[12]. As such, the eradication of this pervasive societal issue is prioritised in Sustainable Development Goal (SDG) 5. To date, much has been learned about the nature and multifaceted impact of VAWG, from its physical and psychological consequences for individual women, to its wider effects on families, communities and societies. Research on the wider social and economic costs of VAWG is gaining momentum, thus expanding our knowledge base, and providing data to more directly inform budgetary allocations for addressing VAWG[13]. To date, this costing research has predominantly emerged from, and focused on, countries of the Global North. In addition, few studies, particularly of countries in the Global South, provide economic costs of VAWG at the national level[14].

'In Ethiopia, violence against women and girls continues to be a major challenge and a threat to women's empowerment'[15]. For example, the 2016 Ethiopian Demographic and Health Survey (EDHS) revealed that 34% of ever-married women aged 15-49 had ever experienced emotional, physical or sexual violence by their current or most recent husband/partner[16]. To date, the wider social and economic costs of VAWG in the country were unknown. UN Women Ethiopia, in collaboration with the Ministry of Women and Social Affairs (MoWSA), thus sought to address this gap in knowledge by commissioning a national study on the economic costs of intimate partner violence (IPV) that incorporates an exploration of its social costs. The National University of Ireland, Galway (NUI Galway), in collaboration with in-country partner, Frontieri, conducted this research, thus contributing to the growing global evidence base on the costs of VAWG.

1.2 Aims of the Study

The overarching aim of the study is to provide reliable estimates of the economic costs of IPV in Ethiopia. More specifically, the study provides estimates of the annual direct costs of IPV for households. Such costs include expenses for accessing services for medical care, shelter, mediation, and judicial resolution, as well as consumption costs related to the replacement of property.

The study also aimed to estimate the indirect costs of IPV, including income loss due to missed work and loss of reproductive labor, while providing an insight into the social costs associated with IPV, including reproductive health, physical health and mental health outcomes. Due to a dearth of available data, we could not calculate the following costs: children's missed school days and impacts on children's health. In addition, the research produces estimates of the annual IPV service provision costs across the following sectors: healthcare, criminal justice, civil legal services, and social services.

The study thus examines the impact of IPV at both the individual and societal levels. A mixed-strategy design was employed to combine the best of both quantitative and qualitative approaches, enabling complementarity and a fuller, more contextualised understanding of the costs of VAWG in Ethiopia[17]. The data produced will contribute to deepening the understanding among policymakers, political leaders, Non-government Organizations (NGOs), communities and families of the full cost of inaction[18].

[10] World Health Organization [WHO]. (2021). *Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*. Geneva: World Health Organization.

[11] *World Health Organization definition* - https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

[12] Muluneh, M.D and others (2020). Gender Based Violence against Women in Sub-Saharan Africa: A Systematic Review and Meta-Analysis of Cross-Sectional Studies, *International Journal of Environmental Research and Public Health*, 17(3): 1-21.

[13] Duvvury, Nata, and others (2019). *Guidance on Methods for Estimating Economic and Social Costs of Violence against Women and Girls in Low-and-Middle Income Contexts*. Galway: National University of Ireland, Galway; Council of Europe (2014). *Overview of studies on the costs of violence against women and domestic violence/coercive control*. Strasbourg: Council of Europe; Duvvury, N., Callan, A., Carney, P. and Raghavendra, S. (2013). Domestic violence/coercive control: economic costs and implications for growth and development. *Women's voice, agency, and participation research series no. 3*. Washington DC: The World Bank.

[14] Duvvury, Nata, and others (2019). *Guidance on Methods for Estimating Economic and Social Costs of Violence against Women and Girls in Low-and-Middle Income Contexts*. Galway: National University of Ireland, Galway

[15] Central Statistical Agency (CSA) [Ethiopia] and ICF. (2016). *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF, p. 289.

[16] Ibid.

[17] Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? Qualitative Research, 6(1), 97-113; Johnson, R. & Onwuegbuzie, A.J. (2004). Mixed methods research: a research paradigm whose time has come. Educational Researcher, 33(7), 14-2; Mason, J. (2006). Mixing methods in a qualitatively driven way. Qualitative Research, 6(1), 9-25.

[18] Costs incurred as a result of governments failing to adequately address the problem of VAWG.

2. CONTEXT

2.1 Overview of Context

As noted in Section 1.1, VAWG continues to pose a significant problem in Ethiopia. In this section, we review the social, political and economic context of Ethiopia to gain an understanding of the cultural and political structures that shape social life and the economic profile of the country, including the level of economic participation by women. Equally important is the legal and policy context for addressing VAWG in Ethiopia, as it shapes the well of service provision for survivors of violence.

2.2 Social, Political and Economic Context

The oldest of Africa's independent countries, the Federal Democratic Republic of Ethiopia is located in the Horn of the continent. It was the first independent African member of the 20th-century League of Nations and a founding member of the United Nations. Orthodox Christianity is the dominant religion in Ethiopia, followed by Islam[19]. Since the 1970s, droughts, famines and civil conflicts have negatively impacted the country and its economy. While the country has recovered and the state of war with neighbouring Eritrea has come to an end, poverty continues to pose a problem. Ethiopia seeks to progress to the lower-middle-income category by 2025. However, hunger, corruption and a weak infrastructure are significant issues, with the country ranking in the low category of the 2020 Human Development Index (HDI)[20]. Compounding these issues is the current and ongoing conflict in Northern Ethiopia, which will be discussed in section 2.3.

Ethiopia is the second most populous country in Sub-Saharan Africa and one of the fastest growing non-oil and non-mineral economies in the world[21]. According to the latest United Nations figures[22], the total population of Ethiopia is 120.8 million, with the majority of the people (57%) between the ages of fifteen and sixty-four. Females make up just over 50% (50.03) of the population. Administratively, the country is divided into eleven regional (ethnically based) states or Kililoch (Afar; Amhara; Benishangul-Gumuz; Gambela; Harari; Oromia; Somali; Southern Nations, Nationalities, and Peoples' Region (SNNPR); Tigray; Sidama; Southwest Ethiopia Peoples' Region (SWEPR), and two administrative cities (Addis Ababa and Dire Dawa). The national regional states' and two cities' administrative councils are further divided into eight hundred woredas and around 15,000 kebeles (5,000 urban and 10,000 rural). Urbanisation has been a strong feature of Ethiopian society. However, the vast majority (80%) of the population live in rural areas and women provide the majority of the agricultural labor in these communities[23].

2.2.1 Development Goals

Since coming into power in 1991, the Government has recognized peace and security, a governance system based on accountability and transparency, popular participation, and a democratic system that ensures freedom as well as human rights as the basic prerequisites for development[24]. All of Ethiopia's national policies, strategies, plans and programs are focused on sustainable development and the eradication of poverty through the integration of the economic, social and environmental dimensions of the SDGs. The 1995 Constitution of the Federal Democratic Republic of Ethiopia enshrines the economic, social and cultural right of all Ethiopians, regardless of gender. It encompasses all ratified international agreements such as the Convention on Elimination of Discrimination against Women 1979 (CEDAW).

Despite the low HDI ranking, Ethiopia has achieved the majority of the Millennium Development Goals (MDGs). The two MDGs not achieved relate to women - MDG 3: promote gender equality and empower women, and MDG 5: improve maternal health. Given the country's commendable performance overall, it was one of the fifty countries selected to provide data for the development of the 2030 Agenda for Sustainable Development. This agenda, along with the Sustainable Development Goals (SDGs) were adopted by Ethiopia in September 2015. The second Growth and Transformation Plan (GTP II) 2015/16 to 2019/20 has been aligned with the SDGs, building on the Growth and Transformation Plan (GTP I) 2010/11 to 2014/15 and the Plan for Accelerated and Sustained Development to End Poverty 2005/06 to 2009/10. The regional states and city administrations have also developed GTPs (II), signalling the country-wide commitment to the SDGs.

[19] Central Statistical Agency (CSA) [Ethiopia] and ICF. (2016). Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
[20] UNDP (2020). *The human development report 2020*. New York: UNDP.
[21] IMF (2018). *The Federal Democratic Republic of Ethiopia: IMF Country Report No. 18/354*, file:///C:/Users/35387/Downloads/cr18354.pdf
[22] UNFPA (2022). World Population Dashboard Ethiopia, https://www.unfpa.org/data/world-population/ET.
[23] US AID (2020). *Gender equality and women's empowerment*, https://www.usaid.gov/ethiopia/gender-equality-and-womens-empowerment.
[24] UNDP Ethiopia. (2018). Ethiopia's Progress Towards Eradicating Poverty: Paper to be presented to the Inter-Agency Group Meeting On the "Implementation of the Third United Nations Decade for the Eradication of Poverty (2018 – 2027)". Addis Ababa: UNDP Ethiopia.

The SDGs will be mainstreamed via the 10-year Perspective Development Plan for the period 2019/20 to 2029/30[25], which is fully aligned to the 2030 agenda and the SDGs. Several institutional mechanisms have been put in place, such as the National Planning Commission's (NPC) monitoring and evaluation role. In addition, a number of national development priorities have been identified in the GTP (II), including ensuring the agriculture development sector continues to be the backbone of the country's accelerated economic development, enhancing the economy through a greater focus on competitiveness, efficiency, productivity and quality, and enhancing women's labor force participation[26].

The NPC's 2017 SDG review explored progress to date, while highlighting some challenges the country faces in implementing policy directives, such as capacity constraints. Civil unrest is an additional difficulty. In both 2016 and 2018, a state of emergency was declared because of widespread public protests demanding social, economic and political rights to address issues such as youth unemployment and social exclusion in the Oromia and Amhara regions. Climate change and recurring droughts also pose a problem. These challenges are being addressed. For example, the current Prime Minister, Abiy Ahmed, is working to achieve improved domestic political participation and to enhance government transparency.

2.2.2 Poverty Reduction and Economic Growth

With regard to progress, Ethiopia has enjoyed sustained economic growth over the past decade, as well as making substantial progress on poverty reduction, mainly in urban areas[27]. Between 1995/96 and 2015/16, poverty decreased by 22%[28]. Pro-poor policies and development strategies implemented in urban and rural areas are credited for this achievement[29]. For example, the agricultural development strategy seeks to commercialize and enhance the productivity of smallholders, while the industrial development strategy focuses on promoting the development of competitive micro and small-scale enterprises. Initiatives, such as urban development programs, and the expansion of medium and large-scale private sector investments have also played a vital role in poverty reduction. In addition, income inequality remains low and stable over the past two decades (approximately 30%, measured by the Gini coefficient). However, the rural poverty gap (7.4%) is twice the urban poverty gap (3.6%)[30].

The country is currently implementing a Homegrown Economic Reform Plan[31], which comprises a mix of macroeconomic, structural and sectoral policies aimed at addressing imbalances, debt vulnerabilities, inflation and impediments in the private sector. The Ethiopian economy is mainly agricultural, and coffee is its largest export commodity. As the private sector grows, other exports include gold, leather products, oilseeds and, more recently, cut flowers. Labour force participation is 74.4% for females, compared to 85.6% for males[32]. Over half (66.5%) of the employed population work in the agriculture sector, followed by 23.7% in the services sector.

As of 2020, GDP per capita is 936.3[33]. Between 2003/04 and 2016/17, economic growth averaged 10.5%[34]. In addition, real per capita GDP more than doubled, from $32 billion in 2010/11 to $81 billion in 2016/17. Accordingly, per capita income also doubled, from $396 to $862, during the same period. 'The service sector has taken over the lead from agriculture in terms of its contribution to GDP while the share of agriculture declines but it was simply a shift from low productivity agriculture to another low productivity service sector which is characterized by a good deal of informality'[35]. The service sector contributes 39.3% of GDP, while agriculture contributes 36.3% and industry, the remainder.

2.3 Conflict in the Northern and Western Parts of the Country

As indicated in section 2.2, the ongoing conflict between the Ethiopian government and forces in the Northern Tigray region is having a disastrous impact on the country. It would seem that factors such as Ethiopia's system of government, human rights and the level of democracy underly the current crisis.

Though the situation has become relatively calm in most areas, recently and to a certain extent, there has been tension and armed clashes along areas bordering Tigray that may affect the flow of humanitarian and commercial supplies into Tigray and other conflict af-

[25] *Ethiopia 2030: The Pathway to Prosperity – Ten years Perspective Development Plan (2021-2030)*, file:///C:/Users/35387/Downloads/10_year_plan_english_final.pdf.
[26] National Planning Commission (2016). *Growth and Transformation Plan II (GTP II) (2015/16-2019/20)*, https://ethiopia.un.org/sites/default/files/2019-08/GTPII%20%20English%20Translation%20%20Final%20%20June%2021%202016.pdf.
[27] World Bank (2020). *Ethiopia Poverty Assessment: Harnessing Continued Growth for Accelerated Poverty Reduction*. Washington DC: World Bank.
[28] Planning and Development Commission (2018). *Poverty and Economic Growth in Ethiopia 1995/96-2015/16*. Addis Ababa: Planning and Development Commission.
[29] National Planning Commission (2016). *Growth and Transformation Plan II (GTP II) (2015/16-2019/20)*, https://ethiopia.un.org/sites/default/files/2019-08/GTPII%20%20English%20Translation%20%20Final%20%20June%2021%202016.pdf.
[30] Planning and Development Commission (2018). *Poverty and Economic Growth in Ethiopia 1995/96-2015/16*. Addis Ababa: Planning and Development Commission.
[31] IMF (2019). IMF Country Focus: Six Things to Know about Ethiopia's New Program, https://www.imf.org/en/News/Articles/2019/12/23/na122319-six-things-to-know-about-ethiopias-new-program.
[32] UNDP (2020). *The human development report 2020*. New York: UNDP.
[33] World Bank (2020). GDP per capita (current US$) - Ethiopia, https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=ET.
[34] UNDP *Ethiopia*. (2018). *Ethiopia's Progress Towards Eradicating Poverty: Paper to be presented to the Inter-Agency Group Meeting On the "Implementation of the Third United Nations Decade for the Eradication of Poverty (2018 – 2027)"*. Addis Ababa: UNDP Ethiopia.
[35] Ibid: (p. 4)

fected areas[36]. According to IOM's Displacement Tracking Matrix (DTM), Ethiopia is one of the world's largest internally displaced populations, with an estimated 4.2 million Internally Displaced Persons (IDPs) as of September 2021[37]. Of the total number of IDPs, 1.8 million were in Tigray, 151,040 in Amhara and 149,329 in the Afar regions[38]. Conflict (85%), climatic shocks such as drought, floods, and desert locust infestations were identified as primary drivers of displacement in Ethiopia[39]. The IOM report indicated that the displacement level doubled in 2021, when compared to 2020 (2.1 million), increasing dramatically due to armed conflict escalating and moving from Tigray Regional State to the neighbouring Amhara and Afar regions, resulting in an overwhelming humanitarian situation. Hostilities in other regions, particularly in the East, West and Haro Guduru Wollega zones of Oromia and the Benishangul Gumuz Region, were also contributing to the growing number of IDPs in Ethiopia. Due to the growing ethnic violence, horrific killings have been reported at different times, including women and children, with hundreds of thousands fleeing in search of safety and assistance[40].

2.4 Status of Women in Ethiopia

Gender equality is a fundamental right enshrined in the Ethiopian constitution (Article 35). However, as noted in section 2.2, the substantial economic progress Ethiopia made in relation to the MDGs was not matched by similar achievements in gender equality. To address this, the 2017 Women's Development and Change Strategy aims to foster an enabling environment for women to participate in economic, social, and political activities[41]. For example, rural women have been supported to obtain employment in a variety of sectors and they have been provided with land title-deeds[42]. In 2015/16, women in the industry sector also participated in training to build their capacity, with almost 100,000 micro and small women-owned businesses transitioning into medium level enterprises and 755,942 women joining the micro and small business sectors. In the first six months of the 2016/17 fiscal year, 1,073,833 women benefited from short and long-term loans, in particular from revolving funds. Furthermore, President Sahle-Work Zewde, Ethiopia's first woman president elected in October 2018, has made a commitment to the realisation of gender equality.

While Ethiopia was the most-improved country in the 2020 Global Gender Gap Index[43], closing 70.5% of its overall gender gap, it slipped by 15 points in 2021[44]. Overall, Ethiopia's ranking thus fell from 82nd (out of 153 countries) to 97th (out of 156 countries). Areas of note include health and politics. Ethiopia has achieved full parity on its Health and Survival sub-index. In addition, 32% of ministerial positions are held by women[45]. However, problems persist. For example, a lack of respect for female-headed households' right to use land resources has been recorded, along with a shortage of loan services, particularly for poor women[46]. In addition, the educational attainment gap continues to require work (25%)[47]. For example, though the primary school enrolment rate of girls has increased to 91% (from 21%) over the past three decades, the majority of girls are unable to transition to secondary and tertiary school due to distance, personal security and economic challenges[48].

Ethiopia has also yet to close 50+% of its gender gap with regard to income and wages[49]. Labor force participation is skewed towards men (86.7% v 76%) and few women are employed as skilled workers (29.9%) or at senior levels (26.5%). Furthermore, for every 100,000 mothers, 401 die giving birth, and only 27.7% of births are attended by skilled health personnel. VAWG is another serious issue, which is discussed in section 2.5.

2.4.1 Gender Equality Legislation

Ethiopia seeks to learn from other countries to ensure that gender equality is achieved. The Ethiopia Ministry of Women and Social Affairs (MoWSA) works to ensure gender equality and protects the rights and wellbeing of children. In addition to ratifying CEDAW in 1981, Ethiopia ratified the Maputo Protocol (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa), with reservation, in 2018. This protocol provides a legal framework for addressing gender inequality, as well as the underlying causes of women's subordination.

[36] OCHA (2022). *Situation Report: Northern Ethiopia Humanitarian Update*, https://reports.unocha.org/en/country/ethiopia.
[37] DTM (2022a). *DTM Ethiopia: Mobility Overview 2021*, https://dtm.iom.int/reports/ethiopia-%E2%80%94-mobility-overview-2021.
[38] Ibid
[39] IOM (2022b). *Ethiopia Crisis Response Plan 2022 (Summary)*, https://reliefweb.int/report/ethiopia/ethiopia-crisis-response-plan-2022-summary.
[40] Aljazeera (2021). *Worsening violence in western Ethiopia forcing civilians to flee, 20 Mar 2021, Updated: 29 Mar 2021; OCHA (2022). Ethiopia Humanitarian Bulletin, 31 January 2022.*
[41] UN Women (2019). *Fifth National Report on Progress made in the Implementation of the Beijing Declaration and Platform for Action (Beijing +25)*, https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/CSW/64/National-reviews/Ethiopia.pdf.
[42] National Planning Commission (2017). *The 2017 Voluntary National Reviews on SDGs of Ethiopia: Government Commitments, National Ownership and Performance Trends*. Addis Ababa: National Planning Commission.
[43] World Economic Forum (2020). *Global Gender Gap Report 2020*, https://www.weforum.org/reports/gender-gap-2020-report-100-years-pay-equality/.
[44] World Economic Forum (2021). *Global Gender Gap Report 2021*, https://www.weforum.org/reports/global-gender-gap-report-2021/.
[45] Data received from UN Women.
[46] National Planning Commission (2017). *The 2017 Voluntary National Reviews on SDGs of Ethiopia: Government Commitments, National Ownership and Performance Trends*. Addis Ababa: National Planning Commission.
[47] World Economic Forum (2021). *Global Gender Gap Report 2021*, https://www.weforum.org/reports/global-gender-gap-report-2021/.
[48] USAID (2022). Gender Equality and Women's Empowerment, https://www.usaid.gov/ethiopia/gender-equality-and-womens-empowerment
[49] World Economic Forum (2021). *Global Gender Gap Report 2021*, https://www.weforum.org/reports/global-gender-gap-report-2021/.

The Ethiopia Constitution and the Revised Family Law further mandate that marriage provide equality between spouses during the conclusion, duration and dissolution of the union[50].

In addition, discrimination against female workers, in matters of remuneration, on the grounds of their sex, is prohibited under Article 14(1)b of the Ethiopian Labour Proclamation, while Article 14(1)f prohibits discrimination based on gender and other grounds[51]. However, according to Tewoldebirhan Alemayehu (2019)[52], discriminatory laws isolate women from the labor force by limiting their career opportunities and earning potential. As such, employment law reform is required to support Ethiopia's progress towards greater gender equality.

2.5 Violence Against Women in Ethiopia

A module on violence against women (VAW) was included in the Demographic and Health Survey (DHS) for the first time in 2016, thanks to MoWSA. This module assessed the prevalence of physical and sexual violence perpetrated against women by any individual, prevalence of marital control, prevalence of spousal violence, injuries as a result of spousal violence and women's help-seeking behavior. The Ethiopia DHS (EDHS) also assesses the prevalence of female genital mutilation/cutting (FGM/C).

2.5.1 Intimate Partner Violence

The 2016 EDHS[53] revealed that 34% of ever-married women aged 15-49 had ever experienced physical, sexual or emotional violence by their current or most recent husband/partner. Physical violence 'involves hurting or trying to hurt a partner by hitting, kicking, burning, grabbing, pinching, shoving, slapping, hair-pulling, biting, denying medical care or forcing alcohol and/or drug use, or using other physical force. It may include property damage'[54]. Sexual violence 'involves forcing a partner to take part in a sex act when the partner does not consent'. Emotional violence 'includes undermining a person's sense of self-worth through constant criticism; belittling one's abilities; name-calling or other verbal abuse; damaging a partner's relationship with the children; or not letting a partner see friends and family'.

Intimate partners' controlling behaviors (at least three types) were further reported by 16% of ever-married women. In addition, 28% of ever-married women aged 15-49 have experienced physical or sexual IPV at least once in their lifetime, with 20% of the same population reporting physical or sexual IPV in the last 12 months. In addition, 81% of women who experienced emotional, physical and/or sexual spousal violence reported their husbands/partners were often drunk.

Further analysis of the 2016 EDHS IPV data by MoWSA (then MoWCYA) provides a breakdown of violence by variables such as education and women's property ownership[55]. For example, it was found that the empowerment of girls and young women through higher education translates, to some degree, into lower levels of spousal violence over a woman's lifetimes. The analysis also explored the relationship between VAWG and women's empowerment, negative consequences of VAWG and women's help-seeking behaviors. For example, a mere 23% of women who experienced physical and/or sexual violence sought help.

In addition, some local studies have reported much higher rates of both physical and sexual violence. For example, in a study conducted in Gondar Referral Hospital, the overall prevalence of domestic violence among pregnant women was estimated to be 58.7%, with emotional violence being the most common form (57.8%), followed by physical violence (32.2%) and sexual violence (7.6%)[56].

Further, a systematic review and meta-analysis of eight studies by Alebel et al (2018)[57] reported a 26% overall prevalence of IPV among pregnant women in Ethiopia, with the highest observed prevalence in the Oromia (35%) and Amhara regions (29%), the two most populous regions in the country. For the studies included, the mean age of the respondents ranged from 25±6 to 29.8±5.8. Finally, a 2020 study[58] has shown that 30% of ever-married women in reproductive age have experienced at least one type of IPV in their lifetime.

It is also important to note that the violence women experience takes many forms, including FGM and child marriage, which have not been considered in this report. For example, the 2016 EDHS reported that 40% of women aged 20 to 24 years were first married or in union before the age of 18, while 65% of girls and women aged 15 to 49 years had undergone female genital mutilation/cutting (FGM/C). Though these figures remain high, substantial progress has been made in relation to reducing these issues[59].

[50] Federal Negarit Gazette of the Federal Democratic Republic of Ethiopia. *Labour Proclamation*, https://www.mtalawoffice.com/images/upload/Labour-Proclamation-No_-1156-2019.pdf.
[51] Ibid.
[52] Tewoldebirhan, M. and Kuoh, A. (2019). *The next steps for employment equality in Ethiopia*, https://blogs.worldbank.org/opendata/next-steps-employment-equality-ethiopia
[53] Central Statistical Agency (CSA) [Ethiopia] and ICF. (2016). *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
[54] https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence
[55] MOWCYA (now MoWSA) (2019). F*urther Analysis of Findings on Violence Against Women from the 2016 Ethiopia Demographic and Health Survey*. Addis Ababa: UNFPA and UN Women.
[56] Fekadu, E. and others (2018). Prevalence of domestic violence and associated factors among pregnant women attending antenatal care service at University of Gondar Referral Hospital, Northwest Ethiopia. *BMC Women's Health*, 18: 138, doi: 10.1186/s12905-018-0632-y.
[57] Alebel, A. and others (2018). Intimate partner violence and associated factors among pregnant women in Ethiopia: A systematic review and meta-analysis. *Reproductive Health*, 15(196): 6, https://doi.org/10.1186/s12978-018-0637-x.
[58] Gebeyehu, A. and Tadesse Cherie, K. (2020). Prevalence of intimate partner violence against women and associated factors in Ethiopia. *BMC Women's Health*, 20(1): 22.
[59] UNFPA and UNICEF (2022). *UNFPA and UNICEF in Ethiopia call for renewed commitment to end female genital mutilation in Ethiopia* https://www.unicef.org/ethiopia/press-releases/unfpa-and-unicef-ethiopia-call-renewed-commitment-end-female-genital-mutilation-0

2.5.2 Women's Employment and Intimate Partner Violence

Based on the identification of data gaps and lessons learned from the 2016 EDHS survey, the report set out several recommendations to enhance integral components of the (ongoing) 2021 EDHS, including measures of VAWG, such as economic violence, which 'involves making or attempting to make a person financially dependent by maintaining total control over financial resources, withholding access to money, and/or forbidding attendance at school or employment'[60].

Although such violence was not included in the 2016 DHS VAW module, the 'status of women' theme explores women's decision-making concerning the use of their earnings, as well as their participation in household decisions about large household purchases[61]. However, women's lack of access to the household's financial resources, property and durable goods, as well as the labor market, is not directly measured.

Also omitted is men's deliberate non-compliance with their economic responsibilities, such as alimony or financial support of the family. However, a previous 2013 study by MoWSA (then MoWCYA)[62] identified the following common forms of economic violence by husbands: denying wives money to fulfil household needs; denying wives their share of common property during marriage; denying wives their share of the marital property to which they have contributed equally, when married, upon divorce; denying wives their rights to land (e.g., leasing land, share cropping, selling products of the land). This study also revealed that most incidents of economic violence reported to the police and MoWSA offices involved land claims and divorce cases where women were denied financial support, their share of assets and access to their children.

Economic IPV can also take the form of women being denied the opportunity to work by their partners or, where they are working, partners taking control of their earnings. Indeed, the relationship between women's labor force participation and IPV is complex. There are a number of positive impacts of increased labor force opportunities for women, such as decreasing child marriage and childbearing[63], and improving women's bargaining power within the household[64]. In addition, working women appear to enjoy greater economic independence and freedom of movement[65]. With regard to outcomes for children, women's employment can increase family investments in their children's health and education[66]. However, it is also evident that employment opportunities may increase a woman's risk of suffering IPV[67].

2.5.3 Impact of Intimate Partner Violence

According to the 2019 EDHS, of ever-married women who experienced physical or sexual IPV, 22% reported injuries such as cuts, bruises, or aches (19%), 10% reported deep wounds, broken bones, and broken teeth, while 7% reported eye injuries, sprains, dislocations, or burns. This violence also impedes women and girls' freedom of movement, as well as their ability to study and work, access services, participate in public life, and enjoy recreation opportunities[68]. Indeed, it is well established that IPV often leads to both short and long-lasting physical, emotional and financial consequences that are not confined to the survivor alone, thus impacting their family, friends and wider society[69].

Some of the most immediate economic costs associated with IPV include foregone income from missed work (paid and unpaid), lost employment and productivity, out of pocket expenditures to access services, and the cost of replacing lost property[70]. The long-term costs of IPV for children involve a wide range of emotional, social, cognitive, and behavioral maladjustment problems[71].

---

[60] UN Women. Frequently asked questions: Types of violence against women and girls, https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence.

[61] Central Statistical Agency (CSA) [Ethiopia] and ICF. (2016). *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF

[62] Ibid.

[63] Bandiera, O. and others (2015). *Women's economic empowerment in action: Evidence from a randomized control trial in Africa*. Geneva: ILO.

[64] Heath, R. (2017). *The causes and consequences of increased female education and labor force participation in developing countries. NBER Working Paper Series*. Cambridge, MA: National Bureau of Economic Research

[65] Kabeer, N. (). *Women's economic empowerment and inclusive growth: labour markets and enterprise development*, https://www.lse.ac.uk/gender/assets/documents/research/choice-constraints-and-the-gender-dynamics-of-lab/Women%27s-economic-empowerment-and-inclusive-growth.pdf.

[66] Luke, N. and Munshi, K. (2011). Women as agents of change: Female income and mobility in India. *J Dev Econ* 94(1):1–17.

[67] Hjort and Villanger (2012), cited in Aguero (2012). *The evil of flowers: women's work and domestic violence in Ethiopia*, https://blogs.worldbank.org/impactevaluations/the-evil-of-flowers-women-s-work-and-domestic-violence-in-ethiopia)

[68] UN Women (2019). *Safe Cities and Safe Public Spaces for Women and Girls Global Flagship Initiative: International compendium of practices*. New York: UN Women.

[69] Murray and others (2018). The Intergenerational Effects of Intimate Partner Violence in Pregnancy: Mediating Pathways and Implications for Prevention. *Trauma Violence and Abuse*, 21(5):964-976; Cora Peterson, Megan C. Kearns, Wendy LiKam Wa McIntosh, Lianne Fuino Estefan, Christina Nicolaidis, Kathryn E. McCollister et al . Am J Prev Med. 2018 October ; 55(4): 433–444. doi:10.1016/j.amepre.2018.04.049; Tang et al, 2012; Hill, 2009)

[70] Christopher Krebs, Christine H. Lindquist, Tara D. Warner, Bonnie Fisher, and Sandra Martin, "The Campus Sexual Assault (CSA) Study," (Washington, DC: RTI International, 2007). <https://www.ncjrs.gov/pdffiles1/nij/grants/221153.pdf> (accessed June 20, 2017).; Tang Zhang, Josh Hoddenbagh, Susan McDonald, Katie Scrim (2012). An Estimation of the Economic Impact of Spousal Violence in Canada.

[71] Christopher Krebs, Christine H. Lindquist, Tara D. Warner, Bonnie Fisher, and Sandra Martin, "The Campus Sexual Assault (CSA) Study," (Washington, DC: RTI International, 2007). <https://www.ncjrs.gov/pdffiles1/nij/grants/221153.pdf> (accessed June 20, 2017).; Tang Zhang, Josh Hoddenbagh, Susan McDonald, Katie Scrim (2012). An Estimation of the Economic Impact of Spousal Violence in Canada.; Fortin, Andrée. 2009. L'Enfant Exposé à la Violence Conjugale: Quelles Difficultés et Quels Besoins D'Aide? Empan. 73, 119-127.

IPV further results in negative impacts at the macro-economic level, undermining poverty reduction efforts[72].

The *What Works to Prevent Violence: Economic and Social Costs of VAWG* project (2014-2019)[73] was conducted in Pakistan and two African countries, Ghana and South Sudan, to estimate the costs of VAWG using innovative methods that integrated quantitative and qualitative approaches. In South Sudan, working women who experienced violence and reported missing work missed, on average, 7 days[74]. Lost income as a result of missing work due to IPV amounts to almost US$ 286 million annually to households in Ghana[75]. In addition, children missed 300,000 school days per year in Ghana because of the violence their mothers experienced.

Governments also incur costs in providing services to survivors and, to varying degrees, perpetrators, as well as in investing in programs to prevent violence[76]. In addition, there is the loss of taxes due to lower household incomes and lower economic output for businesses[77].

2.5.4 Violence against Women and the Conflict

VAWG in Ethiopia has been exacerbated by the conflict in the Northern part of the country[78]. There have been reports of widespread gender-based violence by different actors in the conflict including allied militia in the Tigray, Afar and Amhara regions. Between November 2020 and June 2021 alone, 2,204 survivors reported sexual violence to health facilities across the Tigray region[79]. Lack of access to assistance, support and redress for survivors is a further problem, with cases substantially under-reported due to fear, stigma and inability to access services.

UN bodies, such as UN Women, UNFPA and UN OHCHR, among others, have called on the government of Ethiopia and the international community to increase efforts to end the conflict and all forms of violence[80]. The MoJ has established an inter-ministerial taskforce to oversee investigation and legal action concerning human rights violations in the conflict. This taskforce has established four committees that focus on Investigation and Prosecution, Refugees and IDP Affairs, Sexual and Gender-Based Violence, and Resource Mobilization. UN agencies including UNFPA, UNICEF, UN Women and UN OCHA, among others, provide significant support to the government to address violence. For example, UNFPA is expanding support concerning protection, prevention and response to gender-based violence, and delivering quality sexual and reproductive health and rights (SRHR).

2.5.5 Violence against Women Legislation

We will now look at VAWG legislation in Ethiopia. In addition to CEDAW, the elimination of VAWG is further prioritised in the 2017 Women's Development and Change Strategy, the GTP II and the second National Human Rights Action Plan 2016-2020. Legislation addressing VAWG includes the Revised Family Law 2000, which has abolished most of the discriminatory provisions of the Civil Code in relation to marriage, and the Revised Criminal Code 2005[81]. The latter code criminalizes rape, abduction, child marriage and female genital mutilation/cutting (FGM/C). These legal and policy frameworks signify Ethiopia's commitment to eradicating VAWG, as much work remains.

The Revised Criminal Code (RCC) of 2005 criminalizes most forms of VAWG, including rape outside of wedlock (RCC articles 620-28), trafficking of women (RCC article 597), intimate partner violence (IPV) in the context of marriage or irregular union, in the event the violence leads to grave or common injuries to physical or mental health (RCC Article 564), and violence resulting in physical injury and/or mental health problems (RCC Article 555-560). However, significant gaps remain. For example, the criminal code does not criminalize marital rape (yet a woman who 'compels a man to sexual intercourse, irrespective of any marital relationship with him, is punishable with rigorous imprisonment of up to 5 years', Articles 620 & 621). It also lacks a comprehensive definition of domestic violence (Article 564). Indeed, neither Code 'adequately address psychological violence and/or economic violence against women in the context of marriage and family'[82]. Furthermore, there are no procedural protections such as restraining orders or comprehensive, stand-alone laws to combat VAW and sexual harassment at the workplace.

In addition, the Codes fail to treat some forms of violence, such as those committed in intimate relationships, as serious crimes, particularly when such violence does not cause bodily injury or impairment of health. Furthermore, the Family Code has yet to be adopted by two regional states, Afar and Somali, for different reasons.

---

[72] Christopher Krebs, Christine H. Lindquist, Tara D. Warner, Bonnie Fisher, and Sandra Martin, "The Campus Sexual Assault (CSA) Study," (Washington, DC: RTI International, 2007). <https://www.ncjrs.gov/pdffiles1/nij/grants/221153.pdf> (accessed June 20, 2017).

[73] UK Aid. *What Works to Prevent Violence Against Women And Girls?*

[74] Elmusharaf, K. and others (2019). *Economic and Social Costs of Violence Against Women and Girls in South Sudan: Country Technical Report*. Galway: NUI Galway.

[75] ISSER, Ipsos MORI, International Centre for Research on Women (ICRW) and NUI Galway. (2019). *Economic and Social Costs of Violence Against Women in Ghana: Summary Report*. Galway: NUI Galway.

[76] UN Women (2017). *Status of Arab women report: Violence Against Women, what is at stake*, ESCWA, Lebanese American University and UN Women.

[77] Ibid.

[78] UN (2021). *Rights experts call for end to violence against women in Tigray conflict*, https://news.un.org/en/story/2021/12/1107122.

[79] Ibid.

[80] Onabanjo, J. (2021). *Ethiopia: UNFPA calls for the protection and justice for women and girls in Tigray*, https://www.un.org/africarenewal/magazine/july-2021/ethiopia-unfpa-calls-protection-and-justice-women-and-girls-tigray.

[81] Cunningham, C. and others (2018). *Child Notice Ethiopia*. Netherlands: UNICEF Eastern and Southern Africa Regional Office.

[82] (Ministry of Women, Children and Youth 2009, p. 4)

2.6 VAWG Support Services

The Government has also established important institutional mechanisms to address VAWG at both the federal and regional levels, nonetheless. According to the Ministry of Justice (MoJ), the National Coordinating Body on a Coordinated and Comprehensive Prevention and Response to VAW and Children and on Child Justice (NCB), has been monitoring, evaluating, supporting and coordinating the activities of NCB member government institutions. However, it appears that full implementation of their operational plan has encountered impediments[83].

As noted in section 2.4, MoWSA works closely with UN Women to achieve gender equality and eradicate VAWG. MoWSA is committed to ending VAWG by including indicators on violence reduction in its 5-year sectoral plan (2016-2020). In addition, eradicating VAWG is the focus of the 10-year perspective development plan[84]. The UN Women Ethiopia Country Office (ECO) is also implementing a four-year Programme on Ending Violence Against Women and Girls (EVAWG), which contributes to the overall goal of: *"Women and girls live a life free of violence"*.

In terms of the criminal justice sector, police and prosecution offices have Child and Women Protection Units, while federal and numerous regional courts have a special bench for VAW cases. Under the 2012 Revised Sentencing Guidelines, judges are required to increase the lower end of the penalty for GBV and sexual violence crimes under the criminal code, yet implementation has yet to be assessed. The Drafting and Dissemination Directorate of the MoJ is in the process of finalizing a draft National Legal Aid Strategy, which aims to bring together and harmonize current, fragmented legal aid provision in the country. This will have a significant impact on ensuring access to justice for GBV victims/survivors[85].

However, a number of challenges have been noted, such as the dearth of reliable data on the number of GBV investigations, prosecutions and convictions at the national level and the understaffing of the specialist investigative units[86]. Issues concerning current legislation, such as the fact that marital rape has yet to be criminalized, also require immediate attention.

As regards social services, there are an estimated 19 CSO VAWG shelters, providing rehabilitation and reintegration services in Ethiopia, as part of the Ethiopian Network of Women Shelters[87]. There are also an unknown number of government-run shelters/rehabilitation centers. UN Women have provided support for six Association for Women's Sanctuary and Development (AWSAD) shelters in different regions. They have also provided support to other shelters, such as Agar Ethiopia and the Good Samaritan Association. Due to the ongoing conflict in Northern Ethiopia, the Association for Women's Sanctuary and Development (AWSAD) have opened an additional two emergency shelters in Woldiya and Semera, bringing their total number of branches to eight (after the current study's data collection period)[88]. AWSAD is a non-profit organisation established to advance women's social and economic development in Ethiopia. All the above shelters provide holistic rehabilitation and reintegration services for women and girl survivors of violence, including transitional, women's-only shelter, psychological counseling, legal aid and additional services to help survivors recover from their trauma, be reintegrated into society and to create economic independence[89]. Ethiopia also has a number of hotline services such as Alegnta, which is run by Setaweet with the support of UN Women.

Shelter accessibility continues to pose a challenge, nonetheless, as the vast majority of shelters are located in the capitals of the regional states[90]. Restrictive eligibility criteria, which excludes women with disabilities, mental health problems and on the basis of pregnancy, is an additional factor hindering accessibility in some shelters. Government funding is required to expand services, as well as to enhance the capacities of existing services[91]. GBV reporting mechanisms also need to be enhanced in the VAWG social services sector. Further details on service provision concerning IPV will be discussed in section 6.

[83] Joint Report (2019). *Civil Society Joint Report on Violence Against Women in Ethiopia: Submitted For Consideration At The Third Cycle Universal Periodic Review Of Ethiopia*.
[84] *Ethiopia 2030: The Pathway to Prosperity Ten Years Perspective Development Plan (2021 – 2030)*, file:///C:/Users/35387/Downloads/10_year_plan_english_final%20(1).pdf.
[85] Telephone discussion with the Head of Legal Aid the of Ethiopian Women Lawyers Association (EWLA), April 11, 2022. Efforts made to reach the Drafting and Dissemination Directorate of the Ministry of Foreign Affairs have not been successful.
[86] Joint Report (2019). *Civil Society Joint Report on Violence Against Women in Ethiopia: Submitted For Consideration At The Third Cycle Universal Periodic Review Of Ethiopia*.
[87] UN Women Africa (2021). *I got my smile back: providing much-needed support to survivors of violence in Ethiopia*, https://africa.unwomen.org/en/news-and-events/stories/2021/11/providing-much-needed-support-to-survivors-of-violence-in-ethiopia - UN Women confirmed the recent closure of one of these organizations.
[88] Data received from UN Women.
[89] Association For Women's Sanctuary and Development (AWSAD), https://www.womankind.org.uk/partners/association-for-womens-sanctuary-and-development-awsad/
[90] UN Women (2016). *Shelters for Women and Girls who are Survivors of Violence in Ethiopia*, https://www.unwomen.org/en/digital-library/publications/2016/10/shelters-for-women-and-girls-who-are-survivors-of-violence-in-ethiopia
[91] Joint Report (2019). *Civil Society Joint Report on Violence Against Women in Ethiopia: Submitted for Consideration At The Third Cycle Universal Periodic Review Of Ethiopia*.

2.7 Current Knowledge on Social and Economic Impacts of Violence against Women

As highlighted in section 2.5.3, VAWG results in numerous social and economic costs. Despite the high prevalence and multifaceted impacts of IPV, national research on these costs had not been conducted in Ethiopia to date. This could be mainly due to lack of reliable data, or rigorous analytical and methodological requirements, or both issues. As previously noted, determining the economic costs of IPV helps to inform program planning and intervention efforts, as well as demonstrating how violence drains resources from, for example, agencies, the government, community groups and individuals. It further helps to highlight the significant consequences of IPV for economic growth and poverty reduction efforts.

Some costing work has been undertaken in Ethiopia, nonetheless. For example, a 2017 study by the World Bank and ICRW[92] explored the costs of inaction in relation to child marriage in the most impacted States, which included Ethiopia. This research clearly outlines the adverse impacts of child marriage and their associated costs in five domains: (i) fertility and population growth; (ii) health, nutrition, and violence; (iii) educational attainment and learning; (iv) labor force participation and earnings; and (v) participation, decision-making, and investments. The model employed assesses the impact of child marriage in terms of three levels of costs. The first level of costs estimated is the effect on earning, productivity and consumption. For example, the model estimates to what degree the impact of child marriage on education attainment translates into future earnings and productivity of young women, which would have overall implications for household income and, ultimately, on per capita consumption. A second level of costs that are estimated looks at the implications for private and public expenditures, particularly on programs to address the impacts of child marriage on health, nutrition and GBV. The third level estimates intangible costs or the non-monetary and social costs, such as chronic pain and suffering and reduced participation in decision-making.

The World Bank/ICRW model is essentially 'a what if exercise' using econometric techniques. The methodology focuses on establishing the outcome effects of child marriage. For example, the focus is on estimating the effect of an increase in child marriage on outcomes such as education or labor force participation. Once the size of the change is established, the estimation of cost translates the magnitude of impact into monetary terms. For example, a 1 per cent increase in child marriage may result in a 5% decline in labor force participation – this relationship is useful to project how many women could be in the labor force, but are not, due to child marriage. The findings indicate that the domains most negatively affected by child marriage are fertility and population growth, education and earnings, and the health of the children born of young mothers.

Another costing study in Ethiopia focused on the costs of primary health care services provided at government primary hospitals and health centers for 2013/14[93]. This study estimated the total costs (expenditure) of primary health care services and the total costs of services for the various service departments in each facility, consisting of outpatient, inpatient, maternal and child health, and delivery services. It also estimated the costs of specific preventive and curative services exempted from patient fees in public facilities. The sample consisted of 6 primary hospitals and 47 health centers from selected agrarian regions, urban centers, and developing regional states. The average departmental unit costs in primary hospitals were found to vary from 223 ETB (Ethiopian Birr) for out-patient department (OPD) visits to 647 ETB for deliveries. For health centers, these costs varied from 208 ETB for OPD visits to 772 ETB for deliveries (adjusted for outliers). In terms of fee-exempted service costs, individual immunizations amounted to 148-263 ETB for primary hospitals and 65-129 ETB for health centers, depending on the type of vaccine needed.

A supplemental study involving an expanded sample size - 24 primary hospitals (6 from the initial PHC cost study and an additional 18 primary hospitals) – enabled further analysis[94]. It was found that, on average, the majority of primary hospital expenditure is on human resources (51%), while 35% of expenditure is on drugs and supplies. The average unit cost for primary hospitals was estimated at 310 ETB per visit (excluding outliers). Unit costs for services range from an average of 226 ETB for OPD visits to 2,178 ETB for inpatient department (IPD) discharges in primary hospitals (adjusted for outliers). A large variation in unit costs across departments and regions was observed (eg. average of 530 ETB for OPD visit in Amhara versus 41 ETB per OPD visit in Tigray). It was also found that the costs per service for a range of fee-exempted services was lower for individual immunizations (162 ETB-240 ETB for primary hospitals, depending on vaccine type and after adjusting for outliers) than for service bundles requiring repeated delivery or care over time.

[92] Wodon, Q.T. and others (2017). *Economic impacts of child marriage: Global synthesis report (English)*. Washington, D.C.: World Bank Group. World Bank.

[93] Berman, P. and others (2016). *Costs of Publicly Funded Primary Hospitals, Departments, and Exempted Services in Ethiopia Supplement to Paper 1 with expanded sample of primary hospitals*. Harvard T.H. Chan School of Public Health; Breakthrough International Consultancy, PLC: Boston, Massachusetts and Addis Ababa, Ethiopia.

[94] Berman, P. and others (2016a). *Costs of Publicly Funded Primary Care Facilities, Departments, and Exempted Services in Ethiopia*. Harvard T.H. Chan School of Public Health; Breakthrough International Consultancy, PLC: Boston, Massachusetts and Addis Ababa, Ethiopia.

3. METHODOLOGICAL APPROACH

To answer the key research questions and to harness the strengths of both quantitative and qualitative approaches, the research design for this study involves a mixed-methods approach. While the costing aspect of the study places quantitative methods at the center, qualitative approaches are incorporated to strengthen the research. A well designed and executed mixed-methods approach enables the cross-checking of data and information from different sources. It also enables the data collection tools and the assessment of the costs of IPV to the victim/survivor, households, communities and the country to be tailored. In other words, a mixed-methods approach is inclusive in its nature and enhances the credibility of the findings and conclusions of the study, which is especially important when estimating the complex costs of IPV.

The qualitative component of the research was carried out simultaneously with the quantitative research. This enabled complementarity and a deeper understanding of the individual stories of women who have survived IPV. IPV often results in pain and suffering, trauma, fear and isolation. In extreme cases, it could result in loss of identity to victims/survivors and even loss of life. The negative impacts on children include poor academic performance and loss of affection, as well as the intergenerational transmission of violence. It is not possible to quantify or assign a monetary value to costs arising from these impacts. Thus, qualitative data was collected and analysed to provide an understanding of these intangible costs. In addition, qualitative research was undertaken to estimate the costs of service provision.

3.1 Conceptual Framework

In this project, we argue that IPV not only impacts individual women and their families, but also ripples through society and the economy at large. These impacts occur at the individual level (such as through missed workdays and health costs due to injuries and psychological distress), at the community/business level and at the state level. Economic impacts at each of these levels, including lost income at the individual level and loss of economic outputs for businesses via productivity loss, erode national tax income and undermine economic growth. Social costs also accrue at the individual, community and state levels. These impacts have serious consequences for well-being and capabilities, for social cohesion and participation, and for social stability. Many of these impacts cannot be immediately monetized. However, we hypothesise that over time they translate into economic costs, through for instance, chronic disability, limited access to, and performance in, education, and increases in social instability and conflict.

When conducting a VAW costing study, the variety of economic costs that can be estimated are broadly delineated into four main categories: direct tangible, indirect tangible, direct intangible, indirect intangible. Direct and indirect tangible costs have a monetary value, while direct and indirect intangible costs do not. Direct costs stem from the use of goods and services for which a monetary exchange is made. Indirect costs accrue from the effects of VAW that have an imputed monetary value such as lost income or reduced profits. To date, almost 60 studies, predominantly from countries in the Global North, have sought to document and quantify the impact of domestic violence (DV) at the individual, household and community levels[95]. These costs include the direct costs of services to treat and support abused women and their children and to bring perpetrators to justice. The indirect costs include lost employment and productivity, which undermines women's capabilities, and the costs of human pain and suffering[96]. A recent study conducted in Vietnam indicated that the costs of accessing services, missed work, and lowered productivity due to DV amounted in aggregate to 3.12% of GDP[97].

In the current study, the focus is placed on tangible monetary costs, estimates of out-of-pocket costs, foregone income and productivity loss due to violence. In addition, we provide an estimate of the various costs associated with providing violence services.

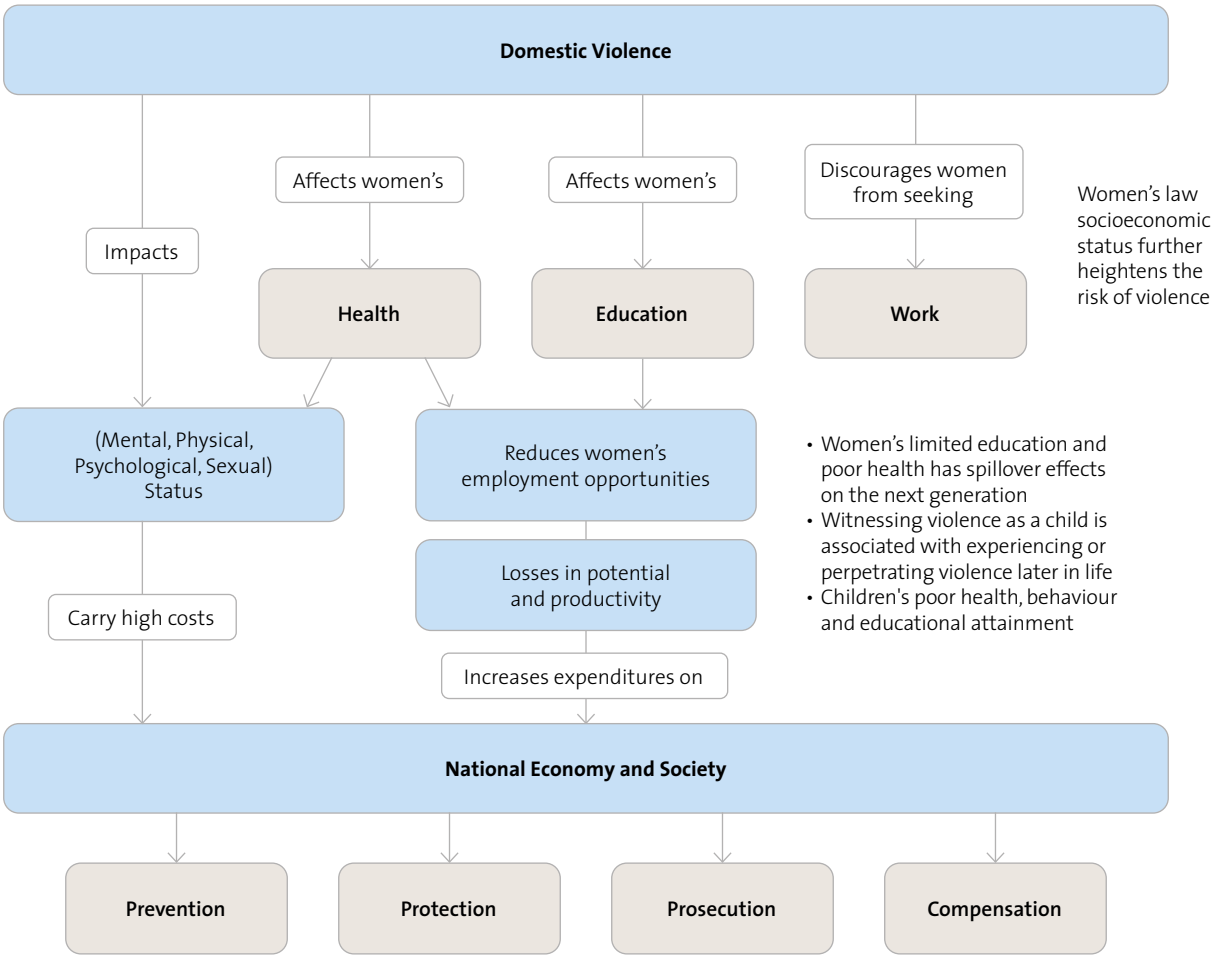
The range of economic and social costs at the individual/household level, community/business level and government/state level can be outlined in a conceptual framework (figure 1). It details the pathways through which economic and social costs contribute to national losses. Economic costs, such as lost personal and household income, undermine economic growth.

[95] See for example, Duvvury, N., Minh, N. and P. Carney (2012). *Estimating the cost of domestic violence against women in Viet Nam*. Hanoi, Viet Nam, UN Women; Duvvury. N., Attia, S., El Adly, N. et al. (2015). *The Egypt economic cost of gender-based violence survey*. Cairo: UNFPA; Walby, S. & Olive, P. (2014). *Estimating the costs of gender-based violence in the European Union*. Vilnius: European Institute for Gender Equality.

[96] Day, and others (2005). *The economic costs of violence against women: An evaluation of the literature - Expert brief compiled in preparation for the Secretary-General's in-depth study on all forms of violence against women*. United Nations; Duvvury, N., Callan, A., Carney, P. and Raghavendra, S. (2013). Intimate partner violence: economic costs and implications for growth and development. Women's voice, agency, and participation research series no. 3. Washington DC: The World Bank.

[97] Duvvury, N., Minh, N. and P. Carney (2012). *Estimating the cost of domestic violence against women in Viet Nam*. Hanoi, Viet Nam: UN Women.

Figure 1. Conceptual framework, economic/social impacts of violence against women and girls



3.2 Data Requirements, Sources and Collection Methods

3.2.1 Data Requirements

When estimating the costs of IPV in countries of the global South, a number of practical factors need to be taken into account[98]. Key among these factors is the absence or limited availability of information systems. In addition, the data requirements depend on the methodology to be used. Please see Annex 10.1 for further details.

3.2.2 Data Sources

Data on IPV can be obtained from different sources. These include household heads and/or women via sample surveys (as the closest proxy to real prevalence or incident rates), and administrative institutions dealing with reported cases of VAW by their partner (such as the police, justice, or health and social services). Official statistics are compiled and produced, usually by National Statistical Offices, based on data from surveys and/or administrative sources, but these only capture a fraction of the actual prevalence and incidence of VAW by their partners. The difference between actual prevalence and incidence of IPV on one hand, and disclosed IPV recorded by sample surveys on the other, can differ significantly. Despite its inability to capture the full prevalence of IPV, administrative data is important for assessing how public services respond to the needs of women who have experienced violence, and to monitor trends over time. However, the dearth of available administrative data in countries of the Global South in general, and Ethiopia in particular, limited the use of such data in this study. Accordingly, this data was complemented by quantitative and qualitative data collected using a mix of primary and secondary data collection methods.

3.2.3 Data Collection Methods

The following specific methods of data collection were employed: (i) Desk review; (ii) Household and women survey; (iii) In-depth Interviews (IDIs) and Key Informant Interviews (KIIs).

3.2.3.1 Desk Review

As in any empirical study, we first conducted a desk review of the available literature focusing on costing of IPV before and after data collection. A systematic review

[98] Duvvury, N. and others. (2004). *Costs of Intimate Partner Violence at the Household and Community Levels*. Washington: ICRW.

of the existing literature, along with the collection of relevant secondary data from different sources by the Frontieri team, and continuous consultative meetings with the NUI Galway team, laid the basis for the desk review. This helped us to identify the different approaches used to estimate the costs of IPV at the individual, household, community and country levels. It also assisted us to identify the types of costs, involving different sectors and actors; the basis for estimating the size of each economic cost; the data collection approach to be followed and evidence required, including surveys, documents concerning service provision and budgets, and interviews with experts; and the methods used to calculate IPV costs and impacts.

3.2.3.2 Quantitative data collection method

Estimation of the costs and impacts of IPV in Ethiopia requires generating quality and detailed quantitative data from a national survey that will allow identification of IPV and estimation of the prevalence, incidence and costs of IPV, as well as the impacts on households, society and the country. This is the most reliable method for collecting information on the extent of violence perpetrated against women in a general population. As such, a Household and Women survey was conducted with women aged 18-59 years and heads of households (who may be the woman)/other knowledgeable adult household member. The questionnaire was developed (drawing from previous costing surveys) and modified to the Ethiopian context in collaboration with the NUI Galway team and UN Women Ethiopia.

The initial sections of the questionnaire focused on the household details and were conducted with a head of household/other knowledgeable household member. The remaining sections of the survey were conducted with a selected woman. The main focus of the survey was to collect information on the selected woman's experiences of IPV and its impact on women, their spouses and children. Unlike data that is generated from other methods, such as administration records, in-depth interviews, and personal observation, population-based surveys help us to obtain information from randomly selected samples, which can easily be generalized to the overall population. Since they more closely reflect actual occurrences of victimization rather than what is reported to officials, population-based surveys that query respondents about victimization help us to understand the levels of IPV against women. The individual interview was conducted by trained enumerators/interviewers face-to-face and via a tablet/computer-based questionnaire.

It is believed that the success of this study, which is very sensitive, depends on the effectiveness of field operations, especially on the recruitment of field staff, that is, supervisors, enumerators and interviewers. Thus, an adequate number of experienced and qualified enumerators, interviewers and supervisors were recruited, trained and deployed to complete the fieldwork within the agreed time frame. Field staff were recruited mainly based on their experience of data collection on IPV, sexual and reproductive health, and HIV/AIDS, their communication skills in local languages and English, and past experience of tablet/computer-based electronic data collection. Recruitment was also underpinned by the following factors: ability to grasp the essence of the questions, interest and motivation to participate in the demanding fieldwork, commitment to work on a full-time basis, physical ability to travel and work in potentially difficult physical settings, familiarity with the study areas, ability to work as a team, sensitivity to different cultures and relevant technical skills and training (in data collection). In addition, more female data collectors were recruited as it is easier for them to approach women respondents and to understand their experiences, compared to male data collectors.

The training for field staff was conducted for one week with the main focus placed on IPV and how to communicate with survivors, as well as an emphasis on ethical standards involving survivor and interviewer safety, and confidentiality[99].

3.2.3.3 Qualitative Data Collection Methods

For the qualitative research, a mix of in-depth interviews (IDIs) and key informant interviews (KIIs) was employed. The IDIs were conducted with women survivors of IPV to explore their experiences, their journeys and how IPV has affected them. Intangible costs were also investigated, such as impacts on self-esteem, relationships, trust and social cohesion. A semi-structured, face-to-face, interview guide was developed and adapted to the Ethiopian context (based on the Vietnam costing study[100] guide). As such, the IDIs provided a deeper understanding of the impacts of IPV.

In addition, sector-wise key informant interviews (KIIs) were conducted with service providers to understand the costs of service provision. The KIIs enabled us to estimate institutional costs incurred by the government and other organizations in providing care and support services for survivors of IPV.

Mock IDIs and KIIs were conducted to ensure that the IDI and KII guide questions are age and gender appropriate, as well as trauma sensitive and informed. The guides were also piloted during the training session for interviewers and facilitators, and revised as required.

3.2.3.4 Translation of Data Collection Tools

The data collection instruments underwent standard quality checks that include questionnaire logic and flow tests, field tests and back-translation. Frontieri translated and tested all data collection instruments, making the necessary revisions. Accordingly, the Frontieri Team produced translated data collection instruments that have the exact same content as the original English version. We also ensured that the translated survey instrument has a semantic equivalence across languages, conceptual equivalence across cultures, and normative equivalence to the source survey instrument. Semantic equivalence refers to the words and sentence structure in the translated text expressing the same meaning as the source language.

[99] World Health Organization (2016). *Ethical and safety recommendations for intervention research on violence against women*. Geneva: WHO.

[100] Duvvury, N., Minh, N. and P. Carney (2012). *Estimating the cost of domestic violence against women in Viet Nam*. Hanoi, Viet Nam: UN Women.

3.3 Sampling Design

3.3.1 Study Area and Target Population

The study was carried out in three of the eleven regions of Ethiopia, namely Oromia, Amhara and SNNPR, and one of the two City Administrations, namely Addis Ababa. Fieldwork was conducted between September 2021 and December 2021. The three regions and one city administration together make up more than 80% of the total population of the country[101] and adequately represent the country's geographic and ethnic diversity. They also contribute about 82% to the country's GDP[102]. The target population for the quantitative component of this study was households and women from both rural and urban areas in Ethiopia. The target population for the IDIs was women in shelters/rehabilitation centers, and for the KIIs, representatives of organizations providing services to IPV survivors in the healthcare, criminal justice, civil legal services, and social services sectors. MoWSA provided support letters to region and sector offices, thus facilitating data collection.

3.3.2 Quantitative Data

3.3.2.1. Sampling techniques for quantitative data

The study employed multi-stage probability sampling (combining systematic, simple random and cluster sampling) techniques for selecting representative households and women. This involved a random selection of sample zones or sub-cities, woredas (districts), kebeles (wards) and households. Woredas (districts), kebeles (wards) and households were selected based on the sample regions'/city's contribution to the country's GDP. According to Amsalu et al. (2017)[103], the contributions of the Oromia, Amhara, and SNNPR regions, as well as Addis Ababa city, to Ethiopia's GDP are 33.6%, 17.3%, 19.9% and 11.2% respectively, totalling 82%. To allocate the 2,095 sample households to the sample regions and the city proportionately, the share of Oromia, Amhara, SNNPR regions and Addis Ababa city from the total sample of households have to be 41%, 21.1%, 24.3% and 13.6%, respectively. This resulted in a random sample of three zones from the Oromia region and two zones each from Amhara and SNNPR, and two sub-cities from the Addis Ababa city administration. Following this, three districts (2 rural and 1 urban) were randomly drawn from each zone of the three regions and three urban districts from the city administration, giving a total of 27 sample districts from three regions and one city administration. This was followed by listing all kebeles in the selected districts and randomly picking three kebeles from each selected district.

A sampling frame (lists of households) was obtained from the respective kebele administration of the selected kebeles. Then, the households to be included in the study were selected randomly. An alternative list of households was also prepared in case there was no woman satisfying the inclusion criteria in the selected household or the selected woman did not agree to participate. In cases where there are clusters in the kebele, 3-4 clusters were chosen randomly from each kebele. The addresses of the selected and alternative households were given to the enumerators and supervisors. It was not possible to get the list of households in some of the selected kebeles. In such instances, the enumerators/supervisors selected a landmark in certain areas of the kebele/cluster, and then every nth (such as 3rd or 4th) household was selected randomly in all directions from the central location marked, based on the density of houses in the kebeles. With regard to the selection of women, in case there was more than one adult woman in the household, one woman was selected randomly using a KISH grid. In addition to this, women in the households in each sample kebele were stratified based on age, education and work status. Finally, probability proportional to population size was used to randomly select 2,095 sample households from these kebeles for a household head/other knowledgeable household member and woman to interview. Table 1 below presents the sample zones, woredas, kebeles, households and women for the quantitative data.

Table 1: Sampling households for quantitative data

Region/City	Total Zones/ Sub-Cities	Sample Zones/ Sub-Cities	Total Woredas	Sample Woredas	Sample Kebeles	Sample Households
Oromia	22	3	287	9	27	858
Amhara	11	2	169	6	18	442
SNNPR	16	2	133	6	18	508
Addis Ababa	10	2	116	6	18	286
Total	60	9	705	27	81	2,095

Source: Schroeder (2017)

[101] Central Statistics Agency Ethiopia (2013). *Population Projections for Ethiopia 2007-2037*. Addis Ababa: CSA.
[102] Amsalu Y.W., H., Georg, L., Hermann and T. Stefan (2017). Economic Effects of Climate Change in Developing Countries: Economy-Wide and Regional Analysis for Ethiopia. CEPIE Working Paper, No. 10/17.
[103] Ibid

3.3.2.2. Sample size for quantitative data

The estimation of a representative sample size begins with identifying the outcome variable(s)/indicator(s) of interest. Given that the primary objective of the study is economic cost estimation of IPV at the national level, a good indicator for sampling purposes would be the estimated proportion of all women who reported experiencing IPV in recent studies. Using one such study by Chernet and Cherie (2020)[104], the prevalence rate of 'ever IPV' in Ethiopia is about 30% (0.3 of the population).

The sample size was thus estimated using the following formula:

$n = \{z2p(1-p)fk\}/e2 = \{z2\ p(1-p)[1+\rho(m-1)]k\}/e2$

Where,

n = sample size in terms of number of households/ women to be selected.

z = z-statistics corresponding to the level of confidence desired. The commonly used level of confidence is 95% for which z is 1.96.

p = estimates of the indicator of interest (i.e., for this study, we use an IPV prevalence rate of 30%)

f = sample design effect.

ρ = intra-cluster correlation coefficient (i.e., range from 0 [no intra-cluster correlation] to 1 [when all households in the same kebele/community are exactly alike].

m = average number of respondents selected per kebele/PSU (primary sampling unit), 15 HHs

e = margin of error, sampling errors or level of precision. The commonly used value for this is 0.05.

k = Factor accounting for non-response. For this study, 1.1 is the factor necessary to raise the sample size by 10% for non-response.

We computed the design effect using the formula: f = 1 + ρ (m – 1), where f is the design effect, ρ is the intra-class correlation and m is average number of sample respondents per cluster. Our choice of sample size is based on a two-sided 95% confidence interval (i.e., z = 1.96), a margin of error of 5% (i.e., e = 0.05), intra-class correlations of 0.35 and average number of respondents per cluster - 15 (i.e., f = 5.9), and prevalence rate of IPV in Ethiopia - 0.3 (30%). This would yield a total sample size of 2,095 respondents. Thus, a total of 2,095 households/ women was selected and the questionnaire was administered to individuals who met the inclusion criteria - the head of household (who may be the woman)/other knowledgeable adult household member (informed adult member of household who can respond to questions about the household in general and who has provided informed consent) and a woman (aged between 18 and 59 years, who has been partnered at least once in their lifetime, who is residing in the participating household and who has provided informed consent). There are two elements to non-response that we have considered – the selected household refused to participate; the selected woman refused to participate.

3.3.3 Qualitative Data

3.3.3.1 Sampling technique for qualitative data

For the IDIs, women who have experienced IPV were recruited through women's shelters/rehabilitation centers, in consultation with counsellors, across the selected study areas. These counsellors were available to provide support to the women if they experienced distress during the interview. Shelters providing rehabilitation and reintegration services for victims of IPV exist in all sample regions, with five in Addis Ababa, four in Amhara, three in Oromia and two in SNNPR. Participants for the study were recruited from two shelters in the Amhara region, namely Agar Ethiopia and the Organization for Prevention, Rehabilitation and Integration of Female Street Children (OPRIFS). In the Oromia region, women were recruited from the Adama rehabilitation center and, in SNNPR, women were recruited from the AWSAD Safe House. IDI respondents were not recruited from one-stop-centers (OSCs), police offices, courts, or prosecutors' offices to avoid re-traumatization.

For the KIIs, service providers were recruited from Women, Children and Youth offices; Police Commissions/Stations (particularly women and children protection units); Federal and regional attorney general offices/ Ministry of Justice bureaus (focusing on the women and children coordination offices at the head office level and the Special Investigation and Prosecution Units at the sub-city/woreda levels); EWLA legal service providers, hotline services and organizations providing shelter services; Federal and Regional Supreme Courts, First Instance Courts, Specialized courts; Hospitals and health centers (providing support services to survivors of IPV at federal, regional and district levels); and rehabilitation centers and shelters at federal, regional and district levels, as well as from offices at the local levels. Health, police, prosecutors and psychosocial service providers were also recruited from women-friendly spaces. These spaces, also known as 'one-stop shops', provide a holistic multi-sectoral response across sexual and reproductive health and IPV through legal, clinical and psychosocial service provision. The Rehabilitation Centers were approached via UN Women. Support letters from UN Women were useful to obtain cooperation from these organizations.

3.3.3.2 Sample size for qualitative data

The research team selected the interview participants using a purposive sampling technique. IDIs were conducted with 20 (5 per region) survivors of IPV. To ensure diversity within the sample, these women were purposively selected from urban/rural areas and different socio-economic backgrounds, including age, educational and marital status (currently married, divorced or separated; or currently or previously cohabiting with an intimate partner, which is considered as informal marriage).

Taking into account the size and availability of the relevant service provider institutions, a total of 87 KIIs were conducted across the study areas. See Table 1 for further details of the IDI and KII distribution.

[104] Chernet, A. G., & Cherie, K. T. (2020). Prevalence of intimate partner violence against women and associated factors in Ethiopia. BMC women's health, 20(1), 1-7.

Table 2: Distribution of KIIs and IDIs per study area/region

	Oromia				Amhara				SNNPR				Addis Ababa				Total			
	Region	Zone	District	Local	Region	Zone	District	Local	Region	Zone	District	Local	AA	Sub-city	District	Federal	Region	Zone	District	Local
Police Commission	1	3	1	2	1	1	1	1	1	1	1	1	1		1	1	4	5	4	5
Court	1	1	2		1	1	1		1	1	1	1	1	1		1	4	4	4	2
Women Affairs	1	1	2		1	1	1	1	1	1	1	1	1	1		2	4	4	4	4
Hospital And HC	1	2	1	1	1	1	1	1	1	1	1		1		1	2	4	4	4	4
Attorney General/ Ministry Of Justice	1	1	1		1	1	1		1		1			1	1	2	3	3	4	2
Rehabilitation Centers/ Shelters	2				2				2				2				8			
Hotline													1							
Lawyers Associations									1				1							
IDI	5				5				5				5				20			
Total	**12**	**8**	**7**	**3**	**12**	**5**	**5**	**3**	**13**	**4**	**5**	**3**	**13**	**3**	**3**	**8**	**47**	**20**	**20**	**17**
Region Total				**30**				**25**				**25**				**27**				**107**

3.4 Data Analysis Methods

3.4.1 Economic Costs of Intimate Partner Violence at Household Level

This section describes the methodology used in the estimation of the prevalence of violence; out of pocket (OOP) costs; unpaid household production, care work and missed school days; and productivity loss, comprising absenteeism, tardiness and presenteeism, predominantly based on Duvvury et al. 2019[105].

3.4.1.1 Prevalence of violence

This study estimates the prevalence of violence in the past 12 months, as well as violence ever experienced in a woman's lifetime. The prevalence rate was estimated by probing if women experienced specific behaviours of economic, psychological, physical and sexual violence. Women who are currently partnered or separated/divorced/or widowed in the last 12 months were asked about their experience in the last 12 months and the time preceding the last 12 months. Women who had been married or cohabitating in the time preceding the last 12 months were only asked about their experiences during this time. The data on behaviors was collected on an ordinal scale, which included 'never', 'rarely', 'sometimes' and 'often'. See Annex 10.2 for the behaviours examined. Given the gap in existing literature, we placed a greater emphasis on behaviors of economic violence in this survey.

If a woman experienced a particular form of violence, even once in the last 12 months, she was categorised as having experienced violence, following international practice[106]. If a survivor experienced violence in the last 12 months and/or violence in the time before the last 12 months, she was categorised as experiencing 'ever' violence.

Women were also asked how many incidents they experienced overall. To ensure better recall, women were asked to provide details of incidents that they experienced in the last 12 months - information on what happened (nature of the incident), any resultant impacts, help-seeking and the costs they incurred. The monetary cost estimation was based on this incident-wise information.

3.4.1.2 Out of Pocket Expenditure

Out of Pocket (OOP) costs are only estimated for incidents which happened in the past 12 months[107]. OOP costs include costs incurred by survivors for accessing health services, legal services, police services, legal services, shelter and mediation, as well as for property replacement.

Health Costs

The OOP health costs include money spent due to an incident of violence on services from a doctor, nurse, pharmacist or technician; hospital, clinic or health center (excluding overnight); hospital (overnight), tests (X-rays, labs... etc.), medicine and treatment; alternative medical treatment (like herbal medicine); other expenses related to health care (food, drink... etc.), including for companions; transportation; medical consultation; medical or health report(s); and receiving healthcare services (from psychiatrist, counsellor, etc) for mental health problems.

Legal and Police Costs

The OOP legal costs include costs incurred due to the incident by survivors for lawyers, court and litigation, consulting (going to a legal consultation centre), legal report(s), legal consultation(s) online and other expenses (transportation, communications, food... etc.). Police costs include police fees and transportation.

Property Replacement Costs

The OOP property replacement costs include expenditure on replacing damaged property due to the incident. These items include plates, tableware, other utensils; electronic devices (mobile, remote control, tablet, laptop...etc); electrical appliances, cars; bicycles/children's toys, antiques, wall clocks, carpets; clothes; furniture such as a sofa set; other (specified by survivors).

Shelter and Mediation Costs

The OOP shelter costs include transportation to a parent's home or other informal source of shelter; leaving the house/where the violence occurred; telecommunications and cell phone bills; other expenses (Accommodation (hotel, privately rented), food, drink, housekeeping... etc.). Mediation costs include expenses such as meals for elders, paying for transport, etc.

Total Out of Pocket Costs

The total out of pocket costs incident-wise are estimated as:

OOP Costs=Health Costs+Legal Costs+Police Costs+ Property Replacement Costs+Shelter Costs+Mediation Costs

[105] Duvvury, N., Scriver, S., Forde, C., Chadha, M., Raghavendra, S., O'Brien, L., . . . Ballantine, C. (2019). *Guidance on Methods for Estimating Economic and Social Costs of Violence Against Women and Girls in Low- and-Middle Income Contexts*. NUI Galway, Galway.

[106] Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet, 399*(10327), 803-813.

[107] While collecting data incident-wise helps to reduce recall bias, compared to data for the last 12 months, it has the limitation of excluding costs that may have been incurred in the last 12 months due to an incident/incidents that occurred prior to the last 12 months.

3.4.1.3 Care Work Loss

Care work loss, in the form of missed domestic work and care work for the elderly and children due to the incident, has also been estimated. Husbands may also cease doing domestic work and care work due to their violence against their wives. Therefore, their lost days have also been estimated.

The care work activities included are supporting children's education (reading, training and assisting them; childcare (feeding, cleaning, baby bathing, changing diapers, preparing children for school, medical/health care for children... etc); and care for the elderly and/or sick (personal care, medical care, accompanying the elderly to medical/health services, preparing food for the sick and/or the elderly).

Domestic activities include various housework chores (preparing meals, routine cleaning of rooms, bathrooms, kitchen, washing clothes, arranging household items, dusting, washing windows, polishing floors, getting rid of garbage...etc.); shopping for household needs (shopping/buying food products (groceries of all kinds), medical supplies, school supplies, gasoline, clothing, household appliances and furniture) and other housework chores (routine external cleaning of the garage, cleaning patio and collection of foliage).

Survivors were asked about the number of days the survivor and her husband completely or partially missed a particular activity due to the incident. If survivors reported 'partially' missing an activity for some days, the respective number of days were halved.

Missed care days were thus estimated as follows:

$$MCW = \sum_i (\sum_t (DFS_t * M_t) + (0.5 * DPS_t * M_t)) / \text{å}\, H_t \quad (2)$$

Where MCW is Missed Care Work, i individual woman, t the care activity (domestic activity, caring for children and caring for elderly or sick members), DFS days fully stopped on care activity t, DPS days partially stopped care activity t, and *M* is the average minutes spent on care activity t in a day. The sum of the hours of care work missed by activity t is divided by the hours spent on care activities in a day to derive missed days of care work.

In the survey, survivors were asked about approximate minutes they spend on these activities. However, as this data was not robust, average time use data from the Ethiopia Time-Use Survey 2013 has been used[108]. Within extended SNA, the Time-Use survey 2013 provides the average minutes for providing unpaid care giving services to children in the household; providing unpaid care giving services to adults in the household; providing unpaid services for domestic uses; and providing unpaid community services. For this study, we have excluded providing unpaid community services.

The Time-Use Survey 2013 report provides time-use for women aged 15-29 and 30-64. To provide an approximate time-use for this study, we have taken an average of time-use for activities for women aged 15-29 and 30-64. The average care-work days for women are estimated as the sum of the average minutes for providing unpaid care giving services to children in the household (77.5 minutes); providing unpaid care giving services to adults in the household (72 minutes); and providing unpaid services for domestic use (282 minutes), which is equivalent to a total of 431.5 minutes or 7.2 hours.

The average care workdays for husbands are also estimated as the sum of the average minutes for providing unpaid care giving services to children in the household (9 minutes); providing unpaid care giving services to adults in the household (91.5 minutes); and providing unpaid services for domestic use (181.5 minutes), which is equivalent to a total of 282 minutes or 4.7 hours.

To monetise care work, the median wages of both women and men were employed. The minimum wage of the sample was not used as it is extremely low. The wage was weighted to represent the wage of a care workday, not a workday.

3.4.1.4 Productivity Loss-Direct Approach

Productivity loss comprises absenteeism (missing work), arriving at work late or leaving work early (tardiness) and working irregularly or working less productively (presenteeism) as a result of violence. The survey included specific questions for the measurement of absenteeism, tardiness and presenteeism, adapted from Vara-Horna (2013)[109], and weights for estimation, drawn from Duvvury et al. 2022[110]. See Annex 10.3 for further details.

To monetise productivity loss, individual women's wages were used. Some survivors (27) had not reported in the screening questions that they had been engaged in economic activity; however, they had responded to questions on productivity loss in the last 12 months. Such survivors were therefore understood to be engaged in an economic activity in the last 12 months.

[108] CSA. (2014). Central Statistical Agency [Ethiopia]. Ethiopia Time Use Survey 2013.

[109] Vara-Horna, A. (2013). *Violence against women and the financial consequences for companies in Peru*. ComVoMujer, International German Cooperation GIZ & San Martin de Porres University, Lima. https://www.giz.de/de/downloads/giz-2013-de-gewalt-u-finanziellen-folgen-peru(1).pdf

[110] Duvvury, N., Vara-Horna, A., & Chadha, M. (2022). Development and Validation of Lost Days of Labor Productivity Scale to Evaluate the Business Cost of Intimate Partner Violence. *Journal of interpersonal violence*, 0(0), 0886260520944532. doi:10.1177/0886260520944532

3.4.1.5 National Costs

The national costs have been estimated as follows:

National Cost=Costs for survivors with 1 incident+Costs of survivors with 2 incidents+Costs for survivors with more than 2 incidents

$$Costs\ (Only\ 1\ incident)=\sum_{i=1}^{n} cost_i * expansion\ weight_i$$

Where n implies the survivor who incur various costs. Costs include OOP expenses, and care work and productivity loss.

$$Cost\ (Only\ 2\ incidents)=\sum_{i=1}^{n} cost_i * expansion\ weight_i$$

Where n implies the survivor who incurs various costs due to 2 incidents. Costs include OOP expenses, and care work and productivity loss.

Cost (More than 2 incidents)=Cost of 2 incidents+Cost of more than 2 incidents (3rd incident,4th incident etc.)

Cost of 3rd incident,4th incident etc.=Average incident cost

$$Average\ incident\ cost=\sum_{i=1}^{n} cost_z$$

Where z implies OOP coats, missed care work and missed work. For missed work loss per incident, incidents were weighted based on possible incidents of working women in the sample.

3.4.1.6 Econometric Methods

We also employed a widely used econometric technique known as propensity score matching (PSM) to rigorously establish the impact of violence experienced by women on various outcome variables of interest such as women's income, household expenditure (as a proxy for poverty), and productivity loss. Using these results of the PSM, we have calculated the costs of violence for the national economy.

The PSM technique involves identifying factors affecting lifetime-IPV and the outcome variables, estimating propensity scores, choosing matching methods, identifying the common support region, carrying out a balancing test, estimating treatment effects of lifetime-IPV across women experiencing this issue, and the population, and, finally, carrying out a sensitivity analysis. Essentially, the PSM technique controls for selection bias of respondents by calculating the probability (or propensity score) of each woman experiencing violence based on key variables that influence a woman's likelihood of experiencing violence. Women in the sample are matched in terms of propensity scores and a comparison is conducted of women who have similar probabilities of experiencing violence, with some experiencing violence and others not. The assumption is that the difference in outcome variables between these two groups of women can be attributed to the experience of violence. In other words, PSM is a method that can establish the causal effect of violence – it helps us to assert that the difference in outcomes, such as women's income, household expenditure, or women's productivity, is due to experiences of violence.

There are certain tests that are required to establish the robustness of the PSM model, including a balancing test, which assesses if the distributions of the probability of experiencing lifetime-IPV are similar between women who had, and had not, experienced lifetime-IPV (treated and control women). The second condition is what is known as 'common support area', which assesses whether women with the same characteristics have a positive probability (i.e. no probability) of experiencing violence. This was assessed by exploring the overlap range of propensity scores for women experiencing, and not experiencing, violence. The PSM steps undertaken in this study are presented in the results section.

3.4.2 Estimates of Costs of Service Provision

The findings from the qualitative research methods are vital for exploring intangible social costs of IPV to individuals, households and communities. The data obtained from the desk review and survey are complemented and validated by this data. The IDIs and KIIs were digitally audio-recorded and transcribed to produce text transcripts. The qualitative analysis of this data was supported by ATLAS.ti version 8 software.

3.4.2.1 Qualitative Analysis of IDIs

Thematic analysis was employed to analyse the qualitative data from the IDIs. The transcribed interviews were read through to enable an analytic framework (see Annex 10.4) involving main coding categories, which were further divided into sub-codes, to be devised. The first codes were developed from the objectives of the project, in conjunction with the theoretical framework and the expectation of certain responses. Once satisfied these coding categories accurately reflected the data, the transcripts were coded accordingly. As each passage of text was coded, additional codes emerged directly from the data, namely the topics and issues raised by the interviewees. As such, the coding process was based on conceptual categories (deductive coding) and emergent coding concepts (inductive coding). Explorations of the coded data were then carried out to further the analysis by identifying frequently occurring concepts and themes, relationships among codes and themes and major findings.

Once all of the transcripts were coded, the data units were brought together in separate code books relating to each coding category. Then, we looked for themes, patterns and contradictions within the data. Next, we produced a summary of elaborated themes from each code book and then explored the relationships between these themes. The material from the interviews was thus combined in order to create a coherent narrative. This analysis has enabled an understanding of important issues including women's experiences of violence and its myriad impacts, help-seeking behavior, the current situation of survivors and the impact of IPV on children. The IDI findings enrich and validate the findings from the survey by providing an insight into individual level experiences and a deeper understanding of the complex impacts of IPV.

3.4.2.2 Estimation of costs in sectors

KII data enabled an estimation of the costs of service provision for IPV in government, civil society and private organizations across the healthcare, criminal justice, civil legal services, and social services sectors. Service provision costs include operational and administrative costs, as well as activity and service costs. Employing the unit costing method, we deemed the bottom-up approach to be the most suitable. The bottom-up approach involves establishing a unit cost for providing a service, including personnel costs, equipment and material costs, infrastructure costs and recurring operational costs. In this study, the administrative cost covers personnel salary costs, infrastructure costs and recurring operational costs, such as utility costs. The service provision cost involves equipment and material costs to provide a service, and personnel training costs comprise expenditure to provide specialized IPV training to employees.

The major challenge for estimating the costs of service provision is the availability of data, particularly comprehensive data from the range of services that are offered to survivors of violence. Where readily accessible, cost data was collected from the participating organizations on the following: annual intake of women and girl survivors of IPV; IPV survivors as a percentage (approximately) of overall service users; unit costs of service provision to survivors; unit costs for service-specific activities; organization employee numbers; unit costs of personnel training on IPV; number of awareness-raising events; unit costs of awareness-raising events; administrative costs of running the service; percentage (approximately) of time spent with IPV survivors or women in general in the last year.

As there was a substantial amount of missing data, we imputed the number of IPV survivors seen by some organizations and associated unit costs, using the data obtained from organizations at the same level (average figures) – Federal; Regional; Zonal; Woreda. Then, we calculated the costs for each organization - service provision costs; personnel training costs; administrative costs. Given that the data obtained was too varied to make any reasonable assumptions for estimation, we excluded awareness-raising costs.

First, we calculated the service provision costs by multiplying the average annual number of women using the service for IPV by the overall unit costs for service provision (data from KIIs - specific service cost data was lacking). Next, we calculated the personnel training costs by multiplying the unit costs for personnel training by the organization numbers for employees working on IPV, which are estimates based on average data for employees at the different levels (federal, regional, zonal, woreda). As the KII participants provided the administrative cost data as an annual cost, rather than as a unit cost, no calculation was required.

The total costs for each organization were then summed. As it became clear from the KII transcripts that it was difficult to distinguish the IPV costs from GBV/VAW costs (no specific/focused services for IPV), we employed the relevant percentage for IPV service users to estimate the costs that can be attributed to IPV.

Once, the total costs for each organization were calculated, we summed the costs across the organizations in each sector to produce the total costs per sector. Aggregation across sectors was then obtained by a summation of the total costs per sector.

3.4.3 Estimate of National Costs of IPV

Given the variation in costs across sectors, we have opted not to impute sector level costs to the aggregate number of facilities in each sector to derive a national cost. Instead, to account for some of this variation, we have calculated a unit average cost of providing services overall and applied it to the prevalence rate of current violence and the EDHS 2019 help-seeking rate for survivors of any form of violence. The weights used were the proportions of the total number of IPV cases reported in the KIIs for each sector (see section 7.2 for further details). This enabled us to estimate the potential cost of service provision.

3.5 Data Quality Assurance Mechanisms

At Frontieri, all activities carried out and services delivered are subject to rigorous internal quality control. Our internal technical quality assurance system has been implemented at different stages of the study, including but not limited to pre-data collection, during data collection, and post data collection. The detailed technical quality assurance review mechanisms at every step of the study are summarized in Annex 10.5.

3.6 Ethical Considerations

The observance of the highest standard of research ethics during the entire study process was ensured. This involved adhering to Standards of UN research guidelines, standard good practice and professional integrity. Ethical considerations were based on the principle of DO NO HARM. As such, the training and data collection guides follow UN standards of ethical and safety recommendations for research[111]. The research team carefully attended to ethical considerations and potential risks for both participants and researchers.

Prior to data collection, ethical approval was obtained from the National University of Ireland, Galway Research Ethics Committee and the Ethiopian Society of Sociologists, Social Workers and Anthropologists (ESSSWA). As the issue of IPV is very sensitive, ethical protocol were put in place and followed strictly throughout the research by preparing gender-responsive ethical guidelines. The ethical guidelines include protocols that were followed during the qualitative and quantitative data collection processes. This included obtaining informed

[111] WHO (2016). *Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication. Putting women first: ethical and safety recommendations for research on domestic violence against women.* Geneva: World Health Organization. February 2016.

consent before conducting interviews, responding to distress and making referrals to support services where necessary, as well as ensuring the anonymity and confidentiality of individual-level data.

Participants were sent a Participant Information Sheet and Consent Form before the IDIs and KIIs outlining the purpose of the study, the role of the participants, what information was required from them, expected duration of participation, explanation of risks and benefits, voluntary participation and their right not to partake in, or withdraw from, the research at any stage. The information sheet also stated how confidentiality would be maintained, as well as the contacts for complaints or queries. Participants were also assured that there would be no negative consequences if they chose not to participate.

In addition, the anonymity of participants and the confidentiality of data have been respected through strict data protection measures. The names of individuals were deleted from the data and replaced by codes in the research notes. All information gathered (interview recordings, transcripts) is stored in a secure location. Identifiers have been used instead of names and the key for identification is stored in a separate secure location. Data will only be used for the agreed purposes and is accessible only to the research team (not shared with third parties). The data will be stored for 1 to 5 years, in accordance with Frontier*i* and NUI Galway policies. Moreover, the raw data from the survey solution server has been accessible to the NUI Galway team on a real time basis from the start of data collection. The link to the server for raw data has only been provided to the team members assigned to the project.

In addition, the research was carried out with respect to Ethiopian cultures, traditions, knowledge and customs. FRONTIERI employed interviewers who are familiar with the local cultures and speak the local languages. The consent and information sheets were translated from English into the relevant local languages. Permission was obtained for audio recording of the interviews. Respondents' names, specific places, and any other identifying details were only captured on an attendance sheet in order to maintain anonymity. Therefore, the names were not captured by the audio recorder or upon transcription.

Accordingly, the research team, in collaboration with the UN Women country office, ensured that the following ethical and safety recommendations for research on domestic violence against women were met:

- The safety and emotional wellbeing of respondents and the research team were paramount and guided all project decisions.
- Confidentiality was protected to ensure both women's safety and data quality.
- All research team members were carefully selected and received specialized training and ongoing support.
  - The training of field workers included sensitization on violence and gender issues, and confidentiality and safety, as well as information on support mechanisms. They were provided with a list of organizations and full contact details for support organizations, where support mechanisms were not in place (the most important organizations for referral are provided in the table below).
  - Field staff, particularly interviewers, received ongoing support from supervisors to combat burnout and secondary trauma (indirect exposure to traumatic experiences). Supervisors conducted regular check-ins. They also contacted enumerators/interviewers to talk through any issues and feelings that arose one-to-one. Emotional well-being was an important agenda item in every fieldwork team meeting. Members of the research team were available to provide any support needed by interviewers or other field staff. A psychological counsellor was also available, should any team member require such support.
- Fieldworkers were trained to refer women requesting assistance to available local services and sources of support (local support mechanisms include Women, Children and Youth representatives at kebele level and Women, Children and Youth offices at woreda level.) Where few resources exist, short-term support mechanisms were created.
  - These included having an individual within the team who is trained in providing psychosocial support.
- The study design included actions aimed at reducing any possible distress caused to the participants by the research.

The Ethics Committee of the National University of Ireland, Galway gave ethical clearance for the project in June 2021. Finally, Frontier*i* obtained the necessary clearances from government offices before conducting the surveys and interviews. This included securing official letters from government agencies informing regional/woreda/city officials about the survey and interviews, and other related documents to facilitate the data collection process in the chosen sites. In addition, a list of organizations to which survivors could be referred to by field staff in case they required psychosocial support was available.

[112] WHO (2016). Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication. Putting women first: ethical and safety recommendations for research on domestic violence against women Geneva: World Health Organization. February 2016.

4. PROFILE OF SAMPLE WOMEN AND HOUSEHOLDS

4.1 Demographic Characteristics of Women

4.1.1 Regions, Residence and Marital Status

The regional distribution of the women who participated in the current survey is presented in Table 3. About 41% and 21% of the 2,095 sampled women were from the Oromia and Amhara regional states, followed by about 24% of the sample from the Southern Nations, Nationalities, and Peoples' Region (SNNPR). The regional distribution for women is comparable to the 2019 EDHS national figures[113], in which about 80% of women live in three major regions: Amhara, Oromia, and SNNPR. Concerning the types of location of the sampled households, 56% of the 2,095 women who participated in the current survey are living in rural areas. This figure is lower than the national figure from the 2019 EDHS report, in which 68% of women live in rural areas.

Almost 94% of the women are living in the household, with 18 years as the mean duration of stay. About eight in ten (83%) women who participated in the current survey were currently married, with 14% of these women married more than once. This finding is higher than the national figure, where the proportion of women who are married or living with a partner has remained relatively constant over time (64% in 2016 and 66% in 2019)[114,115].

Table 3: Individual Women Demographic Characteristics

Variables	Percent	Number
Region		
Addis Ababa	13.65	286
Amhara	21.15	443
Oromia	40.95	858
SNNPR	24.25	508
Residence		
Rural	55.75	1,168
Urban	44.25	927
Women's marital status		
Married (once and more)	83.24	1, 744
Divorced	6.21	130
Separated	4.58	96
Widowed	5.97	125
Type of residential area		
Villa and apartment	0.77	16
House	93.99	1,969
Independent Room	2.63	55
Others*	2.63	55
	Mean	**Number**
Mean duration of stay after marriage	14.13	1,744
Mean duration of stay of women in this community	18.22	2,095
*'Others' refers to those living in temporary shelters, such as a plastic shelter constructed near to a church or in a corner of a street.		

[113] Ethiopian Public Health Institute - EPHI, Federal Ministry of Health - FMoH, and ICF. 2021. *Ethiopia Mini Demographic and Health Survey 2019*. Addis Ababa, Ethiopia: EPHI/FMoH/ICF. Available at https://www.dhsprogram.com/pubs/pdf/FR363/FR363.pdf.

[114] Central Statistical Agency - CSA/Ethiopia and ICF. 2017. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia: CSA and ICF. Available at http://dhsprogram.com/pubs/pdf/FR328/FR328.pdf

4.1.2 Age Distribution of Women

As the survey focused on women in the age range of 18 to 59, the distribution of the women who participated in the current survey indicates that the majority (21%) of women belong to the age group 25-29 years, with a mean age of 34.5 years.

Table 4: Age distribution of women

Age distribution of women	Number	% Women Survey
15-19 years	37	1.77
20-24 years	225	10.74
25-29 years	446	21.29
30-34 years	326	15.56
35-39 years	432	20.62
40-44 years	242	11.55
45-49 years	206	9.83
50-60 years	181	8.64
	Number	**Mean**
Mean age of women	2,095	34.53

4.1.3 Religion and Ethnicity of Women

The religion and ethnicity distributions for women are displayed below in Table 5. About 64% of women are Orthodox Christian and about 37% of women are Oromo in ethnicity.

Table 5: Religion and ethnicity of women

Women's' religion	Percent	Number
Orthodox	63.72	1,335
Islam	20.72	434
Protestantism	15.23	319
Others*	0.33	7
Women's' ethnicity		
Oromo	37.28	781
Amhara	32.98	691
Gurage and Siltie	14.51	304
Gamo and Gofa	11.98	251
Tigranian	1.43	30
Others**	1.81	38
Others* Catholicism, wakefate and kibate Others** Dauro, hadiya, kefa, wolayta, yem, kulo, sidama, kembata and Ari		

4.1.4 Education of Women

The educational status of women was assessed and compared with current and updated national figures to ensure representativeness of our current women's survey. In this regard, 62% of sampled women have 'ever attended' school at all levels, with 57% and 29% of women having attended primary and secondary school education respectively. This finding is comparable with the national figure of the 2019 EDHS report, in which 43% of females have completed some primary education. About 54% of the women 'ever attended with the new curriculum'.

Table 6: Educational Status of the women

Variables	Percent	Number	%EDHS2019
Percent of women who 'ever attended' an educational institution	62.05	1,300	43
Percent of women 'ever attended' by level			
No/Informal education	1.31	17	-
Primary education (1-8 grade)	57.53	748	41.7
Secondary Education (9-12 grade)	29.00	377	12.2
Vocational and Technical College	8.08	105	5.7
University degree and Higher Education	4.00	52	
Don't know	0.08	1	-
Percent of women 'ever attended' by Curriculum			
Previous Curriculum	46.54	605	-
New Curriculum	53.46	695	-

4.1.5 Employment Status of Women

The latest projection by the CSA for 2021 indicates that the female labor force participation rate declined sharply in 2021, from the usual rate of 74.6% to 58.6%[116]. Our survey indicated that about half of the surveyed women (49.45%) were engaged in different kinds of economic activity. Women were primarily engaged in self-employment (74%), with about 22% of working women being employees.

Table 7: Employment status of women and monthly income

Variables	Percent	Number
Percent of women engaged in a job/economic activity	49.45	1,036
Percent of type of work/job engaged In		
Full time	73.55	762
Part-time	26.45	274
Women Employment status		
Paid employee	22.68	235
Self-employed	73.36	760
Unpaid family worker	3.38	35
Other (daily labourer and unpaid employment)	0.58	6

[116] Asfwa, D.M. and Sherpa,S. (2022). 'Women labour force participation in off-farm activities and its determinants if Afar Regional State, Northeast Ethiopia', *Cogent Social Sciences*, 8:1, DOI: 10.1080/23311886.2021.2024675

4.1.6 Women's Income

Women who reported working were also asked about their monthly earnings. The average monthly income is 2,401 Birr, which is in close proximity to the average monthly income for working women, as well as that of women experiencing violence or not. This is detailed in Table 8.

Table 8: Monthly Income of Working Women

	Monthly Income-all women (Birr) N-1036**	Monthly Income-working survivors* (Birr) N-393	Monthly Income- working non-survivors (Birr) N-642
Average	2,401	2,046	2,612
Median	2,000	1,500	2,000

Note: * 'Survivors' refers to survivors of ever violence
**Out of a total of 1,036 women who provided data on their income, one woman did not answer any questions on violence. She was therefore excluded from the violence analysis

On the whole, working women experiencing violence had less income than non-survivors by nearly 22%. We will explore whether this difference stands when we control for variables that influence the likelihood of violence and earnings.

4.1.7 Decision-making and Empowerment Indices

In the survey, women were asked who makes decisions concerning a range of common family matters, from the use of contraception to children's schooling and marriage, to management of financial resources, using a Likert scale from 1 to 5, with 1 being the 'woman only' and 5 'husband only'. Table 9 details the findings from the women's decision-making and empowerment indices created on the basis of these decisions. The current survey shows that 74% of women participate in household decision-making either fully or partially, with only about 27% of women fully participating in household decisions. In addition, about 68% of women were adequately empowered, achieving mean and above scores on the women's empowerment index (see Annex 10.6 for more details).

In sum, the sample of women in this study is similar to the EDHS sample, considering the difference in age range which does influence the average of the sample, education distribution and marital status. Equally, the employment of women is different from the EDHS, but is in-line with the most recent forecasts of employment, which take into account the impact of COVID-19 on economic activity. Next, we provide some details of the households in which the women belong.

Table 9: Women's engagement in household decision making

Variables	Percent	Number
Women's decision making		
Fully or partially decide	73.9	1548
Did not decide	26.1	547
Full decision making		
Fully decide	26.7	559
Did not or partially decide	73.3	
Empowerment index		
Inadequate empowerment	32.27	676
Adequate empowerment	67.73	1,419

4.2 Demographic Characteristics of Sample Households

4.2.1 Perceived Household Income and Food Security

The table below indicates the distribution of the perceived income of the surveyed household, in which about 34% of households perceived their income situation as 'poor' and about 63% of households characterised their income as 'less than their expenses'. The food security status of the households that participated was assessed using the three HFIAS food security index. The score was measured to assess the degree of food insecurity (access) in the household in the past four weeks (30 days). Nearly 14.8% of the total surveyed households reported experiencing mild to severe food insecurity. This finding is lower than the national figure for food insecurity of 66.11% reported by a systematic review, which is more pronounced in female-headed households in Ethiopia[117].

Table 10: Household income situation and Households Food insecurity (n=2095)

Variables	Percent	Number
Household Food insecurity	14.8	310
Perceived household's income situation		
Poor	33.79	708
Average	62.58	1,311
Good	3.63	76
Household income expenses situation		
Our income is higher than the needed expenses	5.54	116
Our income is less than the needed expenses	62.53	1,310
Our income barely covers the needed expenses	31.93	669

4.2.2 Household Wealth Status

Household wealth status is calculated through the wealth index score and summarized to three levels - low, medium and high wealth status (See Annex 10.6). The findings indicated that 63% of the households that participated in the study belong to the middle wealth status. The difference observed below may be due to a difference in the classification of the wealth index between our study and the EDHS.

Table 11: Households' Wealth Status

Households Wealth Status	Percent	Number	EDHS 2019
Low	33.79	708	34.4
Middle	62.58	1,311	39.9
High	3.63	76	25.7

[117] Negesse, A., Jara, D., Temesgen, H., Dessie, G., Getaneh, T., Mulugeta, H., ... & Negesse, Y. (2020). The impact of being of the female gender for household head on the prevalence of food insecurity in Ethiopia: a systematic-review and meta-analysis. *Public Health Reviews*, 41(1), 1-14.

The wealth status was disaggregated by residence of the households (see Table 12). As can be seen, the findings indicated there was not much variation by location or residence.

Table 12: Households' Wealth Status by Location

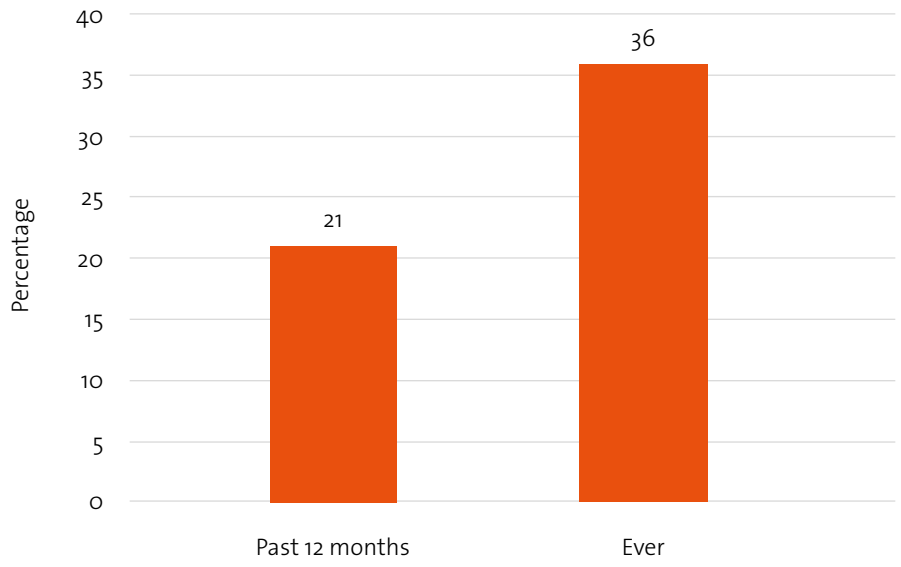
	Rural		Urban	
	Percent	Number	Percent	Number
Households' Wealth Status				
Low	33.62	381	35.28	327
Middle	62.18	738	61.81	573
High	4.20	49	2.91	27

4.3 Prevalence of Intimate Partner Violence and Correlates

4.3.1 Prevalence of IPV: Past 12 Months and Ever

The prevalence of IPV was estimated on the basis of different behaviors - physical, sexual, psychological and economic – that women reported experiencing (See Annex 10.2 for details of the behaviors involved) in the total sample (of women surveyed). For the costing analysis, however, we have focused on estimating the overall prevalence as the impacts of different behaviors are often interrelated. The percentage of women in the study who experienced at least one behavior of violence 'ever' and 'in the past 12 months' is shown in Figure 2 below:

Figure 2: Prevalence of Violence



Source: Authors' own calculations

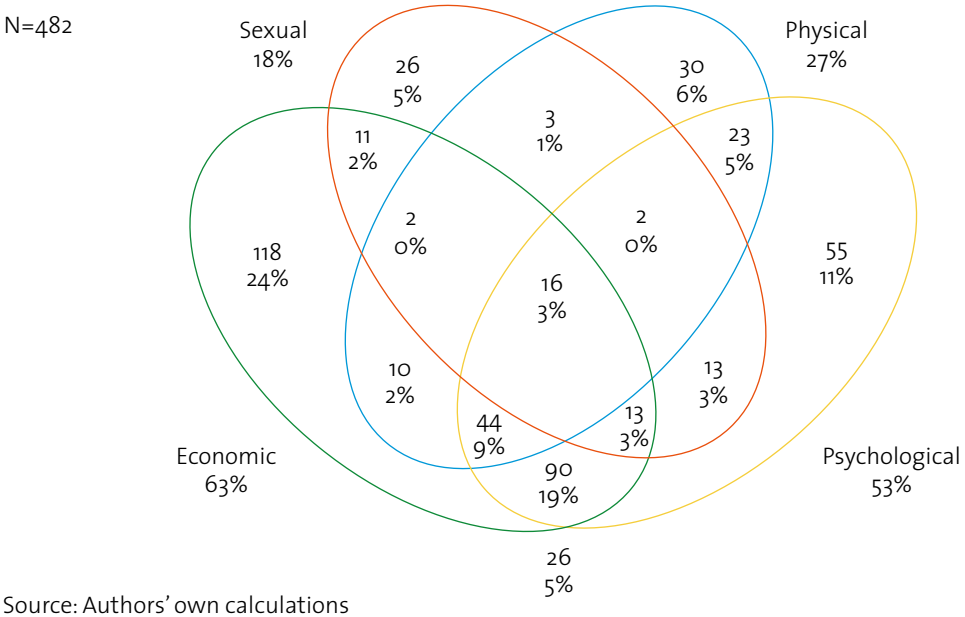
Nearly one in five (21%) currently partnered[118] women experienced at least one behavior of violence in the past 12 months. Approximately, four in ten currently or previously partnered[119] women (36%) experienced violence 'ever' in their lifetime. The prevalence in this study is quite similar to the prevalence rate reported in the 2016 EDHS, in which 34% of women experienced IPV 'ever'. Additionally, 25.8 % of ever married women experienced physical and/or sexual violence once in their lifetime, which is close to the 2016 EDHS prevalence rate of 28% for ever-married women aged 15-49 experiencing physical or sexual violence IPV at least once in their lifetime.

[118] 'Currently partnered women' implies women who have been married/cohabitating/living with a partner in the past 12 months.
[119] 'Currently or previously partnered women' implies women who have been married/cohabitating/living with a partner in the past 12 months or before the last 12 months.

4.3.2 Incidents by Type of Violence

As outlined in the methodology, women who reported experiencing violence in the last 12 months were also asked how many incidents of violence they experienced in the last year. Survivors, on average, reported 2 incidents in the last 12 months, with the median number of incidents amounting to 1. Nearly 75% of survivors reported one incident in the last 12 months, with a further 10% reporting 2 incidents in the last 12 months. In addition, approximately 15% of survivors reported more than 2 incidents in the last 12 months. Figure 3 below depicts the type of incidents experienced by survivors: psychological, physical, sexual, economic. Nearly six in ten incidents (63%) involved economic violence and approximately half of the incidents (53%) were of a psychological nature. It is important to note that the majority of incidents involved different forms of violence.

Figure 3: Venn Diagram of Types of Incidents



Source: Authors' own calculations

The multiple forms of violence experienced by women is further highlighted extensively in the IDIs conducted with IPV survivors. The majority of these women reported incidents of emotional abuse, including insults, threats and isolation. Most women also described physical beatings, kicking, choking and breaking of bones. Four women further reported being abducted by the perpetrator and raped. According to Serkadis in the Amhara region:

> *"He sexually assaults me in a way I don't want... He forces me to do it...It hurts me a lot....".*

Indeed, sexual violence ranged from forced sexual intercourse to refusal to use contraceptives, resulting in forced impregnation. One woman said:

> *"He asked why should he use contraceptives to prevent pregnancy when there was no shortage of income". Then, when she told him she was pregnant, he said he "did not care" (Agitu in the Oromia region).*

Economic abuse also emerged as a strong theme, primarily in the form of being deprived of money, the perpetrator taking the woman's money and preventing her from working.

The qualitative finding concerning deprivation echoes the most frequently reported behavior of economic violence that emerged in the survey, namely the husband refusing to provide money for household expenses even though he has adequate resources.

Table 13: Percentage of Women Survivors Reporting Economic Violence Behaviors

	Last 12 months	Before Last 12 months	Ever
Refused to give you enough money for household expenses even though he had enough money to spend on other things	256	399	417
Asked for details about how you spent your money	166	256	269
Withdrew money from your account or credit card without your permission	36	74	77
Forced you to work	45	91	95
Forced you to quit your work	37	88	88
Prevented you from working	45	91	95
Tried to exploit properties (use properties/ sell and use the income from the sale of properties) you inherited from your family without your permission	43	106	114
Disposed of your belongings without your permission	31	88	94

4.3.3 Correlates of Violence

We undertook logistic regression to explore the key variables that strongly influence the probability of a woman experiencing IPV. The results in Table 14 reveal a number of significant covariates explaining women's experience of lifetime-IPV. Eleven variables were hypothesized to explain the risk of a woman experiencing lifetime-IPV. The results show that, except for the number of children, all the remaining variables included in the logit model were found to be statistically significant at less than 10% probability levels in explaining the variations in the dependent variable (lifetime-IPV). The results further reveal that variables such as partner's education, location, region, women's empowerment, partner's consumption of alcohol and chat, wealth status of the household, woman's employment status, duration of marriage and woman's education are the key drivers of the likelihood that a woman has experienced lifetime-IPV in Ethiopia.

The results also show that the probability of a woman from the Amhara region experiencing lifetime-IPV is significantly higher than for women from Addis Ababa. The results for the Oromia and SNNPR regions are not statistically significant. Moreover, the results show that women who are from rural areas, with a longer duration of marriage, and whose husbands are addicted to alcohol and chat, are highly exposed to lifetime-IPV, compared to their counterparts. In addition, women who are empowered, with an educated partner, from households with a medium and higher wealth status and who are an unpaid family worker, are less likely to be exposed to lifetime-IPV.

Women from rural areas have a higher risk of experiencing lifetime-IPV by up to 6.7%, compared to women from urban areas. This corresponds with the result from Chegere and Karamagi (2020)[120], who found that living in urban areas is negatively associated with women experiencing IPV. When considering the risk for IPV by women's employment status, the lowest risk is among women who are unpaid family workers, compared to women who are paid employees. This result coincides with the results of the study by Vyas and Watts (2009)[121], who argue that a woman's increased economic engagement may challenge a man's status and incite violence against his female partner or spouse.

> Serkadis, an in-depth interview participant residing in the Amhara region, said that she left school to work when the abuse worsened. She next left work because her partner was unhappy about her earning an income. She also reported that he beat her daily, attacking her every night after she reported the abuse.

[120] Chegere, M.J. and Karamagi I.J. (2020). Intimate Partner Violence and Labour Market Outcomes in Tanzania. *African Journal of Economic Review*, 8(2): 82-101.

[121] Vyas, S., and Watts, C. (2009). How Does Economic Empowerment Affect Women's Risk of Intimate Partner Violence in Low and Middle Income Countries? A Systematic Review of Published Evidence. *Journal of International Development,* 21: 577- 602.

Table 14: Logit model results on the key drivers of women's lifetime IPV

Variables	Coef.	Marginal effects	Std. Err.	Z	P>z
Partner's education	-0.009**	-0.002	0.005	-2.000	0.045
Location (Rural=1)	0.341***	0.067	0.115	2.970	0.003
Region					
Oromia	-0.183	-0.034	0.204	-0.900	0.370
Amhara	0.715***	0.148	0.172	4.170	0.000
SNNPR	-0.203	-0.037	0.184	-1.110	0.268
Women's empowerment index	-2.195***	-0.429	0.361	-6.080	0.000
Woman's employment status					
Self-employed	-0.062	-0.022	0.172	-0.360	0.721
Unpaid family worker	-0.347**	-0.077	0.164	-2.110	0.035
Wealth status of the household					
Medium	-0.639***	-0.132	0.108	-5.920	0.000
High	-1.314***	-0.246	0.350	-3.760	0.000
Partner consumes alcohol	0.783***	0.153	0.107	7.340	0.000
Partner consumes chat	0.571***	0.111	0.130	4.400	0.000
Number of children	0.004	0.001	0.043	0.080	0.933
Duration of marriage	0.010*	0.002	0.005	1.840	0.066
Woman's education	0.370***	0.072	0.118	3.140	0.002
Constant	-1.828		0.469	-3.900	0.000
Number of observations	2,094				
LR chi2(15)	329.33				
Prob > chi2	0.000				
Log likelihood =	-1201.95				
Pseudo R2	0.121				

However, the study by Canedo and Morse (2019)[122] in Mexico found a non-significant effect of unpaid household employment on IPV and relates it to relative resource theory. If a woman is not being paid, then she may not be perceived as being "economically empowered". As such, there may be less violence at the hands of her partner. The study also found that men who drink alcohol are more likely to abuse their female partners. The probability of women with male partners who take alcohol and chat to experience violence in their lifetime was found to be higher than for women who do not have partners who engage in these activities, by 15.3% and 11.1%, respectively. An in-depth interview participant stated that her partner would come home drunk and beat her (Yordanos, SNNPR).

The results further show that the increased education of a woman's partner is a protective factor for the experience of lifetime IPV. However, a woman's higher level of education has been found to be a risk factor. This result is in line with the results by Rao (1997)[123] and Ahinkorah et al. (2018)[124]. Women who are empowered (higher decision-making power) are less likely to experience IPV compared to less empowered women. An increase in women's decision-making capacity by 1 decreases exposure to ever-IPV by 42.9%, keeping all other factors constant. This result corroborates the study results of Ahinkorah et al. (2018).

[122] Canedo, P.A. and Morse S.P. (2019). An Estimation of the Effect of Women's Employment on the Prevalence of Intimate Partner Violence in Mexico. *Journal of Interpersonal Violence*, 1–25.

[123] Rao, V. (1997). Wife-beating in Rural South India: A Qualitative and Econometric Analysis. *Social Science and Medicine*, 44: 1169–1180.

[124] Ahinkorah, B.O. Dickson K.S. and Seidu A.A. (2018). Women Decision-Making Capacity and Intimate Partner Violence among Women in sub-Saharan Africa. *Archives of Public Health*, 76(5): 1-10.

5. ECONOMIC AND SOCIAL IMPACTS OF INTIMATE PARTNER VIOLENCE FOR WOMEN AND HOUSEHOLDS

This section provides the results of the economic impacts of IPV for women and households in the form of out-of-pocket (OOP) costs, as well as care work and productivity loss due to incidents in the last 12 months. Due to a dearth of available data, we could not calculate the following costs: children's missed school days and impacts on children's health.

5.1 Out of Pocket Expenditures

Table 15 below shows the results of OOP expenditures due to various incidents of violence. Approximately 14% of incidents led to some form of health expenditure, with an average cost of 2,349 ETB (or median cost of 620 ETB). Similarly, one in ten incidents (10%) resulted in some form of shelter cost, with a median shelter cost of 160 Birr. Women also incurred costs for repairing and replacing property in 13% of incidents, with an average cost of 3035 ETB. Overall, 34% of incidents led to some form of OOP costs - on average, 2,349 ETB (median OPE cost of 500 ETB). ***This level of OOP expenditure amounts to approximately 10% of the average annual income of working IPV survivors***, representing an important source of drain on household resources.

Table 15: Out of Pocket Expenditures in last 12 months

	N	% of Incidents	Average Cost (Birr)	Average Cost (USD)	Median Cost (Birr)	Median Cost (USD)
Health	67	14%	1,346	27	620	12
Legal	23	5%	2,270	45	650	13
Police	20	4%	289	6	175	3
Property	64	13%	3,035	60	300	6
Shelter	48	10%	618	12	160	3
Mediation	53	11%	249	5	200	4
OVERALL (Birr/USD)	164	34%	2,349	47	500	10

*Assumed exchange rate of 1 USD to 50.59 Birr as of 7th February 2022, based on average buying and selling exchange rate of Commercial Bank of Ethiopia (https://www.combanketh.et/en/exchange-rate/)
Source: Authors' own calculations

5.2 Care Work Loss

Loss of care workdays was reported by respondents in the in-depth interviews, partly due to the financial and mental health impacts of violence. As one woman reported: " There was physical abuse and financial hardship. I was suffering from a mental illness. I couldn't perform household chores' (Workae, Oromia region).

Care work loss also emerged as an important cost in the quantitative survey. Tables 16 and 17 provide the results of care work loss for survivors and husbands, respectively. Nearly one in five (19%) incidents led to missed days of childcare and supporting children's education, with survivors unable to undertake childcare or supporting children's education for 12 days. Weighting by the average minutes spent by women in Ethiopia on childcare and supporting children's education results in 2.2 care workdays being missed. Overall, 25% of incidents led to 13.7 missed care workdays.

Table 16: Care Work Loss of Survivors in last 12 months

Type of Care Work	N	% of Incidents	Days Missed	Average Minutes Spent	Care Workdays Missed
Childcare and Education	91	19%	12.2	77.5	2.2
Caring for Elderly and Sick	42	9%	5.7	72	0.95
Domestic Activities	97	20%	22.6	282	14.8
Overall	122	25%	29	N/A	13.7

Source: Authors' own calculations

Nearly one in ten incidents led to domestic activities being missed by husbands of survivors, resulting in 12.6 care workdays missed. Overall, 11% of incidents led to 12.2 care workdays being missed by husbands of survivors. As can be seen, husbands do engage in both caring for children and in domestic activities.

Table 17: Care Work Loss of Husbands in last 12 months

Type of Care Work	N	% of Incidents	Days Missed	Average Minutes Spent	Care Workdays Missed
Childcare and Education	43	9%	12.9	9	0.41
Caring for Elderly and Sick	30	6%	6.1	91.5	1.97
Domestic Activities	47	10%	19.6	181.5	12.6
Overall	55	11%	30	N/A	12.2

Source: Authors' own calculations

5.3 Productivity Loss

Productivity loss due to IPV against women, in the form of absenteeism, presenteeism and tardiness is shown in Table 18 below. As can be seen, 7% of incidents resulted in survivors missing work to seek medical treatment and legal services, with a median of 0.4 days and 0.2 days missed, respectively. Nearly one in ten incidents (9%) also led to survivors missing work because they were unwell, with a median of 0.71 days lost. Overall, 14% of incidents resulted in survivors missing work for an average of 9.87 days (median of 2 days)

Approximately one in ten incidents (11%) also resulted in presenteeism, with an average of 6.3 days lost. A total of 50 incidents (10%) further involved survivors either leaving work early or arriving to work late (tardiness), resulting in an average of 0.29 days lost. Overall, two in ten incidents (19%) led to some form of productivity loss for 9.95 days on average (median of 2.6 days).

Table 18. Productivity Loss in last 12 months

Type	N	Percentage of Incidents (%)	Mean Days Missed	Median Days Missed
Absenteeism				
Missed work because you had to seek medical treatment	33	7%	4.38	0.37
Missed work because you had to attend legal services (e.g, family counselling)	36	7%	2.28	0.21
Missed work because you had to visit police stations	31	6%	1.13	0.09
Missed work because you were unwell	42	9%	3.85	0.71
Missed work because you had to take care of your child/ children	22	5%	2.44	0.14
Missed work because you stayed with friends or family	37	8%	4.98	0.47
Overall-Absenteeism	67	14%	9.87	2
Presenteeism				
Was not as productive at work as you normally would be	45	9%	0.55	0.5
Had difficulties dealing with clients and/or customers	39	8%	0.37	0.04
Had to stop working because you were worried	35	7%	2.19	0.2
Had to stop working because you had an accident at work	22	5%	10.46	0.6
Overall-Presenteeism	55	11%	6.3	0.9
Tardiness				
Late for work by 1 hour or more	46	10%	0.18	0.07
Left work early by 1 hour or more	35	7%	0.18	0.02
Overall- Tardiness	50	10%	0.29	0.13
Overall-Productivity Loss	91	19%	9.95	2.63
Note: Mean absenteeism days, tardiness days and presenteeism days do not equal mean productivity loss days because the means are based on different proportions of survivors.				

Source: Authors' own calculations

The negative impacts on women's productivity were discussed by some women in the in-depth interviews. One woman reported being unable to work due to a broken leg, which resulted in not being able to pay her rent. Another woman left school so she could work when the abuse worsened, yet then had to leave her job when her partner became unhappy about her earning an income. Additional issues identified include lack of trust from an employer, who questioned a woman's ability to do her job, as she had' so many issues' and was juggling school and work for almost the entirety of a pregnancy.

In addition, one woman left a job because of being afraid to tell her employer that she was pregnant. She then struggled to find employment despite pleading with employers, offering to work without pay and promising to give up her baby to the government after the birth.

The in-depth interviews provide an insight into the multiple constraints women face when trying to maintain economic activity after experiences of violence, which leads to absenteeism and presenteeism. A productivity loss equivalent to almost 10 days after an incident of violence is indicative of the potential cycle of poverty that IPV imposes on survivors, as indicated above.

5.4 Impacts on Well-being: Mental Health and Reproductive Health Outcomes

In addition, IPV survivors experiencing 'ever violence' have relatively poorer health compared to non-survivors. As shown in Table 19, 55% of survivors have excellent health compared to 77% of non-survivors reporting excellent health. This association between health and experience of IPV is statistically significant ($\chi 2=114.4$, $p<0.01$). However, the effect size ($V=0.23$) shows a weak association.

Table 19: General Health and 'Ever IPV'

General Health	Survivors(%)*	Non-Survivors (%)
Excellent	55	77
Fair	39	20
Ill	5	3
Seriously ill	0.7	0.4
* 'Survivors' refers to survivors of ever IPV **Pearson chi2(3) = 114.4,p<0.01, V=0.23		

Source: Authors' own calculations

IPV survivors also have relatively greater psychological impacts compared to non-survivors. As shown in Table 20, 61% of survivors have experienced headaches, compared to 38% of non-survivors. This association between headaches and being a survivor of IPV is statistically significant ($\chi 2=102.2$, $p<0.01$). Survivors have additional greater psychological impacts, such as loss of appetite (27% vs 14%), sleeping badly (30% vs 14%), feeling nervous (38% vs 13%). Survivors of 'ever IPV' are also more likely to report finding it difficult to work (13% vs 3%) and to being less productive than usual (10% vs 3%).

Table 20: Psychological Impacts on Survivors of 'Ever IPV'

	Survivors(%)*	Non-Survivors (%)	Chi-Square	Cramers' V
Headache	61	38	102.2***	0.22
Loss of appetite	27	14	55.5***	0.16
Slept badly	30	14	76.9***	0.19
Felt nervous or tense about something	38	13	173***	0.29
Had trouble thinking clearly	16	5	63.7***	0.17
Felt unhappy or sad	36	14	136.4***	0.26
Cried more than you normally would	19	6	80.1***	0.20
Found it difficult to carry out daily activity	13	4	55.5***	0.16
Had difficulties making decisions	11	2	76.9***	0.19
Were less productive than usual	10	3	48.4***	0.15
Lost interest in things that you usually enjoy	11	2	73.1***	0.19
Felt worthless	15	4	87.7***	0.20
Felt tired	33	15	92***	0.21
Note: * 'Survivors' refers to survivors of 'ever' IPV; *** signifies statistically significant at 1% and ** signifies statistically significant at 5%				

Similar to the mental health impacts reported in the quantitative survey, women in the in-depth interviews expressed the emotional impacts they have experienced as a result of violence perpetrated by their husbands/partners in different ways. Some women said they felt desperate, depressed, frustrated and immensely stressed, while others described feelings of loneliness and suicidal ideation, with two women attempting suicide. The following quotes encapsulate these impacts:

"I felt like the whole world had crumbled." (Aida, Addis Ababa)
"I am psychologically affected badly." (Belaynesh, Amhara region)
"I am psychologically injured." (Chaltu, Oromia region)

One woman expressed self-hate and feelings of guilt:
"I hated being a woman. I felt that I was causing trouble for myself." (Chaltu, Oromia region)

These findings indicate the global and pervasive issue of victim-blaming in our societies, which often leads to self-blame. Indeed, stigma and shame were among the emotional impacts experienced by the IDI participants. Some of these women discussed how they experienced these emotions because of being pregnant outside of marriage or for living with their partner, without having been introduced to his parents. However, it was the partner who demanded control and placed the woman in these situations.

A higher proportion of survivors, compared to non-survivors, have also reported having had abortions (13% vs 7%) and stillbirths (9% vs 6%). The association for both of these reproductive health outcomes has been found to be statistically significant, but weak, as shown in Table 21. This finding is in-line with other studies exploring reproductive health impacts of IPV[125] [126].

Table 21: Reproductive Impacts and 'Ever Violence'

	Survivors(%)*	Non-Survivors (%)	Chi-Square	Cramers' V
Miscarriage	14	13	0.27	Na
Abortion	13	7	22.5***	0.11
Stillbirths	9	6	4.2**	0.05
Note: * 'Survivors' refers to survivors of ever IPV; *** signifies statistically significant at 1% and ** signifies statistically significant at 5%				

Source: Survey results

[125] Sarkar, N. N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynaecology*, 28(3), 266-271.
[126] Grose, R. G., Chen, J. S., Roof, K. A., Rachel, S., & Yount, K. M. (2021). Sexual and reproductive health outcomes of violence against women and girls in lower-income countries: a review of reviews. *The Journal of Sex Research*, 58(1), 1-20.

5.5 Poverty Impacts

A PSM analysis was conducted to establish the impacts of 'ever IPV' on women's income, household income and household expenditure to understand the effect of IPV on household poverty. As explained in the methodology, the PSM analysis is based on matching women who experience violence with women who do not experience, with the same probability of experiencing violence. In other words, both groups of women have the same characteristics in term of the drivers of IPV – the analysis establishes this fact through a balancing test and a common support area test.

Balancing Test

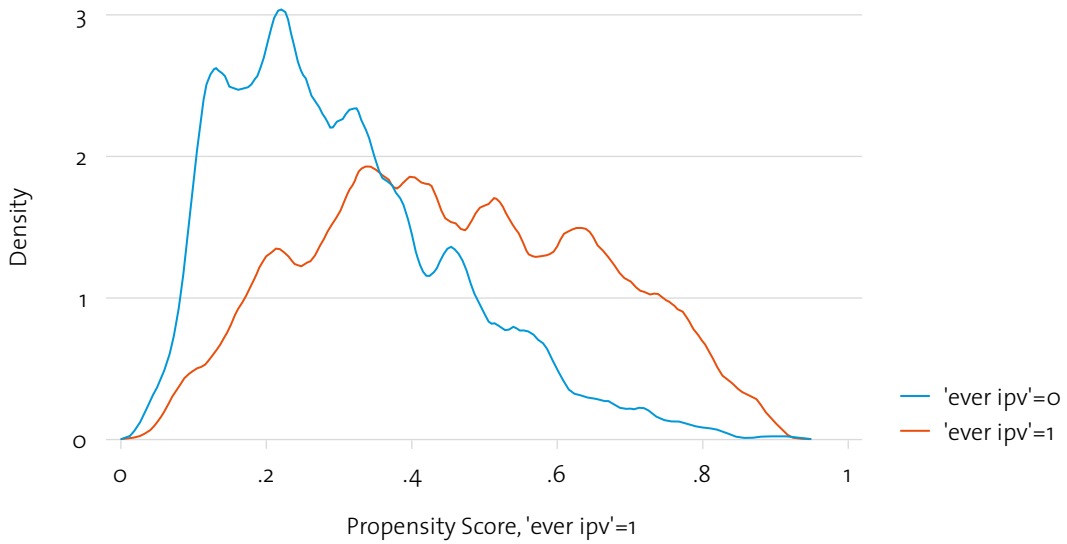
We performed balance checks to assess whether, following matching, the distributions of the probability of experiencing lifetime-IPV were similar between women who had and had not experienced lifetime-IPV (treated and control women). We selected the propensity score model that resulted in the highest reduction in mean bias for the least loss to sample size by iterating over different forms of nearest neighbor matching with varying caliper sizes. To evaluate whether the appropriate balance was achieved in the matching method, we used two statistics, namely *standardized differences* for continuous variables, defined as the weighted difference in means between women exposed to IPV and women not exposed to IPV, divided by the standard deviation and raw differences in proportions for categorical variables in the full, unadjusted sample[127 128]) and *variance ratio*, defined as the ratio of the sample variance of the logit values between those exposed to IPV and those not exposed to IPV[129]. According to Stuart (2010)[130], a sufficient balance is achieved if the matched treatment group and control group yield standardized differences under 0.25 and a variance ratio close to 1.00 or between 0.50 and 2.00.

For the evaluation of the impact of lifetime-IPV on all the outcome variables using PSM, the covariates used in the analysis were successfully balanced between the two groups. This is because the highest standardized bias stands at 0.23 and the highest variance ratio at 1.98, indicating that the covariates are balanced after matching. PSM was performed in STATA 15 using the effects match command.

Common Area of Support

Another important step in investigating the validity or performance of the treatment effects estimation is verification of the common support or overlap condition. It is assumed that the probability that a woman has experienced lifetime-IPV, conditional on observed characteristics, lies between 0 and 1 (implying exposure to IPV is not perfectly predicted, that is, $0 < P(D = 1|X) < 1$). This assumption is critical to estimation, as it ensures that women with the same X values have a positive probability of being both a survivor of IPV and being a non-survivor of IPV (Caliendo and Kopeinig, 2008)[131]. By choosing caliper matching, we restrict ourselves to an area of common support. The distribution of the estimated propensity scores and the overlap between women experiencing IPV and not experiencing IPV are shown in Figure 5. This Figure indicates that the common support condition is satisfied, as there is a substantial overlap in the distribution of the estimated propensity scores for the two groups.

Figure 4: Distribution of propensity score across treatment and comparison groups



Results of the PSM Analysis

[127] Kainz, K., Greifer, N., Givens, A., Swietek, K., Lombardi, B. M., Zietz, S., and Kohn, J. L. (2017). Improving Causal Inference: Recommendations for Covariate Selection and Balance in Propensity Score Methods. *Journal of the Society for Social Work and Research*, 8(2): 279–303.

[128] Stuart, E. A. (2010). Matching Methods for Causal Inference: A Review and a Look Forward. *Statistical Science*, 25(1): 1–21.

[129] Kainz, K., Greifer, N., Givens, A., Swietek, K., Lombardi, B. M., Zietz, S., and Kohn, J. L. (2017). Improving Causal Inference: Recommendations for Covariate Selection and Balance in Propensity Score Methods. *Journal of the Society for Social Work and Research*, 8(2): 279–303.

[130] Stuart, E. A. (2010). Matching Methods for Causal Inference: A Review and a Look Forward. *Statistical Science*, 25(1): 1–21.

[131] Caliendo, M., and Kopeinig, S. (2008). Some Practical Guidance for the Implementation of Propensity Score Matching. *Journal of Economic Surveys*, 22 (1): 31-72.

Livelihood outcomes measured in terms of women's income and participation in the labor force, partner's income, household income and household expenditure could be affected by lifetime-IPV in a way that standard regression methods cannot account for, even after adjusting for confounding. This study again used PSM, a technique widely employed in econometrics to address this bias in cross-sectional studies. The results from the treatment effects method using the PSM algorithm with caliper (0.25) and pstolerance (1e-50), which was found to fit the data well for all outcome variables, are presented in Table 5.8. Our findings indicate that women's exposure to lifetime-IPV has significant negative impacts on four of the five livelihood indicators included in the PSM model - women's income, household income, household expenditure and women's economic activity (working or not).

Table 22: Average treatment effect on the treated (ATET) of lifetime-IPV on livelihood outcomes using PSM estimator

Outcome variable	Coef.	AI Robust Std. Err.	Z	P>z
Woman's income (n=1035)	-372.82**	180.41	-2.07	0.039
Partner's income (n=1600)	-161.75	419.24	-0.39	0.700
Household income (n= 1905)	-929.90**	380.18	-2.45	0.014
Household expenditure (n=2094)	-332.95***	122.78	-2.71	0.007
Woman working or not (n=2094)	0.09***	0.04	2.61	0.009
Note: ** and *** refer to significance at 5% and 1% probability levels respectively				

The results from the PSM estimator show a statistically significant negative effect of women's lifetime-IPV on women's and household's incomes, and household expenditure, at less than 5% probability levels. The results of the ATET indicate that a woman's lifetime-IPV will, on average, reduce a woman's income, the household's income and the household's expenditure by 372.82 Birr, 929.90 Birr, and 332.95 Birr per month, respectively. A key result from this study is that women who were survivors of IPV had significantly lower income compared to their counterparts, which is in line with the findings of the studies conducted by Morrison and Orlando (2004)[132] and Duvvury, Minh and Carney (2012)[133]. Further, the results demonstrate that households with women exposed to IPV have lower expenditure and lower income compared to households with no exposure to IPV. However, the result involving the significantly lower expenditure by households with IPV survivors contravenes our expectation and requires further study. Moreover, the results show that violence against women by their partner has a significant positive effect on women working or not. The positive association between women working or not, and physical as well as emotional abuse by partners, indicates that employed women are more exposed to IPV compared to unemployed women (Paul, 2016)[134].

Using PSM analysis, we also explored the overall productivity loss in terms of absenteeism, tardiness and presenteeism due to IPV among working women only. In the survey, detailed productivity questions were asked of all working women, similar to the questions posed to violence survivors reporting specific incidents in the last 12 months. Given that violence in the past has significant impacts for survivors' status today, we felt it was important to explore the productivity impacts of women experiencing 'ever' violence. Using 'ever' violence as the variable expands the base of women explored in the analysis given the sharp differences in the prevalence rates of women experiencing 'ever' violence (36%) and current violence (21%). The results of the PSM analysis indicate that working women who have experienced 'ever' violence had a significantly higher number of days of productivity loss than working women not experiencing violence.

Table 23: PSM Result of Productivity Loss

Productivity loss	Coef.	AI Robust Std. Err.	Z	P>z	[95% Conf. Interval]	
					Min	Max
ATET	16.67409***	3.946552	4.22	0.000	8.938989	24.40919
Note: Significant at 1% probability						

[132] Morrison, A.R. and Orlando M.B. (2004). The Costs and Impacts of Gender-Based Violence in Developing Countries: Methodological Considerations and New Evidence. World Bank Discussion Paper.

[133] Duvvury, N. Minh, N. and Carney, P. (2012). *Estimating the cost of domestic violence against women in Viet Nam*. Hanoi, Viet Nam: UN Women.

[134] Paul, S. (2016). Women's Labor Force Participation and Domestic Violence: Evidence from India. *Journal of South Asian Development*, 11(2): 224-250.

In fact, working women who have experienced 'ever violence' have a productivity loss of almost 17 days annually, ranging from 9 days to 24.4 days, with a 95% confidence interval. These findings are consistent with other studies and with the results of the analysis of the mental and physical health effects of 'ever violence' in this study. This indicates that women who experience 'ever violence' are potentially more likely to work, yet their work is more interrupted, leading to a higher productivity loss. It also suggests that simply enhancing women's employment may not result in positive benefits, unless women's exposure to violence is simultaneously reduced.

5.6 Women's Stories: Selection of Cases

The findings above highlight the pervasive and profound nature of IPV for women in Ethiopia, the qualitative data adding depth to the quantitative results. In this section, we provide a further insight into the lived experience of IPV through a selection of cases from our IDI Interviews. These cases detail the stories of four women who have escaped an abusive relationship, from the violence and control they were subjected to, to the devastating impact of the abuse, to their journeys of recovery. The difficulties they have faced when seeking help are also detailed. In addition, the four women discuss what brings them happiness and their hopes for the future.

5.6.1 Eyerus, Addis Ababa

Eyerus was recovering from a broken leg in a rehabilitation center when she recounted her experiences of violence. She was twenty years old when she was admitted to the rehabilitation center with her one-year-old son, as there was no one else to look after the toddler. Though Eyerus and the father of her son were not officially married, they were living as a couple in Addis Ababa. She said that their first fight was triggered by her stomach illness. He hit her brutally and punctured her ear with a nail. First, Eyerus went to the Woreda Women and Children's Affairs office. Then, she went to the nearest health center and obtained treatment, which cost 200 Birr.

The second incident of IPV resulted in her broken leg. She said:

> *"I was so desperate and intimidated and suffered a lot after the attack. My neighbors took me to the police but they couldn't help me much, mainly because we didn't have a marriage certificate. Following this, the violence was repetitive. He hit me, slapped me, whenever he gets angry, cursed at me and nagged me."*

Eyerus was also subjected to financial abuse. Originally, she was a housewife but because he refused to give her any money for household expenses, she began working in the kebele - 'ye timhrt bet mgeba' or 'school feeding'. Unfortunately, this job was not well paid. Indeed, there were times when she did not receive pay, yet still she advised that it did help her considerably to cover the expenses for her stomach treatment, which amounted to 17,000 Birr:

> *"If I didn't have that job, I wouldn't be alive today. St. Paul's Hospital is very farm from the place where I lived, so I spent over 100 Birr for taxi and the appointment was every week. My child also needed food to survive. Even there were times other patients paid for my treatment."*

However, Eyerus could not continue to work after her ex-partner broke her leg. Compounding this, she could not obtain her share of the property they had accumulated together because he took all of this property, and she could not get any organization to help her. The reason given was that they were not officially married.

Discussing her difficult help seeking journey, Eyerus said:

> *"The first time that I told other people about the violence was in **** when my child was one year old. I told the case to my neighbors and they used to visit our house to consult us. Yet, he attacked me the following day. I told my neighbors and elderly people many times that he was torturing me and that I can't live with him anymore. When I tell him to divide the property and give me what's mine, he refused. Even my brother came from **** before my leg was broken and asked him to get separated and give me my share of our property, but he told him that its rainy season and that he didn't want our baby to get hurt as a result of the divorce. I had no intention to take the case to court because I didn't have enough money to open the case and had no one to help or lend me money."*

After her ex-partner broke her leg, Eyerus sought help from the Women and Children's Affairs office, yet they did not come to see her as requested. She also sought assistance from the law enforcement office and the police to no avail. The police asked her to bring witnesses:

> *"When he hits me or broke my leg, there was no one around. Even the one witness who saw everything said nothing when asked by the police because she was afraid for her life. I shouldn't be the one who brings witnesses. The police should do this because I couldn't move. I think the government should be the first to respond when women get assaulted."*

The only help Eyerus received was from her neighbors, who supported her by paying for food and medication. She then relocated to a small rented house (800 Birr per month), but could only afford to pay for six months' rent:

> *"At that terrible time no one visited me. Even my family couldn't support me. Finally, the Federal police brought me to the shelter because I couldn't make a living for my child."*

Eyerus discussed the vital importance of the rehabilitation center that housed her. They hired a lawyer for her, as well as covering the costs for all of her medical treatment and legal expenses.

> *"To tell you the truth, if this organization didn't take me in, I had nowhere to go. I couldn't pay rent or feed my child. The shelter is covering all expenses but why should they pay for transport to travel to **** every time to find a witness. Why aren't the police doing this? I want to emphasize that."*

Eyerus also described her difficult recovery process concerning her broken leg. Though she can now walk by herself, she cannot stand for a long time. To further her skills, she has started to participate in training on traditional carpet making, known as 'kacha', in addition to training in injera baking and beauty treatments.

She further explained how the violence impacted her child:

> *"He was there when he broke my leg and was shouting at his father to stop hurting me and when they take me to Minilik Hospital in an ambulance he was with me and he was shouting and crying. He repeatedly said: 'I will kill my dad with a gun'. Even when the doctor asked me what happened I didn't say anything, he was the one saying: 'It's my dad who broke her leg'".*

Her son did not want to see his father after that. As there was no one to look after him, Eyerus was terrified that he might take his life, as he had previously planned to throw himself down the stairs. He has struggled immensely. He is now enrolled in school and Eyerus believes that he will "forget soon, as he is a child."

Reflecting on what brings her happiness, Eyerus said:

> *"Right now, my happiness comes from seeing and making my child happy and healthy, seeing him do whatever he wants, and seeing him wear nice clothes and enrolled in the best school. My future hope depends on the length of time it will take me to recover from my injury. My leg still has metal in it. The injury is in a very sensitive area, and it requires time to heal. I should get out from here after I have finished my treatment. Otherwise, I will need a lot of money for treatment, renting a house and enrolling my child in school. Doctors promised me that I will recover soon if I could sustainably work out in physical therapy. I hope to get engaged in carpet work and improve my livelihood."*

5.6.2 Semira, SNNPR

Semira was 20 years old and a mother of two when she recounted her story, which involved abduction and rape when she was only 14 years old. She was then forced to marry the perpetrator. Initially, her parents reported the abduction, but they acquiesced when the community elders pleaded with them to 'settle the matter'. As noted by Semira:

> *"Community elders are highly respected in our community and my family accepted the plea and received the dowry for my betrothal to him."*

Semira dropped out of school at grade six and was engaged in farm work with her parents, but she did not have any private income. Describing the abduction, rape and marriage, Semira said:

> *"I knew him before. He was a friend of my uncle-in-law's friend. He visited my aunt's house from time to time. When he abducted me, I was staying at my aunt's house. My aunt fought with her husband because of what happened to me. The sexual assault occurred after I was abducted. After he raped me, I gained consciousness three days later. They abducted and had their way with me. Following that, I contemplated a lot to run away from him. I didn't know I was pregnant until the sixth month. I called my mom to tell her about the pains I was having. I was too young to give birth, I had to go under a C-section when I was in labor. My second child was also delivered by C-section. Marriage is hard but I feel it was especially harder on me. I got married at the age of 14. Sometime after I got pregnant, he began treating me awfully."*

Semira's husband abandoned her when she was due to give birth to her second daughter. Her sister-in-law called, asking them to come as she needed help. Following the journey, Semira felt unwell, so a doctor recommended that she only travel after the birth. While she stayed with her sister-in-law, her husband returned to look after their house. Once Semira was admitted to hospital, her sister-in-law abandoned her, taking all of the money he had left for Semira, as well as all of her valuables and phone. Describing her isolation and subsequent support from the rehabilitation center, Semira said:

> *"I have lost contact with all my relatives and husband. That's how I ended up in the rehabilitation center. My husband didn't answer his phone and I didn't know my aunt's phone. I was abandoned in a town I didn't know and robbed. My husband left me 1,500 Birr. From this, I gave 1,000 Birr to my sister-n-law. When she abandoned me, she took the money I gave her and also the little money I had on me. Hospital staff and students helped me pay my bills. One gave me 350 Birr and others 200 Birr. Then, I went to the Women and Children office and they brought me here. At the time, my*

anxiety had taken over me. The staff helped me feel at home and also when the other girls came and when I heard their stories, I felt a lot better because I wasn't alone."

Semira also reflected on how the violence affected her first child:

"Sometimes, she sees us arguing and she might have suffered some emotional distress. I tried to explain to her that it wasn't what she thought. I also gave her her favorite toy that I hid from him. She forgets everything when she plays with her friends."

Semira stayed in the rehabilitation center for about two years, where they provided her shelter, food, and other necessitates. She contributed by undertaking chores, as she did not have an income. She has engaged in a variety of trainings, such as personal skills and tailoring, and is egger to integrate into the community. Her health has improved immensely - anxiety. Discussing how she has benefited from being admitted to the shelter, she said:

"The institution gave me a place to sleep, a clean place to eat and we received trainings to develop various skills such as tailoring. Now that we are all trained, it's almost time to re-enter society."

Semira also reflected on what brings her happiness, saying:

"When I become successful, I will help the community, especially women who are abused. One day, I hope to go to a first-world country, be successful and build a mosque there."

5.6.3 Serkadis, Amhara

Serkadis was staying in the rehabilitation center when she described her experiences of IPV during an in-depth interview. The 19-year-old completed grade nine, then dropped out of school and became a full-time bean sweeper. She said that she decided to live with her partner because her family did not have enough income to keep her in school. After she started living with him, she returned to her education.

Talking about the violence she experienced, she said:

"He used to argue with me every day, he beats me hard, he used to drink alcohol, had love and sex affairs with other women, and insulted me. Since we were married, I decided to tolerate him until I complete my education. But from time to time the attack became worse than improving and I decided to drop out from school and work. I searched for a job and got employed as a cook, but he started to quarrel with me every day after I worked for some time. He always argued and beat me when I get back home by saying, 'Why did you come home late in the evening and why do you go out early in the morning?'. It affected me very much. He personally didn't like that I was employed and generated income, so I stopped working and stayed home. He didn't give me money for anything. I was psychologically affected."

Serkadis elaborated on the profound impact the abuse has had on her, saying that she did not want to go back to her husband:

"I would rather beat someone or commit crime to be imprisoned than go back to my husband. To this extent the attack affected my life."

Her help-seeking journey did not resolve the violence, but finally helped her to escape from the abusive relationship. Initially, she disclosed the violence to her neighbors. Serkadis also sought help from a friend of her ex-husband, who intervened, yet her ex-husband continued to be violent. Though she then obtained a divorce, both of their families facilitated a reconciliation. Then, one afternoon, her ex-husband suddenly asked her to 'go with him somewhere'. He took her to the forest and attacked her brutally, resulting in extensive injuries. When they returned home, he warned her not to tell anyone about the violence. However, one of her neighbors noticed some of the injuries and asked her what had happened. At first, Serkadis denied the violence, yet when her neighbor asked her 'again and again', she told her what had happened, adding that her ex-husband threatened to kill her during the night.

Serkadis next reported the violence to the police, explaining how the abuse then worsened:

"Then, I reported to the police after he beat me but at that time the police tried to mediate between us and I returned back home. After that day, he frequently attacked me every night. Finally, again I went to the police station for the second time because I couldn't bear it any longer and informed them about my problems. I told them that I felt angry and disappointed because he attacked me often. I told them that I have nowhere to go. Then they brought me to this organization [rehabilitation center]. I didn't even know the existence of this organization."

Characterising the help she received from the police and the center as vital, she stated:

"There were female polices and they help me very well. The police supported me to come to this organization [rehabilitation center]. I feel very safe here. I feel good when they referred me to this organization. The organization gave me shelter and all the support I needed. This support is more than

anything to me. I didn't incur any money to get this support which was very much helpful...I have nothing to worry about. When I lived with my husband, I used to feel worried and frustrated thinking about what will happen when he gets back home."

Serkadis then reflected on her present situation, what brings her happiness and her hopes for the future:

"I do nothing at the moment. I'm simply living my life, but they [rehabilitation center] told me that they will give me training. I chose to get trained in sewing and now I am waiting for the training. We will not pay any money for the training; it's a free training. I hope to start my own work and help my mother...Having my own work and helping her mother will bring happiness in my life. I have the ability to do any types of work. My only hope in the future is my mom. I live for my mom."

5.6.4 Workae, Oromia

Workae was 25 years old and living in the rehabilitation center with her young son and daughter when she participated in an in-depth interview. Reflecting on her journey, she said:

"I came from Amhara region of Debre Birhan town where I moved to from the rural area. I never went to school. I came to Adama after a discussion with my partner. He rented a house and we started living together. I didn't know anyone in this town except him. We have stayed in peace for about two years. Then I conceived a child. Then, when I reached 8 months of pregnancy, he separated from me. I asked him for the reason, but he didn't have any justifiable response. I begged him to stay with me, but he refused. Sometimes, he visited me and gave me 100-200 birr. The money was not enough to buy enough food for anyone, let alone alone for a pregnant woman. I suffered a lot and finally I gave birth and when he learned that I give birth he visited me and asked me to give the baby to him. Then, I was really nervous and told him, 'Whatever happens in my life, I will never give my daughter to you. If you want to stop the little support you give because of it, you can start now.' However, my daughter frequently got sick because I didn't eat sufficient food to produce enough milk for her."

Subsequently, Workae told her ex-partner that their baby was unwell. He came immediately, but upon seeing their baby, he demanded to know why she said the baby was sick, when she was 'fine'. She explained the situation and that she hoped he would give her money to buy food. He then called the Woreda Administrator to force her to give their daughter to him. Though the Administrator tried to force her to do so, she firmly refused. Workae's ex-partner asked for a reconciliation. Agreeing, she began living with him again. On the third day, he repeatedly beat her. Leaving her badly injured, he then barred her from the house, taking her baby away from her:

"My whole body was injured and wounded. I couldn't stand with both legs. I recovered after I came in the rehabilitation center."

Workae told a friend what had happened. Her friend took her in for the night and advised her to report the case to the police, eventually convincing her to do so. The police officer called her ex-partner into the station and asked why he attacked her. Workae's ex-partner accused her of wanting to kill their daughter by starvation, saying that he took her away to protect her. The police officer then ordered him to bring the baby to the police station, where she was handed over to Workae, while her ex-partner was imprisoned. The police next referred her to the Women Affairs office in Adama, where was she was referred to the rehabilitation center.

Reflecting on the impact the violence has had on herself and her children, she said:

"I was suffering from mental illness. There was physical abuse and financial hardship. I couldn't perform household chores. I also experienced lack of confidence and ostracization because I am Amharic language speaker and he is Oromo language speaker. There are many situations in which I have been attacked. The impact on my elder child is very severe. He has suffered psychologically because my ex-spouse is not his father and he didn't treat him well. My daughter however misses her father very much. She frequently cries calling out 'Daddy, Daddy'".

Workae described the help she has received from the police, elders, her friend and the rehabilitation center as 'very supportive'. Of the center, she said:

"It is important that they brought me to the shelter. In the shelter, I get legal aid and it is good to go to court. I didn't spend any money. When I was admitted to the shelter, they conducted medical examinations for me and my daughter. They provided us with food and clothing. They have given me counseling to recover from stress. I got everything for free. Now I am comfortable and feel fine. My health is improving. My daughter is growing well."

Discussing her present situation and future hopes, she said that the shelter plan to provide her with a variety of training programs:

"We learn to cook for ourselves and take care of our children. I don't like to go anywhere else. I have tried to start a family. After completing the training, I agree that I will leave this institution. When I am able to start my own business and begin to live a stable life, that will bring happiness in my life. My future hope is to upgrade my business and create opportunities for women who pass through difficult and dangerous situations."

6. COSTS OF SERVICE PROVISION

As can be seen from the preceding section, organizations such as rehabilitation centers are pivotal in a woman's recovery process. Here, we turn our attention to the costs of providing such services. This section provides an estimation of the costs for service provision associated with IPV perpetrated against women across the following sectors: healthcare, criminal justice, civil legal services, and social services. It begins by providing an overview of the services offered by healthcare organizations, Women's and Children's Affairs offices, the police, legal organizations, attorney general's offices/Ministry of Justice bureaus, courts, shelters/rehabilitation centers and the Alegnta hotline. This is then followed by an estimation of the costs of providing IPV services by sector, as well as a total national cost for violence service provision across the sectors. Utilization rates, which underpin the calculation of these costs, are documented.

6.1 Costs in Different Sectors

6.1.1 Health Services

We begin by detailing the services for IPV provided in the health sector. As of 2021, there are 3,777 health centers and 367 hospitals, as well as 17,699 health posts in Ethiopia[135]. Twenty-seven of these hospitals have a GBV One Stop Center (OSC) providing free medical, legal and psycho-social services to survivors. In addition, there are three stand-alone OSCs in Dessie, Bahirdar, run by the Regional Justice Bureau[136]. In total, the MoJ run seven OSCs in Addis Ababa (Dessie, Bahirdar, Ghandi, Milinik, Tirunesh Bejing and Paulos hospitals) and one OSC at the Dire Dawa Dil Chorra hospital. According to an MoJ representative, a total of 1,841 victims of violence received services from the MoJ OSCs in 2021, of which 1,731 were women and girls (391 women). While they could not provide the percentage of these cases concerning IPV, they confirmed that, in the majority of cases, the perpetrator was an individual from outside the family.

With regard to staffing, as an example, according to UNICEF, the Adama OSC in Oromia houses a trained and dedicated social worker, a prosecutor, police officers, a nurse, a clerk, a doctor, and a professional psychiatrist[137]. The Center is also linked with the Bureau for Women and Children Youth Affairs, the Attorney General's office, the police, the Special High Court, and local NGOs.

A total of 16 healthcare organizations participated in this research, 3 hospitals with GBV OSCs, 6 general hospitals and 7 health centers, across the study regions. The OSCs that participated in the research provide shelter, legal services, support from social workers/counseling, medical services (such as physical examinations), laboratory tests (including for sexually transmitted infections, urine test and swab) and medication (such as emergency contraceptives, ceftriaxone and doxycycline) for survivors of IPV.

The general hospitals provide free health services such as emergency room care, laboratory tests, medication and free medical reports for police cases. They also work to provide awareness-raising activities/events to sensitise the community and the elder people (shemagele) to the pervasive nature of IPV.

By contrast, the health centers generally provide minimal services, such as free medical examinations and medication (sometimes there is a cost of approximately 50 Birr), referring survivors to OSCs for specialized care. If women accessing health centers for IPV require laboratory tests, there may be a charge (approximately 75 Birr). The Addis Ababa Woreda 8 Health Center, the Dodota Health Center, the Qucha Health Center and the Debre Health Center also provide counseling. In addition, the Dodota Health Center and the Tenguma Health Center offer a VAW awareness-raising program free of charge.

While some of the healthcare organizations that participated in the research provide specialized IPV/VAW training to their healthcare workers, the majority of participating organizations do not.

In Table 24 below, we provide a synopsis of the costs for providing IPV services for the healthcare organizations that participated in our research (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) from each organization.

[135] Ministry of Health Ethiopia (2021). *Annual Performance Report 2013 EFY (2020/2021)*. Addis Ababa: Ethiopia.
[136] List of OSCs provided by the Ministry of Women and Social Affairs.
[137] UNICEF Ethiopia (2019). *Providing a coordinated response to survivors of sexual violence in the Oromia Region*, https://www.unicef.org/ethiopia/stories/providing-coordinated-response-survivors-sexual-violence-oromia-region

Table 24: Annual Healthcare Service Provider Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
ADDIS ABABA_Yeka subcity Woreda 08 Health Center_ Woreda	48	34,560	600	248,880	**284,040**
ADDIS ABABA_Gandhi Hospital_Federal_OSC~	19	6,840,000	1,750	11,596,933	**18,438,683**
ADDIS ABABA_Tirunesh Bejing Hospital_Federal_OSC~	19	6,840,000	1,750	1,901,408	**8,743,158**
Amhara Region- Felege Hiwot Hospital_Region	27	1,620,000	15,000	166,405	**1,801,405**
AMHARA_East Gojjam Zone-Debre Markos Comprehensive Specialized Hospital*_ zone/region	554	76,729,000	17,500	921,411	**77,667,911**
AMHARA_ East Gojjam Zone- Enemay District-Hospital_ Woreda	4,200	67,796,400	1,800	1,020,000	**68,818,200**
AMHARA_East Gojjam Zone-Enarj Enawga District-Debre Work Health Center	150	2,850,000	1,800	102,000	**2,953,800**
AMHARA_East Gojjam Zone-Enarj Enawga District-Tenguma Kebele-Tenguma Health Center_ Woreda	2	19,000	1,800	34,000	**54,800**
ADDIS ABABA_Minilik Hospital_ Federal_OSC~	19	6,840,000	1,750	14,863,666	**21,705,416**
ADDIS ABABA_Yeka sub city Woreda 07 Health Center	24	13,824	1,800	2,191	**17,815**
OROMIA_ South Shewa zone Becho Woreda Tulu Bolo hospital	7,263	117,239,346	1,800	849,965	**118,091,111**
SNNPR_Qucha Kebele Health Center_ Woreda	12	456,000	1,800	583	**458,383**
SNNPR_Endibir Kebele Health Center	4	174,800	3,000	467	**178,267**
SNNPR_Adare Hospital	285	5,130,000	15,000	31,251	**5,176,251**
OROMIA_Assela Referral Hospital_ zone/region*	15	3,900,000	12,500	3,000	**3,915,500**
OROMIA_Arsi zone Dodota_ Woreda Health Center	55	82,500	1,800	35,000	**119,300**
Total	**12,696**	**296,565,430**	**81,450**	**31,777,161**	**328,424,041**
Total IPV Costs					**328,424,041**

* There is no data for the zones, so it is better to consider them as regions in terms of imputing costs.
~ OSCs predominantly provide services for sexual offences (mainly to survivors in an irregular union or to divorced women), with physical violence within intimate relationships, for example, catered for by the wider hospital.
^ Health Centers have an exclusive budgetary support (to complement the governmental regular budget) named Health Care Financing (donor support administered by the MoH), which enables them to purchase additional resources, such as materials and equipment.

6.1.2 Criminal Justice

6.1.2.1 Police

We now detail the services provided by the Police Commissions and the average annual costs of providing these services. Although the exact figures could not be sourced, there is an approximate total of 1,148 Police Commissioner Offices in Ethiopia - 1 at the federal level, 11 at the regional level, 2 at the City Administration level, 89 at the zonal level and 1,047 at the woreda level[138]. There are also structures at the Commission and other levels that handle cases of GBV, such as the Women and Child Protection Units. Of the Police Commissions, 17 organizations across the levels and the study regions participated in our research.

The Federal and Regional Police Commissioners work for the public, to uphold human and democratic rights, and to ensure the public's safety and welfare. Their duties include crime prevention, detection, investigation, coordination of national state police commissions and the development of national policing standards. The Federal Police has its own budget structure, is accountable to the Federal Government and works in collaboration with regional police commissioners, providing operational support. Regional Police Commissioners mainly provide the following services - crime protection, detection, exploration services through community policing offices, counselling services/ psychosocial support, detaining suspected perpetrators of violence, awareness-raising events/activities. They are accountable to the regional government and have a sub-structure at zonal and woreda levels.

Beyond directly serving victims, the SNNPR Gamo Zone Chencha Woreda Police Office is well-known for establishing links with concerned bodies, such as Women and Children's Affairs offices, health centers, legal service providers, and non-governmental organizations (NGOs).

All of the IPV services offered by Police Commissions are provided free of charge.

In Table 25 below, we provide a synopsis of the costs for providing IPV services for the police (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) from each organization.

[138] Data based on number of regions, zones and woredas.

Table 25: Annual Police Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
Amhara Region- Bahir Dar- the Amhara National Regional State Police Commission	36	20,300	132,000	500,000	**652,300**
Amhara Region- East Gojjam Zone- Enemay District- Police	31	3,275	1,800	500,000	**505,075**
Amhara Region- East Gojjam Zone- Enarj Enawga District- Police	31	2,000	1,800	500,000	**503,800**
Amhara Region- East Gojjam Zone- Enarj Enawga District-03 Kebele Police	31	3,275	1.800	500000	**505,075**
ADDIS ABABA_Yeka Woreda 06 Police office	60	9,000	1.800	500,000	**510,800**
ADDIS ABABA_Federal Police_	135	81,000	132,000	120,000	**333000**
SNNPR_GURAGHE_CHEHA_ EMDIBIR	31	2,000	1,0-800	500,000	**503,800**
SNNPR_Wolkete Zone Police	48	3,000	3,750	100,000	**106,750**
SNNPR_GAMO ZONE_ KII_ CHENCHA WEREDA_POLICE OFFICE_MEHIRET	31	3,275	1,800	500,000	**505,075**
Oromiya Jimma Zone agaro woreda local police	30	3,275	1,800	500,000	**505,075**
OROMIA_Jimma Zone goma woreda police	3	3,275	1,800	500,000	**505,075**
OROMIA_ jimma zone police commission	48	25,500	3,750	250,000	**279,250**
OROMIA_REGIONAL POLICE OFFICE_MESKEREM	36	20,300	132,000	500,000	**652,300**
OROMIA_ARSI ZONE_POLICE OFFICE_ROMAN	48	48,000	5,000	120,000	**173,000**
OROMIA_ARSI_DODOTA WOREDA_ALEM KEBELE_KII_ CP_ROMAN	31	100	1,800	500,000	**501,900**
UN WOMEN_SNNPR_ POLICE COMMISION_MEHIRET	36	20,300	13,2000	500,000	**652,300**
UN WOMEN_OROMIA_SW SHOWA ZONE_POLICE OFFICE_MESKEREM	48	25,500	2,500	156,667	**184,667**
Total	**714**	**273,375**	**559,200**	**6,746,667**	**7,579,242**
Total IPV Costs					**7,579,242**

*For organizations at the regional and federal levels, it was difficult to differentiate between GBV and IPV costs, so these costs are likely to be an overestimate

6.1.2.2 Attorney General/Ministry of Justice

In this section, we provide details concerning the Attorney General/Ministry of Justice (MoJ) offices/bureaus and the average annual costs for providing IPV services. There is a total of 11 MoJ branch offices at the federal level, with 89 Attorney General offices/bureaus (BoJ) at the zonal level and 1,047 at the woreda level[139]. Of these, 11 offices across the different levels and the study regions participated in this research.

Through a multi-sector steering committee, the MoJ manages and coordinates the provision of key services such as counselling, medical treatment and legal services, while increasing survivors' safety and working to bring perpetrators to justice[140]. The duties of the Federal MoJ include ensuring law and order, drafting laws, consulting the federal government and representing the state in civil litigations and arbitrations.

The Federal MoJ has two main Directorate Directors in its head office that are established to coordinate GBV interventions. The first directorate is responsible for planning, allocating budgets and executing empowerment and supportive activities for women (amongst others). The duties of the second directorate relate to coordinating protection and litigation support for violence perpetrated against women (amongst others). This directorate mainly receives, and ensures justice for, crimes involving homicide. Concerning GBV, it also provides VAWG training, as well as serving as the secretariat for the National Coordinating Body on VAWG/Child Justice, and advocacy, and establishing and monitoring OSCs.

The Federal MoJ has branches in Addis Ababa (in all 11 sub-cities), 1 branch office at Dire Dawa and 1 new branch office recently opened in Hawassa. Each sub-city has an administration at the woreda level (on average 9-12 woredas) and, on average, 6-8 police stations. These offices have key staff that provide support in collaboration with the police in each police station. On average, each woreda has one public prosecutor in their police station, who mainly works on investigation and litigation for any kind of violence or crime against women (amongst others). A special GBV investigation and prosecution unit has also been established in all sub cities. These units engage in investigation and prosecution of GBV, represent destitute women in civil matters and organize public legal education and community mobilization on VAW, as well as working with the police and other stakeholders to ensure survivors receive comprehensive services including counselling.

Cases coming to the Federal MoJ are also referred to other organizations providing IPV services such as OSCs and shelters. Before beginning a criminal investigation, victims receive any health services and psychological treatment they might need. When OSCs are not available, IPV victims are referred to sub-city police stations and hospitals, where the evidence collection process begins. According to an Attorney General office/MoJ bureau representative who participated in our research, in such cases, women become re-traumatized, as they have to report the details of their cases repeatedly - to the hospital, to the police and the prosecutor.

The Women, Children and Crosscutting Issues Directorate coordinates activities related to GBV, such as training for employees on issues related to women and children. However, the office could not provide the stress/burnout training planned due to budget constrictions. While some Attorney General offices/MoJ bureaus provide VAW training, the majority do not.

The Dire Dawa branch has a similar structure. However, the Hawassa branch does not work on investigation and litigation crimes relating to women. These cases are addressed by regional Attorney General offices/MoJ bureaus. Each region has the mandate to organize offices/bureaus at the following levels - regional, zonal and woreda.

According to the participant from the Amhara region Attorney General's office/MoJ bureau, services are provided to victims of IPV by first identifying the type of case involved. Criminal cases are sent to the criminal investigation department and cases are investigated by gathering evidence in collaboration with the police, while civil cases are sent to the civil legal service department and then presented by civil lawyers. Divorce cases are mostly handled at the district level. No employees have received IPV training, yet they have received general training on violence and child marriage.

The Oromia region Attorney General's office/MoJ bureau provides training to staff members and organizes awareness-raising programs for the community (aba geda or community leader, religious leaders, etc.). Direct services are not provided by the regional office, with free legal services provided at zone and woreda levels, as well as at universities to which the office refers cases.

In Table 26 below, we provide a synopsis of the costs for providing IPV services for the attorney general offices/MoJ bureaus that participated in our research (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) from each organization.

[139] Data received from the MoJ.

[140] UNICEF Ethiopia (2019). *Providing a coordinated response to survivors of sexual violence in the Oromia Region*, https://www.unicef.org/ethiopia/stories/providing-coordinated-response-survivors-sexual-violence-oromia-region.

Table 26: Annual Attorney General/Ministry of Justice Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
Amhara Region- Attorney General	150	375,000	37,010	2,000,000	**2,412,010**
Amhara Region- East Gojam Zone-Attorney `General	18	135,000	20,000	2,500,000	**2,655,000**
Amhara Region- East Gojam Zone- Enemay District-Attorney General	5	18,725	1,600	250,000	**270,325**
Addis Ababa- Yeka Sub-city Attorney General	66	33,000	10,750	2,500,000	**2,543,750**
Addis Ababa- Federal Attorney	272	1,462,000	0	10,303,030	**11,765,030**
oromiya- South West shewa becho woreda Attorney office	5	25,000	1,400	250,000	**276,400**
SNNPR_Qucha Woreda General Authority	5	12,500	1,500	250,000	**264,000**
SNNPR_GURAGHE Z_ ATTORNEY_MIHRET	149	130,673	1,500	2,500,000	**2,632,173**
SNNPR_ATTORNEY	150	375,000	25,000	2,000,000	**2,400,000**
OROMIA_jimma zone_ ATTORNEY_OFFICE	2	5,918	10,750	2,500,000	**2,516,668**
OROMIA_REGIONAL_ ATTORNEY OFFICE	150	375,000	49,020	2,000,000	**2,424,020**
Total	**972**	**2,947,816**	**158,530**	**27,053,030**	**30,159,376**
Total IPV Costs					**30,159,376**

6.1.2.3 Courts

IPV services provided by the courts at the different levels are presented in this section, followed by an estimation of the costs of service provision. There are a total of 11 first instance courts, 5 high courts and 1 supreme court at the federal level[141]. At the regional level, there is 1 supreme court. In addition, there is 1 high court at the zonal level, as well as 1,047 first instance courts at the woreda level.

At the federal level, the highest court is the Federal Supreme Court, followed by the Federal High Court and then the Federal First Instance Court. The high courts are located in 4 sub cities of Addis Ababa, as well as one high court in Dire Dawa[142]. There are first instance courts in all 11 sub cities of Addis Ababa, as well as one first instance court in Dire Dawa. It is the MoJ and its branch offices, as well as the Federal Courts (Supreme, High Court and First Instance), in Addis Ababa that predominantly address civil and criminal cases related to IPV. First instance courts have their own benches, which only deal with cases concerning women and children. For the most part, one (and in some cases 2) judges are assigned to trials involving such cases.

At the regional level, the court framework follows the same structure - Regional Supreme Court, Regional High court, Regional First Instance Court. The criminal and civil benches of these courts mainly handle IPV cases. Each region has the mandate to organize courts at the following levels – first instance courts at woreda level and high courts at zone level. The courts are required to follow the Criminal Procedure Code[143] and the Courts Establishment Proclamation[144].

Ten courts across the different levels and the study regions participated in this research. Through its Women's and Youth Affairs Directorate, the Federal Supreme Court, which is the highest court in Ethiopia, is responsible for building the capacity of women employees through training or formal education, as well as conducting research. The Directorate does not provide direct services to survivors of IPV, aside from counseling. However, some women come to this office seeking services and, if they have children, following counseling, they are referred to the EWLA and/or the Child Justice Project Office.

[141] Data received from the MoJ.
[142] Data received from the MoJ.
[143] Criminal Procedure Code of Ethiopia, https://www.policinglaw.info/assets/downloads/Criminal_Procedure_Code_(English).pdf.
[144] Ethiopian Federal Courts Establishment Proclamation, https://utcd.org.tr/wp-content/uploads/formidable/2/ethiopian-federal-courts-establishment-proclamation.pdf.

In the Oromia region, the court provides legal support to survivors and there are "legal aid providers" from different universities who support survivors, while the court offers them equipment and materials such as an office, stationary, a computer, a printer and furniture (purchased using the general budget).

The regional court of SNNPR provides legal services and mediation, as well as coordinating the legal services in the region and working collaboratively with other institutions. In addition, judges or court employees may refer survivors to a legal aid service, such as in universities or CSOs. They also provide VAW training and create awareness about the issue. The regional court of SNNPR does not receive referrals unless the perpetrator is an employee of the zonal court.

According to the KII participant from the Enemay District court of the Amhara region, at the woreda level, this court protects the confidentiality of IPV victims through closed trials when they are 'too shy' to speak in court. There are also survivor-friendly benches at federal and regional level courts. In addition, the Jimma zone Gomma woreda court and the Arsi zone Dodota woreda court in Oromia provide training and awareness-raising for their staff.

The Wolkite zonal high court mainly deals with cases related to property division and the question of paternity, rather than IPV. Employees are provided with IPV awareness-raising by the regional government. Most cases concerning violence and divorce are addressed at the first instance court at the woreda level. Appeals are then dealt with at the zonal level.

In Table 27 below, we provide a synopsis of the costs for providing IPV services for the courts that participated in our research (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) from each organization.

Table 27: Annual Court Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
Amhara Region- East Gojjam Zone- Court	5,005	1,000,980	0	28,641,976	**29,642,956**
Amhara Region- East Gojjam Zone- Enemay District- Court_ Woreda	648	2,494,800	0	320,018	**2,814,818**
Addis Ababa-Federal supreme court	108	90,936	384,672	618,061	**1,093,669**
OROMIA_JIMMA ZONE_ GOMMA WOREDA_COURT OFFICE	15	131,250	108	120,007	**251,365**
OROMIA_REGIONAL_COURT OFFICE_MESKEREM	20	189,820	5,129	115,257	**310,205**
SNNPR_GURAGHE Z_ EMDEBER WOREDA_COURT	51	505,200	432	480,027	**985,659**
SNNPR_ Regional Supreme court	20	189,820	5,129	115,257	**310,205**
SNNPR_WOLKITE ZONE_ COURT	1,575	11,809,800	2,400	9,011,329	**20,823,529**
OROMIA_Arsi Zone Court	60	231,000	0	343,367	**574,367**
OROMIA_Dodota Woreda court Office	21	157,275	108	120,007	**277,390**
Total	**7,522**	**16,800,880**	**397,978**	**39,885,306**	**57,084,164**
Total IPV Costs					**57,084,164**

6.1.3 Civil Legal Services

Next, we will examine the IPV services provided by the Ethiopian Women Lawyers Association (EWLA), followed by an estimation of the costs of service provision. The EWLA is a non-profit and non-partisan organization seeking to promote the legal, economic, social, and political rights of Ethiopian women. Areas of activity include women's empowerment and access to justice, strengthening the capacity of duty bearers, and influencing policies, laws and practices to realize women's equal rights. The EWLA provide legal services and legal aid to women suffering from GBV and discrimination. At the advocacy level, their achievements include supporting the revision of gender-insensitive articles in the law, as well as the establishment of the Family Law.

The EWLA head office is located in Addis Ababa and there are six branches in Bahir Dar, Assosa, Hawassa, Adama/Nazareth, Dire Dawa and Gambella. According to each of the EWLA representatives who participated in our research, the cost of providing legal services varies depending on the applicant's case. COVID-19 has exacerbated IPV and increased the level of support required because most courts were closed due to the pandemic. The participating EWLA organizations record the number of IPV cases they deal with.

In Table 28 below, we provide a synopsis of the costs for providing IPV services for the lawyer's associations that participated in our research (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) from each organization.

Table 28: Annual Women Lawyer Associations Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
ADDIS ABABA_Ethiopia Women Lawyer Association	2,020	30,300,000	5,600	41,040,000	**71,342,020**
SNNPR_Hawassa Branch Coordinator of the Ethiopian Women Lawyers Association	83	1,245,000	80,000	3,153,600	**4,398,683**
Total	**2,103**	**31,545,000**	**85,600**	**44,193,600**	**75,740,703**
Total IPV Costs					**75,740,703**

6.1.4 Social Services

In this section, we focus on the organizations providing social services to survivors of IPV, namely hotline services, rehabilitation centers/shelters and Women's and Children's Affairs Offices.

6.1.4.1 Hotlines

There are 14 free GBV hotlines in Ethiopia. One of these hotlines, the Alegnta hotline located in Addis Ababa City and established by Setaweet, with the support of the Canadian Embassy and Ethio Telecom, participated in our research. This hotline mainly provides counseling and referral to organizations offering services to individuals experiencing all forms of GBV. They do not record the number of IPV cases they deal with. They have 2 telephone lines and 2 shifts (morning and afternoon), enabling them to provide the service to approximately 50 people experiencing GBV per month. Hotline employees receive specialized GBV training.

In Table 29 below, we provide a synopsis of the costs for providing IPV services for the Alegnta hotline (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) from the organization.

Table 29: Annual Alegnta Hotline Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
Addis Ababa City Hotline_ 6383_Alegnta	350	960,024	1,600	1,278,720	**2,240,344**
Total IPV Costs	**350**	**960,024**	**1,600**	**1,278,720**	**2,240,344**

6.1.4.2 Rehabilitation Centers/Shelters

There are also an estimated 19 CSO VAWG shelters/rehabilitation centers (one closed recently) in the Ethiopian Network of Women's Shelters providing rehabilitation and reintegration services to survivors of IPV in Ethiopia at the regional level[145]. The majority of these are located in Addis Ababa, with the others located in the regional capitals. Accessibility issues relate to the small number of shelters/rehabilitation centers available, as well as their locations, with women from rural areas at a particular disadvantage[146].

Due to the ongoing conflict in Northern Ethiopia, the Association for Women's Sanctuary and Development (AWSAD) have opened an additional two emergency shelters in Woldiya and Semera, bringing their total number of branches to eight (after the current study's data collection period)[147]. According to Maria Munir of the Ethiopian Network of Women's Shelters, the AWSAD shelters/rehabilitation centers provide food, personal items, healthcare, transport, training and education, as well as leaving and reintegration funds. In addition, they are generally staffed by a manager, nurses, psychosocial service providers, a cook, cleaners, guards and drivers.

Five shelters/rehabilitation centers across the study regions participated in this research. The participating shelters/rehabilitation centers provide shelter, materials (such as food, sanitary products, toothpaste and toothbrush, soap, hair oil, clothes and diapers) and counseling, as well as referral to other organizations addressing IPV. Some of the shelters/rehabilitation centers also provide basic literacy education and training including tailoring and basket weaving, while others provide medical services or pay for these costs.

In addition, the Adama Rehabilitation Center in Oromia provides legal, social work and nursery care, as well as play therapy for children. With regard to housing, they have invested approximately 40,000 birr per woman for 110 women to renovate their houses, which were burnt down in the last year.

According to an AWSAD Safe House representative, their cases usually involve women who are abandoned by their partners once they become pregnant. Women usually stay for 3 months, but they can stay for a maximum of 6 months if needed, or even longer if they have nowhere else to go. When women leave, they give them a small amount of money to help them make a new start. Some of these women have obtained jobs in the textile industry and as bakers. The Agar Ethiopia Safe House also provides women with money to relocate and re-integrate into the community - 3,000 birr.

All but one of the participating shelters/rehabilitation centers record IPV cases.

In Table 30 below, we provide a synopsis of the costs for providing IPV services for the shelters/rehabilitation centers who participated in our research (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) of the participating organizations, including unit costs and number of women experiencing IPV who access their services.

[145] UN Women Africa (2021). *I got my smile back: Providing much-needed support to survivors of violence in Ethiopia*, https://africa.unwomen.org/en/news-and-events/stories/2021/11/providing-much-needed-support-to-survivors-of-violence-in-ethiopia - UN Women confirmed the recent closure of one of these organizations.

[146] UN Women Ethiopia (2016). *Shelters for women and girls who are survivors of violence in Ethiopia: National assessment on the availability, accessibility, quality and demand for rehabilitative and reintegration services*. Dublin and Addis Ababa: Irish Aid and UN Women. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2016/Shelters-for-Survivors-of-Violence-Ethiopia.pdf

[147] Data received from UN Women.

Table 30: Shelters/Rehabilitation Centers Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
ADDIS ABABA_AWSAD_Region	100	1,810,000	29,400	1,530,000	**3,369,400**
OROMIA_Adama Rehabilitation Center_Region	99	297,000	37,800	4,500,000	**4,834,800**
Amhara Region- OPRIFS Shelter	75	450,000	20,000	25,000	**495,000**
AMHARA REGION –B/DAR CITY-REHABLITASHION CENTER- Agar Ethiopia-Agar Safe House	191	667,800	0	27,000	**694,800**
SNNPR- Region-AWSAD Safe House	70	1,504,020	14,400	1,525,500	**3,043,920**
Total	**535**	**4,728,820**	**101,600**	**7,607,500**	**12,437,920**
Total IPV Costs					**12,437,920**

6.1.4.3 Women's and Children's Affairs Offices

Next, we detail the services provided by the Women's and Children's Affairs Offices and the average annual costs of providing these services. There are a total of 1,148 Women's and Children's Affairs offices in Ethiopia - 1 at the federal level, 11 at the regional level, 89 at the zonal level and 1,047 at the woreda level[148]. Of these, 17 offices across the levels and the study regions participated in our research.

The Women's and Children's Affairs Offices mainly provide counseling services/psychosocial support and awareness-raising events/activities and/or training concerning VAW, and women's social and economic empowerment. They also work collaboratively with other governmental and non-governmental organizations addressing IPV, as well as UN agencies and the World Health Organization. Some offices further provide legal services to IPV survivors.

However, regional State bureau organizations do not provide direct services to IPV survivors. Rather, they coordinate IPV services and provide referrals to the relevant organizations providing IPV services. In addition, they focus on prevention, awareness-raising activities and training concerning VAW. Some kebele-level offices also only offer a referral service.

In addition, the federal Women's and Children's Affairs Offices in Addis Ababa provide legal aid to survivors of IPV, while supporting the work of other organizations addressing IPV. They are also building OSCs in Afar and Dire Dawa, as well as providing 3 million Birr to enhance an OSC in SNNPR. Furthermore, they provide IPV training to workers in a variety of organizations addressing IPV (OSC employees, nurses, police, attorneys, social workers) and work to create employment opportunities for victims of GBV in textile companies.

According to the representative of the Jimma Guma woreda Women's and Children's Affairs Office who participated in the research, the office tries to resolve IPV cases through traditional negotiation. If this is not possible, most offices refer the case to the appropriate services. For example, if a crime has occurred, the case is referred to the police, and if the case involves divorce, they refer it to an attorney and the relevant court. Where survivors have healthcare and other needs, they are referred to a hospital/OSC or health center.

The Yeka Women's and Children's Affairs Office in Addis Ababa also first seek to resolve any disputes within their office, making subsequent referrals where necessary. Their violence prevention team further provide training to workers in a variety of organizations addressing all forms of GBV.

All of the IPV services offered by the Women's and Children's Affairs Offices are provided free of charge. Some offices also provide financial/material support to women survivors of IPV. With regard to the recording of IPV cases, most of the offices note the number of cases received. By contrast, the majority of the offices do not provide IPV specialized training to their employees due to lack of funding.

In Table 31 below, we provide a synopsis of the costs for providing IPV services for the Women's and Children's Affairs Offices who participated in our research (see Annex 2 for a more detailed table). These cost estimates are based on the data provided to us by the representative(s) of the participating organizations, including unit costs and number of women experiencing IPV who access their services.

[148] Data received from the MoWSA.

Table 31: Annual Women's and Children's Affairs Offices Intimate Partner Violence Costs (Birr)

Organization	Average Annual Intake	Service Provision Cost	Personnel Training Cost	Admin Cost	Total Costs
AMHARA_REGIONAL_WC&Y_ OFFICE	4,486	2,754,838	0	650,000	**3,404,838**
AMHARA_East Gojjam Zone- Enemay District-WC&Y Affairs_Woreda	40	10,195	0	10,000	**20,195**
Amhara Region- East Gojam Zone WC&Y bureau	238	146,019	0	86,080	**232,099**
Amhara Region- East Gojjam Zone- Enarj Enawga District-Tenguma Kebele-Women Affairs_Woreda	4	0	0	0	**0**
Addis Ababa_Yeka_Woreda 6_Women & Children Affairs office	4	2,549	0	2,500	**5,049**
ADDIS ABABA_Federal Women Affairs	81	49,746	0	1,200,000	**1,249,746**
ADDIS ABABA_Yeka_Women Affairs_Subcity_Zone	161	98,656	111,373	86,080	**296,109**
ADDIS ABABA_CITY_WOMEN AND CHILDREN AFFAIRS_ OFFICE_Region	327	200,899	872,420	940,000	**2,013,319**
OROMIA_REGION_Arsi zone _ Dodota Woreda Women Affairs Office_Woreda	11	11,214	0	11,000	**22,214**
OROMIA_ Jimma Zone goma Woreda_women office	17	11,214	153,138	11,000	**175,352**
OROMIA_REGION WOMEN AND CHILDREN AFFAIRS_ OFFICE	2,900	1,781,019	742,485	800,000	**3,323,505**
OROMIA_SW SHOWA ZONE_WOMEN- OFFICE_ MESKEREM	161	98,656	0	86,080	**184,736**
OROMIA_SW SHOWA ZONE_WOLISO WOREDA_ DILELA KEBELE_WOMEN OFFICE_MESKEREM	42	25,487	348,040	25,000	**398,527**
SNNPR_GURAGHE Z_CHEHA W_WC&Y_MIHRET_Woreda	18	11,214	0	11,000	**22,214**
SNNPR_ WC&Y OFFICE_ MEHIRET_Region	2,900	1,781,019	0	800,000	**2,581,019**
SNNPR_GAMO ZONE_ CHENCHA WOREDA_WC&Y OFFICE_MEHIRET	18	11,214	0	11,000	**22,214**
SNNPR_GAMO ZONE_WC&Y OFFICE_MEHIRET_Zone	83	51,097	0	86,080	**137,177**
Total	**11,490**	**7,045,037**	**2,227,456**	**4,815,820**	**14,088,313**
Total IPV Costs					**14,088,313**

*For some of the organizations, it was not clear from the KII transcripts whether they provide training - cost = 0.

6.2 Costs Across Sectors

We begin by detailing the services for IPV provided in the In table 26 below, we provide the total costs for IPV service provision across the sectors. As can be seen, the largest costs by far (360,943,906 Birr) are incurred by healthcare organizations. This is in-keeping with literature highlighting healthcare as a critical point of service delivery for survivors[149]. IPV is a direct and indirect risk factor for a variety of health problems frequently seen in healthcare settings. Indeed, research has established that women and girls experiencing violence utilize health services more frequently, including the emergency department, outpatient care, primary care services, and counselling services, and are more likely to report a worse health status and quality of life than those who do not experience violence[150].

Expenditure for the criminal justice (104,211,937 Birr), civil legal (83,240,390 Birr) and social services (31,614,984 Birr) sectors is also substantial. Indeed, the costs incurred by the social services is remarkably less than the resources actually required. This finding is borne out in the narratives of the service providers in section 6.3, which focuses on the challenges faced by organizations providing IPV services. When comparing the costs across the sectors, it is, of course, important to note the difference in the number of organizations in each sector that participated in a KII – healthcare (16); criminal justice (38); civil legal (2) social services (23), as well as the services each organization provides.

Table 32: Service Provision Costs Across Sectors

Sector	Total Costs (Birr-Feb 7)	Total Costs *(Birr-April 30)	Total Costs **(USD-April 30)
Healthcare	328,424,041	360,943,906	6,951,780
Criminal justice	94,822,782	104,211,937	2,007,122
Civil legal services	75,740,703	83,240,390	1,603,210
Social services	28,766,577	31,614,984	608,905
Grand Total	**527,754,103**	**580,011,217**	**11,171,016**

*The values have been adjusted for month-on-month inflation from Feb to April, the latest month for which data was available. Data was sourced from https://tradingeconomics.com/ethiopia/inflation-rate-mom
**Assumed exchange rate of I USD to 51.91 Birr as of last working day of April 2022 (29th), based on average buying and selling exchange rate of Commercial Bank of Ethiopia (https://www.combanketh.et/en/exchange-rate/)

[149] Forde, C. and Duvvury, N. (2021). *Assessing the Social and Economic Costs of DV: A summary report*. Dublin: Safe Ireland; European Union Agency for Fundamental Rights (2014). *Violence against women: An EU-wide survey*. Luxembourg: Publications Office of the European Union.; Duvvury, Nata, and others (2015). *The Egypt Economic Cost of Gender-based Violence Survey (ECGBVS) 2015*. Cairo: UNFPA.

[150] See, for example: Grisso J.A., Schwarz D.F. et al. (1999). "Violent injuries among women in an urban area". *New England Journal of Medicine*, 341: 1899–1905.; Bonomi, A. E., Thompson, R. S. et al. (2006). "Domestic violence/coercive control and women's physical, mental, and social functioning." *American Journal of Preventive Medicine*, 30(6): 458-466.

6.3 Service Provision Challenges

The KII participants also shared a variety of challenges they face in providing services to women who have experienced violence. Many of these participants, across the different sectors, discussed the difficulty of the work, especially when they witness women returning to their abusive partners or when the justice system fails women. Employee exhaustion, physical and psychological health problems and, in some cases, burnout and/or employees leaving, were identified as consequences in this regard. Loss of trust in men was also highlighted:

> *"It has a huge effect on us. The type of case that you see in this facility makes you question your faith in your husband, brother, and uncle. Meaning, it makes the question all males. It makes question why other males can't do this. And it makes you lose sleep too. Thinking about the case will drive you mad. So, the professionals working here are affected psychologically"(Healthcare facility employee).*

The dearth of a specific budget for IPV is an additional challenge discussed by several KII participants. This has a number of ramifications, such as employees being overburdened (not enough staff) and underpaid. In addition, employees sometimes cover OOP costs for survivors seeking help. A representative from a Women's and Children's Affairs office further expressed concern regarding the lack of privacy in the office for women seeking support for IPV.

Another representative from a Women's and Children's Affairs office described the positives of their work, nonetheless:

> *"Normally, working with females (especially for IPV victims) is a kind of blessing for us. You are working on humanistic work. You will be satisfied when you solve the problem of victims. Sometimes, you will be depressed when you see such cases, but you get relief when their problem is solved".*

6.4 Survivor and Service Provider Recommendations

Both survivors and service providers made several recommendations concerning what can be done to better address IPV. Given the challenges detailed above, many KII participants spoke of the need for a greater focus on the issue of IPV. These participants identified the fact that most women do not report their experiences or seek help as a particular problem. Recommendations to address this issue mainly focused on the need for the government to provide education and awareness-raising activities, such as education for men and elders in rural areas and campaigns across media outlets and in schools. As stated by a woman who participated in an IDI, the government, community, and NGOs should work together to raise awareness of IPV.

IDI and KII participants also advocated for harsher sentences for perpetrators, as well as an increased focus on their behavior, rather than the victim's. They also spoke of the need for the law to change, particularly concerning the existing stipulation for 3 witnesses to proceed with a criminal case. In the following quote, a healthcare facility employee discusses these issues:

> *"The government must strongly penalize this kind of attacker. The penalty should serve as an education to the community. This kind of attack is becoming more prevalent nowadays. There is a misconception among the community about rape. The community thinks that the attacks happen because the women don't dress properly. But that is not the case at all. And the community is not willing to come outside to say that their daughter has been raped. Because they think that this might affect her future life. When the woman comes to our facility, it is not because of their intentions. They are mostly forced to come here".*

Indeed, one woman who participated in an IDI asserted that the government should be the first point of support for women who experience IPV and that such support should not be left to NGOs.

In terms of service provision, KII participants recommended a variety of measures for the government - earmarked and comprehensive budgets for all organizations providing IPV services; an increase in the number of organizations providing IPV/GBV services; more OSCs where survivors can access all services in the one location; provision of accessible services, including protection, particularly in rural areas; and specialized training for employees working on IPV cases. A woman who participated in an IDI specifically discussed the need for the police to identify witnesses to IPV, rather than requesting survivors to do so, while another advocated for institutions that 'at least create work for us, something to support ourselves'. A KII participant working in a rehabilitation center also high-

lighted the need for the government to provide financial assistance to women who have been abandoned with a baby and are finding it difficult to manage.

The need for multi-sectoral collaboration was also identified, with a representative of a healthcare facility specifically advocating for strengthening of the link between legislators and law enforcement agencies.

IDI and KII participants, alike, further discussed the need to enhance women's rights concerning divorce, particularly with regard to ensuring women obtain their share of the assets, including land. Economic empowerment and support for 'strong women in the community' were also identified as actions for the government, with the need for women's participation in women's issues being significantly increased, including in addressing IPV.

An IDI participant further discussed the importance of families playing the 'biggest role in the community', as she believes that violence against women is learnt within the family unit. Her recommendation is that the community encourage families to attend weekly religious services. She also advocated for education within the family:

> *"Most of our men forget that a woman is a mother, a sister, a daughter and a wife. Mothers should teach their sons about the dignity of women so they will not repeat the attack on women in the future."*

Indeed, another woman survivor believes that the community should 'teach boys and men to respect their wives and women in general' and to educate men who perpetrate IPV. IDI participants further discussed the need for the community to take care of women in abusive relationships, as well as for an end to the culture of silencing victims, which would include the community to speaking out against IPV.

The issues of addiction and poverty were also raised by some KII participants across the sectors, who believe that the government need to acknowledge and address this issue, as these are seen as risk factors for the perpetration of IPV.

As we can see, a range of measures at different intersecting levels is needed. This is encapsulated in the following quote from a representative of a shelter:

> *"The government should start from scratch, designing projects for schools and communities. This means creating a generation that hates violence, young and old alike. I think it would be better if they planned something to get out of poverty, and the other thing is to do different things to keep people from getting addicted. I always regret that I think the legal issue needs to be strengthened. In particular, when potential men come, I say it is better not to negotiate with the police, for the perpetrator to be prosecuted in the strongest possible terms, and for the health facilities to use the right tools to provide the right information".*

7. ECONOMIC CONSEQUENCES OF INTIMATE PARTNER VIOLENCE FOR ETHIOPIA

In this section, we present the overall economic costs due to IPV in Ethiopia. We first provide the national estimates of costs for women and households based on the incident data and then estimate the national impacts on women's income, household income and expenditure, and overall productivity loss.

7.1 National Estimates of Costs for Women and Households

The aggregate costs for women and households are presented in tables 7.1, 7.2 and 7.3, based on the incident data. As Table 33 indicates, nearly 47% of survivors report incurring an average of 2,710 Birr in costs. The national cost is approximately 5.2 bn Birr.

Table 33: National OOP Costs

	N	N (Extrapolated)	% of Survivors	Average Cost (Birr)	Median Cost (Birr)	National Cost (Birr-7th Feb)	National Cost (Birr- April 30)*	National Cost (USD- April 30)
OOP	181	1,745,161	47%	2,710	680	4,729,678,186	5,198,001,082	100,113,501

*The values have been adjusted for month-on-month inflation through April 2022, the latest month for which data was available. Data was sourced from https://tradingeconomics.com/ethiopia/inflation-rate-mom
**Assumed exchange rate of I USD to 51.91 Birr as of last working day of April 2022 (29th), based on average buying and selling exchange rate of Commercial Bank of Ethiopia (https://www.combanketh.et/en/exchange-rate/)
*** Extrapolation weights, derived at the time so the survey reflects the national population of women aged 18 to 59, have been used.

Table 34 details the results of lost care work and productivity loss. Nearly 36% of survivors and 23% of survivors' husbands report missing 19 and 11 care workdays respectively.

Table 34: Aggregate Care Work Loss and Productivity Loss Costs based on Incident Data

	N	N (Extrapolated)	% of Survivors*	Average Days	Median Days	National Days Lost	Workday Wage (Birr)**	National Cost (Birr-7th Feb)	National Cost (Birr- April 30)*	National Cost (USD- April 30)
Care Work	140	1,244,751	36%	19	8.78	23,360,401	61	1,429,656,531	1,571,218,147	30,261,662
Care Work-Husband	87	732,640	23%	11	5.614	7,787,234	60	468,791,483	515,210,241	9,922,949

*As the minimum wage in the sample comprises both part-time and full-time employees, median wages of both women and husbands have been used for monetising care work. The monthly wage was converted into an hourly wage and then multiplied by the respective no of care work hours of women and men to provide a care work wage day. Individual women's wages have been used for productivity loss.

However, the cost estimates based on the incident data are partial estimates given they are based on experience of 'current violence' (i.e., violence experienced in the last 12 months) and do not capture some of the longer-term impacts on women who have experienced 'ever violence' (in the last months and before the 12months). To capture these impacts, we have produced an estimation based on a comparison between women experiencing 'ever violence' and those not experiencing 'ever violence'. Given that the sample selected for this study is representative of the Ethiopian population, the national estimates of women's income loss, household income loss, household expenditure and productivity loss are derived as follows:

Women's income loss = All working women who experienced 'ever IPV'* income loss from PSM*12. The PSM analysis established that women experiencing IPV had lower monthly income by 372.88 Birr or an annual income difference of 4,474.56 Birr.

Following the same logic, Household income loss = Total no of households with women experiencing 'ever IPV'[151]* household income loss from PSM per month*12. The PSM analysis established that household income was lower by a monthly income of 929.90 Birr or an annual income difference of 11,158.80 Birr.

Similarly, the Household expenditure loss = Total no of households with women experiencing 'ever IPV'* household expenditure loss from PSM per month*12*. The PSM analysis shows that there is lower expenditure in households with IPV by about 332.95 Birr monthly or by 3,394 Birr annually.

Productivity Loss = All working women who experienced ever IPV* monetized productivity loss (productivity loss from PSM*individual woman's daily wage). The PSM analysis established that the difference between those experiencing IPV and those not experiencing IPV was 16.67 days. All the results were adjusted for month-on-month inflation and Birr-USD exchange rate. Table 35 below presents the loss for women and households extrapolated to the national level.

Table 35: Income and Expenditure Loss for Women and Households

Category of Loss	Extrapolated National Number of Survivors	Unit Cost (Annual) Birr	Total Estimate Birr (7th Feb)	Total Estimate Birr (April 30)*	Total Estimate USD (April 30)**
Women's Income	3,779,897	4474.6	16,913,375,920	18,588,103,224	358,006,868
Income loss of Households with IPV	2,377,863	11,850	28,177,676,550	30,967,771,472	596,439,279
Expenditure loss of Households with IPV	2,377,863	3393	8,070,467,022	8,869,587,880	170,828,263
Productivity loss	3,779,897	1271.9	4,807,650,994	5,283,694,596	101,763,958

*The values have been adjusted for month-on-month inflation up to April 2022, the latest month for which data was available. Data was sourced from https://tradingeconomics.com/ethiopia/inflation-rate-mom
**Assumed exchange rate of I USD to 51.91 Birr as of last working day of April 2022 (29th), based on average buying and selling exchange rate of Commercial Bank of Ethiopia (https://www.combanketh.et/en/exchange-rate/)

[151] The total number of households with 'ever IPV' have been estimated using the total national number of women aged 18-59 experiencing 'ever IPV in Ethiopia', divided by the average household size of 3.1.

7.2 National Costs for Service Provision

Given the variation in costs across sectors, we have opted not to impute sector level costs to the aggregate number of facilities in each sector to derive a national cost. Instead, to account for some of this variation, we have calculated a unit average cost of providing services overall. The weights used were the proportions of the total number of IPV cases reported in the KIIs for each sector. Table 36 below provides the weights and the average unit cost for each sector. The overall weighted unit cost of service provision comes to 14,506 Birr for an IPV survivor. Using the prevalence rate of current violence, we project that, in 2021, there were 4,390,532 survivors. Next, taking the EDHS 2019 help-seeking rate of 22.5% for survivors of any type of physical or sexual violence perpetrated by anyone, we estimate that there are 987,870 survivors seeking help annually. Applying the weighted unit cost, the potential cost of service provision comes to 14,329,951,115 Birr (USD 284,889,684). After adjusting for inflation from February to end of April, the cost is 15,748,873,068 Birr (USD 303,323,295).

Table 36: Weights and Average Unit Cost per Sector

Sectors	IPV Cases	Total Cost	Unit Cost per Sector	Weights	Weighted Cost
Women's and Children's Affairs Offices	11,490	14,088,313	1,226.136902	0.315815513	387.2330548
Rehabilitation Centers/ shelters	535	12,437,920	23248.4486	0.014705074	341.8701556
Hotline	350	2,240,344	6,400.982857	0.009620142	61.57836293
Women Lawyers Associations	2,103	75,740,703	3,6015.55064	0.057803309	2,081.818014
Courts	7,522	57,084,164	7,588.960915	0.206750591	1,569.022154
Attorney General Offices/ MoJ Bureaus	972	30,159,376	3,1028.16461	0.026716508	828.9642131
Police	714	7,579,242	1,0615.18487	0.019625089	208.3239514
Healthcare	12,696	328,424,041	25,868.30821	0.348963773	9,027.102441
Total					**14,506**

7.3 Overall National Cost of IPV

The national cost of IPV includes both the loss for women and households due to income loss, expenditure loss, and productivity loss, including care work loss on one hand and the costs of service provision on the other. In table 37 below, we give the national cost of IPV in Ethiopia, including the potential cost of service provision.

Table 37: Total Annual Cost of IPV in Ethiopia

Sector	Total Costs (Birr-Feb 7)	Total Costs *(Birr-April 30)	Total Costs **(USD-April 30)	% of GDP***
Total Loss (household income, household expenditure, care work and productivity loss)	47,683,921,766	52,405,484,517	1,009,329,632	0.93
Potential Cost of Service Provision	14,329,951,115	15,748,873,068	303,323,295	0.28
Total	**62,013,872,881**	**68,154,357,585**	**1,312,652,927**	**1.21**

*The values have been adjusted for month-on-month inflation from Feb to April, the latest month for which data was available. Data was sourced from https://tradingeconomics.com/ethiopia/inflation-rate-mom
**Assumed exchange rate of 1 USD to 51.91 Birr as of last working day of April 2022 (29th), based on average buying and selling exchange rate of Commercial Bank of Ethiopia (https://www.combanketh.et/en/exchange-rate/)
***We have used 2020 GDP of USD 107.6 billion as the final 2021 GDP figure is not available at the time of writing

8. ASSUMPTIONS AND LIMITATIONS

Due to the unavailability of data, this study has made assumptions to estimate the costs of IPV. While every effort has been made to ensure the robustness of the data, the results should be viewed as an approximation, rather than precise estimates, and as potentially underestimating actual costs. In the following sections, we detail the specific limitations concerning the quantitative and qualitative aspects of the research.

8.1 Quantitative Research

As widely recognised, surveys based on self-reporting are often biased and likely to result in underreporting given the social norms constraining acknowledgement of violence in an intimate relationship. An additional limitation in our particular survey is that the behaviors of psychological violence covered were very limited, likely resulting in underreporting of the actual prevalence of overall experiences of violence. However, we explored economic violence behaviors in greater depth than the EDHS. We would argue that, overall, the prevalence of 'ever' and 'current' violence are in line with the EDHS 2016 prevalence rates.

A number of limitations regarding cost estimates also need to be highlighted. First, the survey collected cost data on an incident basis for the last 12 months. While the majority of women reported cost information for one or two incidents, a small proportion reported having 3 or 4 incidents, but did not provide information for these additional incidents. For these survivors, an average incident cost was assumed for the additional incidents experienced. Therefore, the estimates should not be considered as precise estimates, but rather as an approximation. Second, the data on the approximate minutes spent by participants on domestic and care work activities was not robust. Therefore, average time use data from the 2013 Ethiopia Time-Use Survey has been employed[152]. To provide an approximate time-use for this study, we have taken an average of time-use for activities for the ages 15-29 and 30-64.

Furthermore, PSM, which was employed to estimate productivity loss, is a very sensitive method, prone to bias due to omitted variables. Due to poor, or lack of, data, it was not feasible to incorporate all the relevant covariates in the model. The respondents were asked about productivity loss in the last three months. To estimate productivity loss for one year, the loss for 3 months was multiplied by four. This extrapolation may result in an overestimate, as it assumes that respondents miss the same number of days in the whole year as they did in the last three months.

Finally, the monetized costs are significant underestimates, as these do not include the cost of psychological trauma, pain and suffering for survivors or family members.

8.2 Qualitative Research

KIIs

Concerning the qualitative research, there is a dearth of administrative data concerning IPV in Ethiopia. Many of the organizations that participated in the KIIs could not provide some of the costs and/or the annual intake for IPV. This was because the data was not recorded or because they did not have access to the data. Our interviewers were thus referred to a finance officer, who either requested an independent letter to enable them to provide the requested information or they were too busy to provide the data on time. Only a small amount of additional data could be gathered by conducting follow up calls.

In addition, it seems that most of the costs concerning service provision are for GBV/VAW, rather than IPV (no specific/focused services for IPV). Furthermore, some government offices seem to have limited experience in handling IPV cases. For example, the Women, Children and Youth Affairs, and Attorney General's Offices, in the Amhara region could not provide the information needed. To address these gaps in data, we inputted missing data from similar institutions at the same level (federal, regional, zonal, woreda) across the sectors.

It is also important to note that the individual costs for service provision detailed are average costs. When analysing the KII data from the transcripts, translation issues also emerged. Frontieri followed up on any resultant queries to the extent possible.

Another limitation of the KIIs relates to the interviewers' apparent misunderstanding of the costs required. For example, it appears that specificity was lacking concerning the difference between service provision (costs to the organization for providing a service) and service access (costs to survivors for accessing a service).

Finally, due to time constraints, it was not possible to investigate government expenditure on prevention programs.

IDIs

The limitations of the IDIs concern apparent interviewer misunderstandings, as well as translation issues. There was a notable lack of depth to the interviews. Probing and follow-up questions were not evident from the transcripts. In addition, translation issues emerged. Where needed, Frontieri revisited the audio recordings and resolved any resultant queries.

[152] CSA. (2014). Central Statistical Agency [Ethiopia]. Ethiopia Time Use Survey 2013.

9. CONCLUSION AND RECOMMENDATIONS

This research underscores the significant costs of IPV for women, households, the government and the broader society of Ethiopia. By examining the impact on both the individual and society, the study highlights the tangible and intangible costs associated with VAWG more broadly, which can greatly help to inform policy and economic priorities.

9.1 Prevalence and Factors Associated with IPV

We estimate the overall prevalence of 'ever' IPV and 'current' IPV (past 12 months) to be 35.86% and 21% respectively. Working women had a higher prevalence rate of 'ever' violence at 37.97%, which is in- line with other studies indicating that work may indeed be a risk factor for violence[153]. Education was also found to be a risk factor, as women with higher than primary education had a 7% increased risk of experiencing IPV. The study further confirms that the standard factors, such as a higher household wealth status and women's empowerment, reduce the risk of IPV, whereas rural residence or husband's habits such as alcohol or substance abuse (chat) increase the risk of violence.

Echoing previous research[154], the current data also indicates that a variety of IPV types are experienced in combination. The majority of the women reporting incidents of IPV in the past 12 months reported experiencing more than one behaviour per incident. In determining costs, we considered all behaviors, rather than limiting the analysis to physical and sexual violence.

9.2 Costs of IPV

The study also stablished the significant costs that women and households incur due to IPV, including OOP expenditure for seeking help, care work loss, missing work and overall productivity loss. On average, women missed 19 care workdays due to IPV and husbands missed 11 care workdays. In 34% of incidents, women reported an average OOP cost of 2,934 Birr, amounting to about 10% of the annual income of working survivors. Additionally, through PSM analysis, we found that IPV led to a loss in women's income (equivalent to 372.83 Birr), in household income (929.90 Birr) and in household expenditure (332.95 Birr). Interestingly, women who experienced 'ever' IPV were more likely to work than not. However, working women experiencing 'ever' violence had a productivity loss of about 16.67 days. This suggests that women experiencing IPV are more likely to work to manage the tension and dependence associated with IPV, yet are, at the same time, more like to have productivity loss, indicating an interrupted work pattern that results in a lower income. Thus, IPV produces a vicious cycle, which is compounded by the fact that IPV survivors have poorer health outcomes and a poorer mental health status.

The overall impact for women and households involves significant income insecurity and negative social well-being. The costs estimated for the population as whole in the study areas comes to a total loss of 52 billion Birr, or USD 1 bn. This amounts to roughly 0.9% of Ethiopia's 2020 GDP.

9.3 Costs of Service Provision

We further estimated that the potential cost of service provision across all sectors comes to 15.75 billion Birr (USD 303.3 million). More specifically, the service provision costs for the organizations that participated in our research amount to 580,011,217 Birr (USD 11,171,016) across the sectors. The largest costs among these participating organizations are in the health sector - 360,943,906 Birr (USD 6,951,780), followed by 104,211,937 Birr (USD 2,007,122) for criminal justice, 83,240,390 Birr (USD 1,603,210) for civil legal services and 31,614,984 Birr (USD 608,905) for social services.

These costs are substantial, yet they do not reflect the total resources required to provide comprehensive IPV service provision. An important finding that also emerged from the KIIs involves the difficulty faced by participants when trying to distinguish between costs for GBV/VAW and costs for IPV. It Is evident that there are no specific services in Ethiopia for IPV and that specialized training for IPV is lacking. Given that IPV is the most prevalent form of VAW, in addition to the fact that the needs of IPV survivors are unique and extensive, this is a situation in need of remedy. Specific budgets for specialized service provision by comprehensively trained service providers across the relevant sectors must be allocated by the government.

[153] Alzahrani, T. A., Abaalkhail, B. A., & Ramadan, I. K. (2016). Prevalence of intimate partner violence and its associated risk factors among Saudi female patients attending the primary healthcare centers in Western Saudi Arabia. *Saudi medical journal*, 37(1), 96–99. https://doi.org/10.15537/smj.2016.1.13135

[154] WHO. (2005). *WHO multi-country study on women's health and domestic violence against women : summary report of initial results on prevalence, health outcomes and women's responses*. World Health Organization. https://apps.who.int/iris/handle/10665/43310

9.4 National Costs of IPV

Finally, the study has estimated the total cost of IPV, including losses for women and households, as well as the potential cost of service provision, which amounts to slightly more than 68 billion BIRR or roughly USD 1.3 billion. This cost is equivalent to 1.21% of 2020 GDP, indicating, without a doubt, the significance of IPV for the overall economy. These results underscore the importance of expanding efforts to prevent IPV in order to ensure the economic health of an economy facing severe vulnerabilities due to factors such as COVID-19, the ongoing conflict and the fragility in the world outlook due to widening unrest in Europe.

9.5 Recommendations

Government

- Build GBV prevention and response into national policies and budgets, and scale up current efforts to prevent and address GBV, including by mainstreaming evidence-based violence prevention and response approaches into education, health, social protection and other sectors.
- Invest in improving administrative data management and documenting budget allocation for GBV and IPV.
- Devote special attention to IPV in overall GBV programming and training, as the current response is primarily focused on GBV, and, in particular, sexual assault.
- Establish accountability mechanisms to ensure budget allocation for GBV/IPV.
- Integrate attention to impacts of IPV in macroeconomic and social planning and policies.
- Establish more IPV services, as well as better supports for frontline workers.
- Increase investment in research to establish the predominance and unique nature of IPV to catalyse efforts to legislate for IPV (marital rape etc.) and adequate sentencing for perpetrators.
- Establish accountability mechanisms to ensure budget allocation for GBV/IPV
- Enhance women's rights concerning divorce, particularly with regard to ensuring women obtain their share of the assets, including land.
- Provide economic empowerment and support for women, including enhancement of women's participation in women's issues, such as IPV.
- Multi-sectoral collaboration, including strengthening of the link between legislators and law enforcement agencies.

Private Sector

- Introduce zero tolerance policies on GBV, including IPV, in the workplace and introduce code of conduct that upholds the right to be free from abuse.
- Introduce workplace policies including domestic violence leave to support survivors of domestic violence, whose productivity loss is a significant cost to business's reputation, profitability and sustainability.
- Establish financial and/or disciplinary sanctions for violations of the GBV, including IPV, code of conduct governing employees. Employers should also work with family members of perpetrators of abuse to identify and address their support needs.
- Liaise with civil society organisations to establish prevention campaigns within the workplace, as well as to establish a system of supports/referrals to meet the needs of both victims and bystander employees.
- Given that differences in economic power are a driver of IPV, businesses to review wage policies to minimize the gender differentiated wage gap, as a key policy to address IPV.

Civil Society

- Multi-sectoral collaboration to prevent and address IPV.
- Develop templates to record budget information for IPV, as well as a module to help build understanding of budgets.
- Advocate for gender-responsive budgeting, including allocation of adequate budgets for GBV/IPV-related interventions.

Donors

- UN organizations to motivate the government to increase their investment in IPV services.
- Bilateral and multilateral donors to coordinate their funding of violence services to ensure a comprehensive response.

Community

- Recognise the importance of families playing the 'biggest role in the community' and leading in the implementation of IPV interventions focused on education, awareness raising and prevention.
- Facilitate community and household level dialogues on strengthening interpersonal communication.

10. ANNEXES

10.1 Data Requirements

As indicated in section 3.2.1, a number of practical factors need to be taken into account when estimating the costs of IPV in countries of the global South[155]. Key among these factors is the absence or limited availability of information systems. Lack of infrastructural services, coupled with the lack of record keeping on IPV cases, creates significant information gaps, putting the burden of extensive primary data collection on the study. Although institutionalized services may be more likely to keep records, women's usage of these services is thought to be limited and traditional institutions are less likely to keep records. Thus, there is a lack of data from service providers (police, health centers and the justice system).

Measuring the cost of IPV requires a substantial amount of data and the data requirement also depends on the methodology to be used. Lack of reliable, comprehensive and comparable data on various forms of IPV, and the importance of the availability of such data to policymakers and professionals working to combat IPV and/or support its victims, is a major challenge in both developed and developing countries (El Morr and Layal, 2020). Based on the review of literature concerning the costs of IPV, primary data was required on the following variables: The extent of IPV against women, i.e. the number of victims (prevalence) in the last year and over the lifetime; the number of incidents (frequency, type and severity) in the last year; the direct impact of IPV on the individual woman concerned: e.g. physical and psychological health problems and increased family breakdown; the extent of the utilization of services by women affected by IPV (victim support, health services and legal services); the cost of the services utilized, the impact of IPV on employment for the women affected: the measurement of the detriment to employment through lost days of work or lost jobs. In addition, the data requirements for this study are underpinned by the costing methodology/ies used (accounting and econometrics). Table 38 presents the data required for the selected IPV costing methodologies.

Table 38: Data requirements of different costing methodologies

Methodology	Costs	Data Requirements
Accounting	**Direct tangible costs:** health, police, court, shelter, counselling, legal aid **Indirect tangible costs:** i) out of pocket expenditures-accessing services, leaving home, replacing property ii) loss of income due to missed work iii) missed school days	Prevalence rate-percentage of women experiencing in the population, Incident or victimization rate-number of incidents per 100 women Utilization rate-percentage of women experiencing violence using the service Unit cost of service provision-cost per 1 meeting of woman providing service, calculated on basis of detailed breakdown of cost or a proportion total budget of service based on utilization rate Primary data on fees, transport, and other routine costs for accessing services, hotel and transport costs leaving home, expenditure on replacing property (furniture, utensils, phones, vehicles, etc.) Days missed per incident, average wage Days missed by children per incident, total school fees paid in a year to estimate value of missed school days
Econometric Approaches	**Indirect tangible costs:** 1) lost time on the labour market 2) lost productivity/earnings 3) consumption loss	Prevalence of violence/incidents, macro data on age, education, employment rate, occupation, years of employment, hours worked, earnings/wage data, labour force participation, discount rate Detailed data on income for different types of households to calculate equivalent disposable income Data on probability of not being in relationship after violence

Source: Duvvury, N., Callan, A., Carney, P. and Raghavendra, S. (2013). *Domestic violence/coercive control: economic costs and implications for growth and development*. Women's voice, agency, and participation research series no. 3. Washington DC: The World Bank.

[155] Duvvury, N., C. Grown, et al. (2004). Costs of Domestic violence/coercive control at the Household and Community Levels: An Operational Framework for Developing Countries. *ICRW International Center for Research On Women*: 1-42.

10.2 Different Violence Behaviors Covered in the Survey

Table 39 below outlines the different behaviors of psychological, economic, physical and sexual violence covered in the 2021 Ethiopia violence survey. The data on these behaviors was collected on an ordinal scale, which included 'never', 'rarely', 'sometimes' and 'often'.

Table 39: Different Violence Behaviors Covered in Ethiopia Violence Survey 2021

Refuse to give you enough money for household expenses even though he had enough money to spend on other things
Ask for details about how you spent your money
Withdraw money from your account or credit card without your permission
Force you to work
Force you to quit your work
Prevent you from working
Try to exploit properties (use properties/sell and use the income from the sale of properties) you inherited from your family without your permission?
Dispose of your belongings without your permission
Restrict your connections/relations with your first-degree relatives
Prohibit you from going out with your female neighbors
Try to prevent you from meeting your female friends
Throw something at you, which can be harmful
Twist your arm or pull your hair
Assault you, causing bruises, scratches, minor wounds and/or joint pain
Push you hard
Hit you with less dangerous tools, i.e. belt, stick... etc
Suffocate you or try to suffocate you
Hold you tight while attacking you
Try to attack you with a knife, axe, shovel or any other dangerous tool
Hit you on the head, leading to unconsciousness
Slap your face
Attack you, resulting in you breaking one or more of your bones
Burn your skin on purpose
Physically force you to have sexual intercourse when you did not want to
Use threats or intimidation to get you to have sexual intercourse when you did not want to
Physically force you to do other sexual acts that you did not want to do
Use threats or intimidation to get you to do other sexual acts that you did not want to do

10.3 Productivity Loss

Table 40 below shows the items used to measure productivity loss for survivors, with the respective weights. A weight of 1, for example, implies that the workday is counted as a full day, whereas a weight of 0.125 implies that one day is measured as one-eighth of a workday.

Table 40. Productivity Loss Items for Survivors

Type	Weights
Absenteeism	
Missed work because you had to seek medical treatment	1
Missed work because you had to attend legal services (e.g, family counselling)	1
Missed work because you had to visit police stations	1
Missed work because you were unwell	1
Missed work because you had to take care of your child/children	1
Missed work because you stayed with friends or family	1
Presenteeism	
Was not as productive at work as you normally would be	0.25
Had difficulties dealing with clients and/or customers	0.25
Had to stop working because you were worried	1
Had to stop working because you had an accident at work	2
Tardiness	
Late for work by 1 hour or more	0.125
Left work early by 1 hour or more	0.125

Source: Authors' own based on Ethiopia Violence Survey 2021 & Duvvury et al. 2022[156].

[156] Duvvury, N., Vara-Horna, A., & Chadha, M. (2022). Development and Validation of Lost Days of Labor Productivity Scale to Evaluate the Business Cost of Intimate Partner Violence. Journal of interpersonal violence, 0(0), 0886260520944532. doi:10.1177/0886260520944532

10.4 Construction of Indices

10.4.1 Wealth Index

The socio-economic positions of the sample households are classified based on the wealth index score constructed according to the characteristics of the dwelling (type, ownership and sanitary facilities) and assets owned (such as stoves, blanket, mobile phone, televisions, refrigerators, etc) using principal components analysis (Filmer and Pritchett, 2001[157]; Rutstein and Johnson, 2004[158]). Because relevant assets and their importance may vary in urban and rural households, separate indices are derived for each area. They are then combined into a single score using a scaling procedure. The resulting index is a comparable measure of wealth for urban and rural areas. Households are then classified into three based on the resulting score, where Q1 includes 33.3% of poorest households and Q3 33.3% richest households In the country.

10.4.2 Empowerment Index

Women's household decision making is measured using 25 items, with 6 options on a Likert scale (you only, you mostly, you and your husband, your husband mostly, your husband only and other family member), in which the first three responses, you only, you mostly, you and your husband, were considered as fully or partially deciding on the household issues and the remaining three responses considered as not deciding on the household issues. In this survey, we considered the first two responses (you only and you mostly) as representing full decision making by women on household related issues based on the support of scientific literature that indicated that a woman participates in a given decision when she alone, or jointly with someone else, makes the decision (Musonera & Heshmati, 2017; Sariyev, 2018)[159].

The women's empowerment index was constructed by taking mean scores for each woman across all the domains of decision-making, with a lower score representing empowerment. Those women who scored less than mean scores for all women were considered as inadequately empowered, while those who scored mean and above scores were considered as adequately empowered.

[157] Filmer D. and Pritchett L.H. (2001). Estimating Wealth Effects without Expenditure Data--or Tears: An Application to Educational Enrolments in States of India. *Demography*, 38:115.

[158] Rutstein S.O. and Johnson K. (2004). DHS Comparative Report No. 6. The DHS Wealth Index. Calverton, Maryland USA: ORC Macro.

[159] Musonera, A., & Heshmati, A. (2017). Measuring Women's empowerment in Rwanda *Studies on economic development and growth in selected African countries* (pp. 11-39): Springer.
Sariyev, O. (2018). A new index for gendered decision-making, considering all family members, its determinants, and effects on food security

10.5 IDI Analysis Framework

IDI Analytic Framework

1. Relationship
- 1.1. Vulnerability
  - 1.1.1. Significant age gap
  - 1.1.2. Dependency
- 1.2. Abduction
- 1.3. Change in behaviour
  - 1.3.1. Significant change in relationship
- 1.4. Substance abuse

2. IPV
- 2.1. Abduction
- 2.2. Psychological/Emotional
  - 2.2.1. Jealousy
  - 2.2.2. Monitoring
  - 2.2.3. Humiliation
  - 2.2.4. Ignoring her
  - 2.2.5. Nagging
  - 2.2.6. Breaking Promises
  - 2.2.7. Threats
  - 2.2.8. Isolation
  - 2.2.9. Intimidation
- 2.3. Verbal
  - 2.3.1. Aggressiveness
    - 2.3.1.1. Yelling
    - 2.3.1.2. Cursing
- 2.4. Physical
  - 2.4.1. Beating
  - 2.4.2. Slapping
  - 2.4.3. Kicking
  - 2.4.4. Breaking bones
  - 2.4.5. Choking
  - 2.4.6. Other
- 2.5. Sexual
  - 2.5.1. Forced sexual intercourse
- 2.6. Financial
  - 2.6.1. Control of finances – deprived of money
  - 2.6.2. Stealing money
  - 2.6.3. No longer providing financial support
- 2.7. Abandonment
- 2.8. Stalking

3. Impacts
- 3.1. Emotional/Psychological
  - 3.1.1. Feeling desperate
  - 3.1.2. Upset
  - 3.1.3. Angry/frustrated
  - 3.1.4. Stigma and shame
  - 3.1.5. Anxiety
  - 3.1.6. Self-hate
  - 3.1.7. Shock/disbelief
  - 3.1.8. Suicidal ideation/attempts
- 3.2. Loss
  - 3.2.1. Loss of social capital
  - 3.2.2. Loss of self-esteem/worth
  - 3.2.3. Loss of confidence/discouraged
- 3.3. Physical
  - 3.3.1. Injury
  - 3.3.2. Forced impregnation
  - 3.3.3. Weight loss
- 3.4. Financial
  - 3.4.1. Struggling to make ends meet
  - 3.4.2. Lost income
  - 3.4.3. Costs
- 3.5. Productivity
  - 3.5.1. Unable to work
- 3.6. Impact on children
  - 3.6.1. Kidnapping
  - 3.6.2. Psychological
  - 3.6.3. Missed school days
  - 3.6.4. Hunger

4. Help-seeking: Helpfulness of Services
- 4.1. Obstacles
- 4.2. Informal
  - 4.2.1. Family/friends/neighbours/workplace
  - 4.2.2. Mediation
  - 4.2.3. Elders
- 4.3. Formal
  - 4.3.1. Police
  - 4.3.2. Health
  - 4.3.3. Shelter/rehabilitation center
  - 4.3.4. Women's Affairs
  - 4.3.5. Legal
  - 4.3.6. CSOs

5. Moving Forward
- 5.1. Struggle
- 5.2. Strength and resilience
- 5.3. Beginning anew
- 5.4. Hopes
- 5.5. What brings happiness

6. Recommendations
- 6.1. Institutions
- 6.2. Community

10.6 Data Quality Assurance Mechanisms

Level	Specific Activities	Description of Activities
Pre-field quality assurance mechanism	Comprehensive review of data collection tools	Comprehensive review of data collection tools, ensuring that all relevant questions were included. Ensured that all comments and feedback were properly addressed, including for translation of the tools before the start of the training and the deployment of field staff.
	Pre-tests	Quantitative and qualitative research tools pre-tested prior to fieldwork.
	Careful recruitment of field staff	Thorough review of the field staffs' profiles in terms of their qualifications, language skills, relevant work experience, and ethical behaviours, conducted.
	Provision of adequate training	Before the commencement of the training, all the necessary preparation, including the translation of the data collection instruments, the preparation of the training manual, and all other necessary training logistics, was conducted. Then, training was undertaken with the purpose of ensuring uniform application of the data collection materials; explaining the rationale of the study and study protocol; and ensuring quality data gathering. Mock interviews with the enumerators/ interviewers were conducted to check they had a consistent understanding of the concepts and ideas of the study.
Quality assurance during the field work		✓ A monitoring system was established to allow (example dashboards) progress in data collection to be followed and data integrity checks to be carried out. Periodic field reports highlighted any issues encountered and any countermeasures taken. ✓ Data collection progress reports regularly updated (weekly – every Friday) as they unfolded. ✓ Made frequent unannounced spot checks on the teams in the field. ✓ Ensured that the sampling protocol was properly followed. ✓ Ensured that all sections of the data collection tools were accurately completed, where relevant. ✓ The survey field data was synchronized to the server on a real time basis using Survey Solution. ✓ The data manager, together with the study team, reviewed the synchronized data regularly for potential quality improvements. ✓ The data manager produced error log sheets regularly and communicated feedback to the supervisors and enumerators immediately for possible corrections. ✓ Supervisors and study team members continuously discussed any errors or misunderstandings, while gathering both primary and secondary data. ✓ When errors were identified, supervisors first called all enumerators to make them aware of the problem (all enumerators were informed, so that team members could learn from one another as a preventative mechanism). ✓ Furthermore, a log-in address to the Survey Solution was provided for possible review and feedback on the quality of the data on a real time basis. ✓ Application of GPS: Global Positioning System (GPS) used while collecting field data, which allowed the survey manager to identify the locations of the interviews where any errors were found. Regular debriefing sessions were conducted by phone with supervisors/ assistant researcher.
Office-level data quality assurance mechanism		✓ The office level data quality assurance mechanism was assisted by special software that allows finding and fixing any bugs in the dataset.

10.7 Costs of Service Provision: Detailed Tables

Table 41. Service Provision Detailed- Healthcare

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
ADDIS ABABA_Yeka subcity Woreda 08 Health Center_ Woreda	48	720	34,560 [48 x 720]	600	248,880	284,040
ADDIS ABABA_Gandhi Hospital_Federal_OSC~	19	360,000	6,840,000 [19 x 360,000]	1,750	11,596,933	18,438,683
ADDIS ABABA_Tirunesh Bejing Hospital_Federal_ OSC~	19	360,000	6,840,000 [60 x 360,000]	1,750	1,901,408	8,743,158
Amhara Region- Felege Hiwot Hospital_Region	27	60,000	1,620,000 [27 x 60,000]	15,000	166,405	1,801,405
AMHARA_East Gojjam Zone-Debre Markos Comprehensive Specialized Hospital*_ zone/region	554	138,500	76,729,000 [12 x 250]	17,500	921,411	77,667,911
AMHARA_ East Gojjam Zone- Enemay District-Hospital_ Woreda	4,200	16,142	67,796,400 [420 x 1000]	1,800	1,020,000	68,818,200
AMHARA_East Gojjam Zone-Enarj Enawga District-Debre Work Health Center	150	19,000	2,850,000 [7 x 450]	1,800	102,000	2,953,800
AMHARA_East Gojjam Zone-Enarj Enawga District-Tenguma Kebele-Tenguma Health Center_ Woreda	2	9,500	19,000 [7 x 450]	1,800	34,000	54,800
ADDIS ABABA_Minilik Hospital_ Federal_OSC~	19	360,000	6,840,000 [19 x 360,000]	1,750	14,863,666	21,705,416
ADDIS ABABA_Yeka sub city Woreda 07 Health Center	24	576	13,824 [24 x 576]	1,800	2,191	17,815
OROMIA_ South Shewa zone Becho Woreda Tulu Bolo hospital	7,263	16,142	117,239,346 [7,263 x 16,142]	1,800	849,965	118,091,111
SNNPR_Qucha Kebele Health Center_ Woreda	12	38,000	456,000 [12 x 1000]	1,800	583	458,383
SNNPR_Endibir Kebele Health Center	4	43,700	174,800 [4 x 43,700]	3,000	467	178,267
SNNPR_Adare Hospital	285	18,000	5,130,000 [285 x 18,00]	15,000	31,251	5,176,251
OROMIA_Assela Referral Hospital_ zone/region*	15	260,000	3,900,000 [200 x 2000]	12,500	3,000	3,915,500
OROMIA_Arsi zone Dodota_ Woreda Health Center	55	1,500	82,500 [55 x 1,500]	1,800	35,000	119,300
Total	**12,696**		**296,565,430**	**81,450**	**31,777,161**	**328,424,041**

Table 42. Service Provision Detailed- Police

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
Amhara Region- Bahir Dar- the Amhara National Regional State Police Commission	36	564	20,300 [36 x 564]	132,000	500,000	652,300
Amhara Region- East Gojjam Zone- Enemay District- Police	31	106	3,275 [31 x 106]	1,800	500,000	505,075
Amhara Region- East Gojjam Zone- Enarj Enawga District- Police	31	65	2,000 [31 x 65]	1,800	500,000	503,800
Amhara Region- East Gojjam Zone- Enarj Enawga District-03 Kebele Police	31	106	3,275 [31 x 106]	1,800	500,000	505,075
ADDIS ABABA_Yeka Woreda 06 Police office	60	150	9,000 [60 x 150]	1,800	500,000	510,800
ADDIS ABABA_Federal Police_	135	600	81,000 [135 x 600]	132,000	120,000	333000
SNNPR_GURAGHE_CHEHA_ EMDIBIR	31	65	2,000 [31 x 65]	1,800	500,000	503,800
SNNPR_Wolkete Zone Police	48	63	3,000 [48 x 63]	3,750	100,000	106,750
SNNPR_GAMO ZONE_ KII_ CHENCHA WEREDA_POLICE OFFICE_MEHIRET	31	106	3,275 [31 x 106]	1,800	500,000	505,075
Oromiya Jimma Zone agaro woreda local police	30	109	3,275 [30 x 109]	1,800	500,000	505,075
OROMIA_Jimma Zone goma woreda police	3	1,092	3,275 [3 x 1,092]	1,800	500,000	505,075
OROMIA_ jimma zone police commission	48	521	25,500 [48 x 531]	3,750	250,000	279,250
OROMIA_REGIONAL POLICE OFFICE_MESKEREM	36	564	20,300 [36 x 564]	132,000	500,000	652,300
OROMIA_ARSI ZONE_POLICE OFFICE_ROMAN	48	1,000	48,000 [48 x 1,000]	5000	120,000	173,000
OROMIA_ARSI_DODOTA WOREDA_ALEM KEBELE_KII_ CP_ROMAN	31	3	100 [31 x 3]	1,800	500,000	501,900
UN WOMEN_SNNPR_ POLICE COMMISION_MEHIRET	36	564	20,300 [36 x 564]	132,000	500,000	652,300
UN WOMEN_OROMIA_SW SHOWA ZONE_POLICE OFFICE_MESKEREM	**48**	531	25,500 [48 x 531]	2,500	156,667	184,667
Total	**714**		**273,375**	**559,200**	**6,746,667**	**7,579,242**

Table 43. Service Provision Detailed-Attorney General Offices/Ministry of Justice

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
Amhara Region- Attorney General	150	2,500	375,000 [150 x 2,500]	37,010	2,000,000	2,412,010
Amhara Region- East Gojam Zone-Attorney `General	18	7,500	135,000 [18 x 7,500]	20,000	2,500,000	2,655,000
Amhara Region- East Gojam Zone- Enemay District-Attorney General	5	3,745	18,725 [5 x 3,745]	1,600	250,000	270,325
Addis Ababa- Yeka Sub-city Attorney General	66	500	33,000 [66 x 500]	10,750	2,500,000	2,543,750
Addis Ababa- Federal Attorney	272	5,375	1,462,000 [272 x 5,375]	0	10,303,030	11,765,030
oromiya- South West shewa becho woreda Attorney office	5	5,000	25,000 [5 x 5,000]	1,400	250,000	276,400
SNNPR_Qucha Woreda General Authority	5	2,500	12,500 [5 x 2,500]	1,500	250,000	264,000
SNNPR_GURAGHE Z_ ATTORNEY_MIHRET	149	877	130,673 [149 x 877]	1,500	2,500,000	2,632,173
SNNPR_ATTORNEY	150	2,500	375,000 [150 x 2,500]	25,000	2,000,000	2,400,000
OROMIA_jimma zone_ ATTORNEY_OFFICE	2	2,959	5,918 [2 x 2,959]	10,750	2,500,000	2,516,668
OROMIA_REGIONAL_ ATTORNEY OFFICE	150	2,500	375,000 [150 x 2,500]	49,020	2,000,000	2,424,020
Total	**972**		**2,947,816**	**158,530**	**27,053,030**	**30,159,376**

Table 44. Service Provision Detailed- Courts

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
Amhara Region- East Gojjam Zone- Court	5,005	200	1,000,980 [5,005 200]	0	28,641,976	29,642,956
Amhara Region- East Gojjam Zone- Enemay District- Court_Woreda	648	3,850	2,494,800 [648 x 3,850]	0	320,018	2,814,818
Addis Ababa-Federal supreme court	108	842	90,936 [108 x 842]	384,672	618,061	1,093,669
OROMIA_JIMMA ZONE_ GOMMA WOREDA_COURT OFFICE	15	8,750	131,250 [15 x 8,750]	108	120,007	251,365
OROMIA_REGIONAL_COURT OFFICE_MESKEREM	20	9,491	189,820 [20 x 9,491]	5,129	115,257	310,205
SNNPR_GURAGHE Z_ EMDEBER WOREDA_COURT	51	9,906	505,200 [51 x 9,906]	432	480,027	985,659
SNNPR_ Regional Supreme court	20	9,491	189,820 [20 x 9,491]	5,129	115,257	310,205
SNNPR_WOLKITE ZONE_ COURT	1,575	7,498	11,809,800 [1,575 x 7,498]	2,400	9,011,329	20,823,529
OROMIA_Arsi Zone Court	60	3,850	231,000 [60 x 3,850]	0	343,367	574,367
OROMIA_Dodota Woreda court Office	21	7,489	157,275 [21 x 7,489]	108	120,007	277,390
Total	**7,522**		**16,800,880**	**397,978**	**39,885,306**	**57,084,164**

Table 45. Service Provision Detailed- Women's Lawyers Associations

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
ADDIS ABABA_Ethiopia Women's Lawyer Association	2,020	15,000	30,300,000 [2,020 x 5,000]	5,600	41,040,000	71,342,020
Ethiopian Women's Lawyers Association_ Hawassa Branch	83	15,000	1,245,000 [83 x 15,000]	80,000	3,153,600	4,398,683
Total	**2,103**		**31,545,000**	**85,600**	**44,193,600**	**75,740,703**

Table 46. Service Provision Detailed- National Hotline

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
Addis Ababa City Hotline Service Provider	350	2,743	960,024 [350 x 2,743]	1,600	1,278,720	2,240,344
Total	**350**	**2,000**	**960,024**	**1,600**	**1,278,720**	**2,240,344**

Table 47. Service Provision Detailed- Shelters/Rehabilitation Centers

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
ADDIS ABABA_AWSAD_ Region	100	18,100	1,810,000 [100 x 18,100]	29,400	1,530,000	3,369,400
OROMIA_Adama Rehabilitation Center_Region	99	3,000	297,000 [99 x 3,000]	37,800	4,500,000	4,834,800
Amhara Region- OPRIFS Shelter	75	6,000	450,000 [75 x 6,000]	20,000	25,000	495,000
AMHARA REGION –B/DAR CITY- REHABLITASHION CENTER- Agar Ethiopia-Agar Safe House	191	3,500	667,800 [191 x 3,500]	0	27,000	694,800
SNNPR- Region-AWSAD Safe House	70	21,486	1,504,020 [70 x 21,486]	14,400	1,525,500	3,043,920
Total	**535**		**4,728,820**	**101,600**	**7,607,500**	**12,437,920**

Table 48. Service Provision Detailed- Annual Women's and Children's Affairs Offices Intimate Partner Violence Costs

Organization	Average Intake	Unit Cost for Service Provision	Total Cost of Service Provision	Personnel Training	Admin Cost	Total Cost
AMHARA_REGIONAL_WC&Y_OFFICE	4,486	614	2,754,838 [4,486 x 614]	0	650,000	3,404,838
AMHARA_East Gojjam Zone- Enemay District-WC&Y Affairs_Woreda	40	255	10,195 [40 x 255]	0	10,000	20,195
Amhara Region- East Gojam Zone WC&Y bureau	238	614	146,019 [238 x 614]	0	86,080	232,099
Amhara Region- East Gojjam Zone- Enarj Enawga District-Tenguma Kebele-Women Affairs_Woreda	4	0	0	0	0	0
Addis Ababa_Yeka_Woreda 6_Women & Children Affairs office	4	637	2,549 [4 x 637]	0	2,500	5,049
ADDIS ABABA_Federal Women Affairs	81	614	49,746 [81 x 614]	0	1,200,000	1,249,746
ADDIS ABABA_Yeka_Women Affairs_Subcity_Zone	161	613	98,656 [161 x 613]	111,373	86,080	296,109
ADDIS ABABA_CITY_WOMEN AND CHILDREN AFFAIRS_OFFICE_Region	327	614	200,899 [327 x 614]	872,420	940,000	2,013,319
OROMIA_REGION_Arsi zone _Dodota Woreda Women Affairs Office_Woreda	11	1,019	11,214 [11 x 1,019]	0	11,000	22,214
OROMIA_Jimma Zone goma Woreda_women office	17	660	11,214 [17 x 660]	153,138	11,000	175,352
OROMIA_REGION WOMEN AND CHILDREN AFFAIRS_OFFICE	2,900	614	1,781,019 [2,900 x 614]	742,485	800,000	3,323,505
OROMIA_SW SHOWA ZONE_WOMEN- OFFICE_MESKEREM	161	613	98,656 [161 x 613]	0	86,080	184,736
OROMIA_SW SHOWA ZONE_WOLISO WOREDA_DILELA KEBELE_WOMEN OFFICE_MESKEREM	42	607	25,487 [42 x 607]	348,040	25,000	398,527
SNNPR_GURAGHE Z_CHEHAW_WC&Y_MIHRET_Woreda	18	623	11,214 [18 x 623]	0	11,000	22,214
SNNPR_WC&Y OFFICE_MEHIRET_Region	2,900	614	1,781,019 [2,900 x 614]	0	800,000	2,581,019
SNNPR_GAMO ZONE_CHENCHA WOREDA_WC&Y OFFICE_MEHIRET	18	623	11,214 [18 x 623]	0	11,000	22,214
SNNPR_GAMO ZONE_WC&Y OFFICE_MEHIRET_Zone	83	616	51,097 [83 x 616]	0	86,080	137,177
Total	**11,490**		**7,045,037**	**2,227,456**	**4,815,820**	**14,088,313**


Federal Democratic Republic of Ethiopia
Ministry of Women and Social Affairs


FRONTIERi


NUI Galway
OÉ Gaillimh


UN
WOMEN

© June 2022

Frontieri Team:
Dereje Kifle
Jema Haji
Azeb Adefrsew
Medhane Zekarias
Dube Jara

NUI Galway Team:
Nata Duvvury
Caroline Forde
Mrinal Chadha