Addis Ababa University

School of Graduate Studies

Sexual Violence Against Female Adolescents in Jimma Town: Prevalence, Patterns and Consequences

By

Yohannes Dibaba

June, 2003

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

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Demographic Training and Research Center

College of Social Science

Approved by the Examining Board

ASSEFA HAILEMARIAM Chairman, Department Graduate Committee	Assefa Hailem Signature
Dr. Hirut Terefe Advisor	Signature
External Examiner	Signature
R. B. Upadhyay Internal Examiner	R B Upadhyay Signature

Acknowledgement

I am indebted to all those who offered their assistance during the research work.

I owe the deepest gratitude to my thesis advisor, Dr. Hirut Terefe, assistant Professor of Sociology and Social Anthropology, who starting from the inception of the topic to its present form has given me her constructive comments and suggestions. Her interest, advice and encouragement in the completion of the study is most appreciated.

My thanks go to all my friends at Jimma, particularly Dr. Nigussie Alemu and Dejene Takelegn, for their assistance during the conduct of the survey. I am also grateful to all the field enumerators and Supervisors for their cooperation and patience while filling out the questionnaires.

My thanks also go to obbo Chanaqe Fida, Jemal Demma and all others who assisted me by providing a computer. My colleague Tessema Bekele, and all graduates of DTRC also deserve special thanks for their encouragement and moral support during the research work.

My Special thanks are due to Dr. Tesfay Taklu for his insightful comments on my research title and Eshetu Gurmu for his constructive suggestions on my research proposal.

Finally, I would like to forward my thanks to the Center for Research training and Information on Women in Development (CERTWID) and the school of Graduate Studies for financial support to this study.

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Acronyms

AIDS	-	Acquired Immuno Deficiency Syndrome
CSA	-	Central Statistics Authority
DHS	-	Demographic and Health Survey
HIV	-	Human Immunodeficiency Virus
FGAE	-	Family Guidance Association of Ethiopia
FGD	-	Focus Group Discussion
FGM	-	Female Genital Mutilation
IEC	-	Information, Education and Communication
MOH	-	Ministry of Health
STDs	-	Sexually Transmitted Diseases
WHO	-	World Health Organization
UN	-	United Nations
UNFPA	-	United Nations Population Fund
UNAIDS	-	Joint United Nations Programme on HIV/AIDS

CHAPTER ONE: INTRODUCTION

1.1 Research Problem and Rationale of the Study

In the past few decades, violence against women has become increasingly recognized as a major health and human rights concern. It is acknowledged as an important health problem because of its impact on the reproductive health and mental well-being of women and girls. Violence against women is also one of the most pervasive forms of human rights abuse that prevents women's enjoyment of their fundamental freedom (Heise et al, 1993). Thus, recognizing that violence against women is a health problem and a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on the basis of equality with men, the United Nations General Assembly adopted the declaration on the elimination of violence against women in 1993.

The declaration defines violence against women as "any act of gender based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life"(UN, 1994). These acts include battering, sexual abuse of children, rape, dowry- related violence, female genital mutilation and other traditional practices harmful to women, violence related to exploitation, sexual harassment and intimidation at work, trafficking in women, forced prostitution and the like (UN, 1994).

It is evident from the definition that violence against women occurs in numerous forms (physical, sexual, and psychological) that are pervasive and interconnected. Sexual violence is one of the most commonly experienced forms of violence against women that

includes all unwanted or non-consensual sexual act, touching or exploitation that are achieved through force, threat or intimidation and or coercion (Elliot, 1996). It encompasses rape, coerced sexual activity, sexual harassment, forced prostitution, forced marriage and other physical violence and threat to life. Rape is the most extreme form of sexual violence that applies to all pressurized and unwanted sexual experiences, whether or not physical force is involved (Elliot, 1996, WHO, 2002). It is a sexual act that occurs without a women's consent or with her consent where that consent is obtained through fraud or the use of physical force (Lewis and Clark, 1977).

As a manifestation of violence against women, rape and other forms of sexual violence are universal crossing cultural and socio-economic lines (UN, 1997). All women regardless of race, culture, religion or socio- economic status are at risk. But the subject of sexual violence is taboo in many cultures and as a result remains under reported. It is mostly under reported for the reason that women consider it as being painful to remember or too shameful to disclose to an interviewer (Stewart et al, 1996). However, recent Population based studies conducted in several countries around the world have shown a prevalence of rape ranging from 5 to 29% (Heise et al, 1994). For instance, in the USA where several researches are conducted on sexual violence, different investigations have shown that between 14 and 20% of women will experience a completed rape in their lifetime (Kilpatrick et al 1992). In South Africa, it is estimated that one in every three women will be a victim of rape in their lifetime (IPPF, 1998). Forced sexual initiation and coercion during adolescence have also been reported in many studies of young women. For instance, in a multi-country study made in nine countries in the Caribbean region, 47.6%

of the sexually active adolescents (10-18 years) reported that their first sexual intercourse was forced(Halcon et al,2000,cited in WHO,2002).

These figures show that sexual violence is a worldwide problem for women and girls. It happens all over the world from the poorest countries of Africa to the rich countries like the United States. Further, it reveals that for a substantial number of young women, sexual initiation is a traumatic occurrence accompanied by force or fear. Sexual violence also occurs at every stage of women life cycle, even though adolescents have higher rate of victimization as compared to other age groups (Heise et al, 1995). Adolescent's girls and young women are disproportionately affected because of their relative inexperience, limited negotiation skills, dependant financial position and traditional gender norms (Ademola etal, 2001).

Today, Sexual violence is one of the priority health issues in various countries because of its impact on women's health. It is found to be a significant cause of female morbidity and mortality. The World Bank had estimated that rape and domestic violence account for 5% of the healthy years of life lost to women of reproductive age in developing countries (World Bank, 1993). Studies are also indicating that the health impacts of sexual violence is going more severe because sexual violence is linked to some of the most intractable reproductive health issues of our times; including teenage pregnancy, high risk sexual behaviors, sexually transmitted diseases and HIV/AIDS, unsafe abortions and maternal mortality (Heise et al, 1995,WHO,2002). While sexual abuse is associated, directly or indirectly with all these problems, in recent years, an additional danger has emerged for survivors of sexual violence because of the potential transmission of HIV. Violence

increases a women's risk for HIV infection through forced or coercive sexual intercourse and by limiting their ability to negotiate HIV preventive behaviors.

Evidences are also increasing that link the epidemics of HIV and violence against women. One evidence can be the fact that women are the fastest growing population to become infected with HIV/AIDS in most regions of the world (Maman et al, 2002). A study made by Moreno and Watts (2000) on the linkages between sexual violence against women and HIV/AIDS revealed that young women are particularly vulnerable to both coerced sex and HIV/AIDS (cited in global forum for health research, 2001). Similarly, UNAIDS had estimated that 60% of new HIV infections occur among young people between the ages of 15-24,girls in particular being more vulnerable (UNAIDS, 1999). For instance, recent data from Sub-Saharan African countries indicated that young girls have much higher rates of infection than boys of the same age. HIV infection rates among young women of age 15 – 24 are at least twice the rates among young men in South Africa, Malawi, Tanzania, Uganda, Zimbabwe and the like (UNAIDS, 2000). A similar report from the Ethiopian Ministry of Health revealed that the highest infections rates are concentrated among the age group 15 to 24 years and the number of females infected between 15 to 19 years is much higher than the number of males in the same age group (MOH, 2002). The reasons lie in the greater social and biological vulnerability of women.

It is suggested that the higher figure for young girls is a direct result of the sexual exploitation of men, particularly older men to young women. It also reflects the belief among men that they will have fewer possibilities of being exposed to the AIDS virus if they engage in sexual relationships with younger women (UNFPA, 2000, Kiragu, 2001).

Hence, it is a major obstacle to the global agenda for sexual and reproductive health and rights for all.

In Ethiopia, even though many of the aforementioned reproductive health issues are known to be among the health and social problems of adolescents, little has been done to establish the links between sexuality, violence and reproductive health. Knowledge of the magnitude and characteristics of sexual violence in general and rape in particular is very limited because of the relative scarcity of population-based researches. Nevertheless, beyond the paucity of research work and information for policy makers to help understand sexual violence as a reproductive health problem, the few studies available to date on such dimensions of sexual violence as rape have shown that the problem is pervasive (in cities like Addis Ababa) . For instance, a study made by Eshetu (1993) on the attitudes of students towards the promotion of condoms for adolescents in Addis Ababa observed that 21.6% of the sampled sexually active adolescents had forced sexual intercourse as a cause for their sexual debut. Similarly, in his study of sexual violence among female street adolescents in Addis Ababa, Mitike (2000) observed that 43% of the street girls sampled had initiated sexual activity because of rape. His study also found the prevalence of rape in the three months time before the survey to be 15.6%.

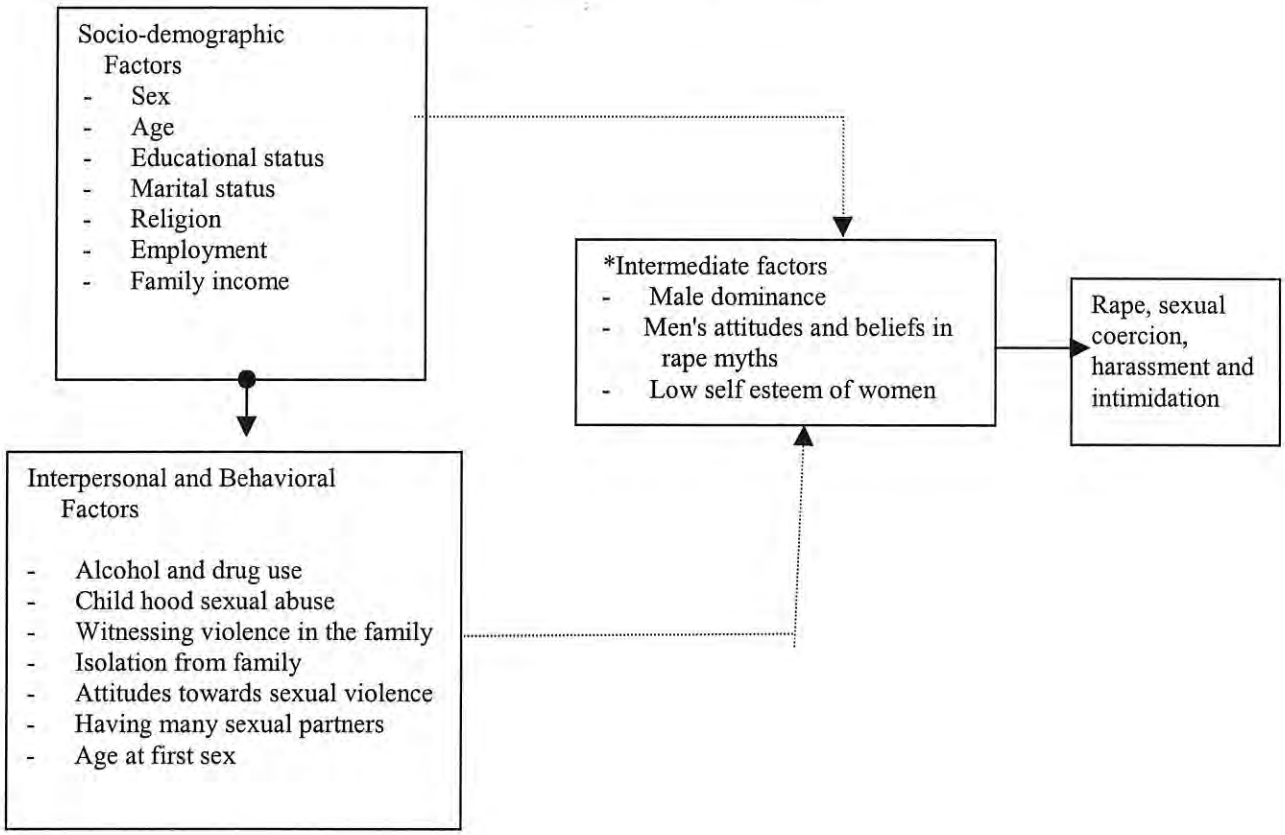
Apart from these, it was identified that no population-based study has been made to estimate the magnitude of sexual violence or measure its outcomes for adolescent's health in the urban areas of the country in general and Jimma town in particular. It is believed that the lack of reliable data on the magnitude and dimensions of sexual violence as well as the sensitiveness and stigma associated with it might be some of the factors that

hampered the understanding and development of appropriate interventions. Hence, the present study has the major purpose of exploring the magnitude, the factors associated with sexual violence and its consequences for adolescent health. Moreover, there is a belief that conducting research in this area may benefit decision makers, female activists, all those interested in gender-based violence and the study population in addressing sexual violence as a reproductive health problem.

1.2 Conceptual Framework of the study

For the analysis of factors that increase adolescent's vulnerability to sexual violence and in the absence of a well-developed model to address factors related to sexual violence, a simple framework was developed based on the literatures reviewed(see the next chapter). In the framework, it is assumed that demographic, socio-cultural and behavioral factors are the basic risk factors for sexual violence. These background factors influence the intermediate factors. Male dominance, low self-esteem of women, and men's attitudes and belief in rape myths are seen as intermediate factors causing sexual violence. Nonetheless, the relationship shown should not be seen as unidirectional only; there can be a complex interaction among the factors shown.

Fig 1: Conceptual Framework of factors associated with sexual violence



* are not testable through the quantitative study

Developed by the author

1.3 Objectives of the Study

The general objective of this study was to explore the magnitude, characteristics and outcomes of sexual violence against female adolescent in Jimma town.

The specific objectives of the study are:

1. To determine the prevalence of sexual violence against female adolescents in Jimma town
2. To identify the health outcomes of sexual violence
3. To identify the factors associated with sexual violence.
4. To describe adolescent's attitudes towards sexual violence
5. To assess the awareness of adolescents on contraceptive use and HIV/AIDS.

1.4 Hypothesis

To study the pattern of sexual violence, to identify the associated factors as well as the outcomes of sexual violence, the following hypothesis were put forward.

1. The younger the girl is at the time of the first sexual debut, the more likely that it is forced .
2. Socio-demographic factors like lower education of the adolescent and low family income may positively relate to the risk of being sexually abused.
3. Living arrangements of the adolescents, particularly living alone and or living with relatives than parents may positively relate to the risk of being raped.

4. There is a higher perceived risk of acquiring HIV/AIDS among victims of rape as compared to those without experience of rape.
5. Adolescent behaviors like alcohol practice and having multiple sexual partners may increase the risk of being sexually assaulted.
6. Adolescent's knowledge of contraceptive use and HIV/AIDS increases with an increase in their education level.

1.5 Operational Definitions of Concepts

Adolescence - is a dynamic concept that refers generally to the transitional period from child hood to adult hood. However, there is no universally accepted definition of adolescence. In the literature on adolescent health, the period of adolescence is variously considered to occur between ages of 10-19, 15-19, 15-24 and 10-24. The terms 'young people 'and 'youth' are often used these days to refer to these age groups. For the purpose of this study, adolescence is used interchangeably with youth and covers age groups of 15 to 24.

Prevalence rate - refers to the percentage of persons within a demographic group (e.g. female or male, adolescent or adults) who are victimized during a specific period, which may be a person's life time and or a year.

Completed rape – is any nonconsensual penetration of the vagina by physical force or threatening of body harm, or when the victim is incapable of giving consent.

Attempted rape – a trail to have sexual intercourse without consent of the girls but without penetration.

Sexual harassment – includes unwanted and repeated sexual advances that range from unwelcome comments and touching to coercive sexual intercourse.

Sexual abuse – a violation (sexual, physical, and emotional) committed by a person who holds, or is perceived to hold, power over some one who is vulnerable.

Sexual coercion – unwanted completed penetration with the threat of non-physical punishment, promise or reward or verbal pressure.

1.6 Organization of the Thesis

The thesis is organized into seven chapters. The first chapter presents background of the problem, the objectives and hypothesis of the study. The second chapter presents a review of related literature. Chapter three deals with data sources and the research methodology. In the fourth chapter, the findings of the quantitative study are analyzed while the fifth chapter contains the results of the focus group discussion. In chapter six, a discussion of the major findings is presented. Finally, chapter seven summarizes the findings of the study and outlines some policy implications.

CHAPTER TWO: LITERATURE REVIEW

2.1 Prevalence of Sexual Violence

As a public health issue, accurate and comparable data on violence against women are needed to strengthen advocacy efforts, help policy makers understand the problem and guide the design of preventive interventions (WHO, 1997). However, studies on the magnitude of sexual violence are recent phenomena, particularly in developing countries and as a result data are relatively scarce. Most of the statistics available through the police, Women's centers and other formal institutions are also believed to be unreliable because of under reporting. The basic reason of under reporting is that, victims of sexual violence do not report cases of violence appropriately because many of them do not characterize their victimization as a crime; for embarrassment, for not wanting to define some one they know who victimized them as rapist (Bonnie et al, 2000, WHO, 1997). Some also blame themselves for their sexual assault.

Population based researches can provide a better and reliable data on the magnitude of sexual violence; but still the lack of consistent methods like variation of sample size, the way questions are posed, the setting of interview, and the definitions used make comparisons across studies difficult (WHO, 1997). In recent years however, surveys are consistently reporting high prevalence of sexual violence. Population based studies conducted in several countries have shown prevalence rates ranging from 5 to 29% (Heise et al, 1994). In the United States alone, six separate investigations showed that between 14 % and 20% of women have experienced a completed rape in their life time (Kilpatrick et al, 1992). The problem is also pervasive in the countries of sub-Saharan Africa. In South

Africa for instance, it is estimated that about one in every three women will be a victim of rape in her lifetime (IPPF, 1998). In a 1992 study of 400 primary school female students randomly selected from 40 schools in the Kabale District of Uganda, 49% of sexually active girls reported that they had been forced to have sexual intercourse, and 22% said they had been given gifts or rewards (Bagarukayo et al, 1993). A similar school based study conducted in Kenya in 1994 showed that 14% of young girls aged 15-24 reported that their first sexual initiation had been forced (cited in Heise et al 1995). Cross national research on the prevalence of sexual assault among college-aged women also revealed high rates of violations ranging between 19 and 27.5% of women surveyed in Canada, Korea, New Zealand, United Kingdom and the USA (Heise et al. 1995).

One important finding of these and other similar studies on sexual violence against women is that a remarkably high percentage of rape victims are young women. Statistics compiled by Heise (1993) on Sex crime in Seven countries (Peru, Malaysia, Mexico, Panama, Papua New Guinea, Chile and the USA) indicated that between 36 and 62% of the rape victims were aged 15 years or less (Heise, 1993). This may lead one to the suggestion that the younger a women is at first sexual intercourse, the more likely that sex is forced. Young girls become easy targets for older male relatives or friends who take advantages of their greater power and children's trusting nature to exact sexual favors through force or deception. Accordingly, evidences from many of these studies indicate that a high percentage of the rapists are acquaintances, friends, relatives of the victim and those in position of trust and power. In researches conducted in Lima (Peru), Malaysia, Mexico city, Guatemala city, Chile and the USA, it was reported that attackers are known to the victim in 60-80% of cases (Heise ,1993). This shows that sexual violence is mostly

committed by and to persons known to each other, even though strangers may also perpetuate it.

2.2 Factors Promoting Sexual Violence

One of the first steps toward preventing violence according to the public health approach is to identify and understand the factors that place people at risk for violent victimization and perpetration. Various researchers of different disciplines like psychology, Sociology, anthropology, public health, philosophy and law have attempted this. Many of them observed that the root causes of violence against women are complicated. No single factor explains why some individuals behave violently towards others, or why violence is more prevalent in some communities than in others (Heise 1999, Ellsberg, 2000). Rather, several complex and inter connected social and cultural factors are involved; all of them being manifestations of unequal power relations between men and women (UNICEF, 2000). It is rooted in the way society is set up, in cultural beliefs, power relations, economic power imbalances and the masculine ideal of male dominance (Bitangaro, 1998). In societies of such characteristics, women are less empowered from an early age to manage their sexual and reproductive lives and traditionally there will be a cultural sanction that deny women and children an independent legal and social status and supports the inherent superiority of male.

Various cross-cultural researches have also shown that rape is most common in cultures characterized by male dominance. Such a male dominated society evokes powerful myths to justify male violence against females and to ensure that these acts will not be punished. Few of the operative myths on rape used to blame the victim include; all women want to

be raped, no women can be rapped if she does not want it, she wearied provocatively, she asked for it, children are seductive and the like (Bitangaro, 1998).

Current researches or causal theories of sexual violence have focused on the characteristics of individuals involved in the abuse (Vulnerability to victimization) and on the structure of the society influencing the behavior of offenders. There are factors increasing the risk of someone being coerced into sex, factors increasing the risk of an individual man forcing sex on another person and factors within the social environment influencing the likelihood of rape and the reaction to it (WHO, 2002). Studies indicate that these various factors have an additive effect so that the more factors present the greater the likelihood of sexual violence. A review of some of the important factors is made below.

2.2.1 Factors Increasing Female's Vulnerability to Sexual Violence

This focuses on the characteristics of the individual that increases the likelihood of being a victim of sexual violence. Some of the factors influencing the risk of sexual violence include age (being young), consuming alcohol or drugs, having previously been sexually abused, having many sexual partners, poverty and or economic dependence, and adolescent's attitudes towards sexual violence (WHO, 2002, Rickert and Weimann, 1998).

A. Age

Young women are observed to be more at risk of rape than older women. This has been substantiated by data from various population-based studies, police and Justice System reports of various countries. For instance, data from rape crisis centers in Chile, Malaysia, Mexico, Papua New Guinea, Peru and the USA indicated that between one third and two

thirds of all victims of sexual assault are aged 15 years or less (Heise, 1993, WHO, 2002). Younger age, age at first date, and age at first sexual activity have all been shown to increase vulnerability to sexual assault in adolescent and young adult women (Rickert and Weimann, 1998). It is believed that women who begin dating early encounter a higher number of potential perpetrators. It is also suggested that sexual assault is a result of power disparity between dating partners, making age differences of a couple a possible risk factor contributing to date or acquaintance rape.

B. Early Childhood Experiences of Violence

Experiences during childhood, such as being sexually abused in childhood and witnessing violence in the family have been identified as a factor predisposing to sexual violence during adolescence or adulthood. Studies have shown that childhood sexual victimization results in low self esteem of women and girls making them less skilful at protecting themselves from further rape. It increases their chances of further victimization by making them accept their victimization as part of being female. For instance, an experimental research conducted by Russel (1986) found that 68% of incest victims have been victims of rape or attempted rape latter in their lives as compared to 17% of non-abused control groups. A National study of violence against women in the USA also found that women who were raped before age 18 years were twice as likely to be raped as adults, compared with those who were not raped as children or adolescents (Tjaden and Thoennes, 2000, WHO, 2002). Moreover, early sexual victimization contributes to adolescent prostitution, alcohol and drug abuse, early sexual initiation and other risky behavior (Heise et. al. 1999). Witnessing violence in the family also increases the likelihood of being perpetrators or victims of violence in later life because violence may be learnt as a means of resolving

conflict and asserting manhood by children who have witnessed such patterns of conflict resolution (Heise et. al. 1994).

C. Alcohol and Drug Use

Increased vulnerability to sexual violence also stems from the use of alcohol and drugs. Consuming alcohol or drugs makes it more difficult for women to protect themselves by interpreting and effectively acting on warning signs. Under alcoholic situation women will be more at risk of having diminished coping responses and being unable to ward off a potential attack (Rickert and Weimann, 1998).Drinking alcohol may also place women in settings where their chances of encountering a potential offender are greater. Moreover, it is suggested that men perceive women who are drinking alcohol as more sexually available than women who are not .It is also important to note that the use of drugs such as Marijuana, Cocaine and the like increase women's vulnerability to rape.

D. Having many sexual partners

Even though it is not clear if having more sexual partners is a cause or consequence of sexual abuse, it has been suggested that young women who have many sexual partners are at increased risk of sexual violence (koss etal,1989, WHO,2002).On the other hand, longitudinal studies of young women conducted in Norway, New Zealand, and Nicaragua have indicated that women who had experienced attempted or completed rape during childhood or adolescence were more likely to have a higher number of sexual partners in adulthood, compared with non abused ones (WHO,2002).But, in various studies, it has been observed that having many sexual partners by adolescents increases their vulnerability to sexual abuse.

E. Poverty and Economic Dependence

Women's lack of economic resources underpins their vulnerability to violence. Poverty forces many women and girls into occupations that carry a relatively high risk of sexual violence particularly sex work (Omorodian, 1998, WHO, 2002). Poor women and girls may be more at risk of rape in the course of their daily tasks than those who are better off, for example when they walk home on their own from work late at night, or work in the fields or collect firewood alone. It also creates enormous pressures for them to find jobs, to pursue trading activities and if studying to obtain good grades- all of which render them vulnerable to sexual coercion from those who can promise these things.

Studies indicate that most sexual assault against young women often comes from the same population of men whom women depend on for support and protection (Heise et al, 1994). Similarly, it has been observed that for many young schoolgirls in some sub-Saharan African countries, particularly for those from low-income families; money, gifts and promises of marriage are some of the ways through which schoolboys, teachers or "sugar daddies"(older men forming relationships with young girls by giving money and material gifts) tempt them into sexual liaisons (Leach et al, 2001, Ahlberg et al 2001). According to a research conducted in Zimbabwe (Leach et al, 2001), boys and girls in the study agreed that many young girls enter sexual relations with adult men primarily for money. This reflects conditions of society in which girls look onto men for physical, financial and mental support. Economic and social dependence, thus pre-disposes women for sexual assault.

On the other hand, studies have shown that poor or unemployed men are more likely to rape than middle class and successful men (Mechelen, 1992). For instance, surveys of the socio-economic status of rapists in the United States indicated that the vast majorities of offenders come from lower socio-economic classes and are unemployed or unskilled laborers. Cross cultural studies from Denmark, Australia also confirm that unskilled, unemployed and poorly educated males – those who lose out in sexual competition are more often rapists than other men (Mechelon, 1992).

F. Isolation (Social Fragmentation)

The isolation of children from their family and community is also known to promote violence. Isolation reduces the intensity of supervision and monitoring parents have to make for their children. This creates poor emotional attachment of children to their parents. Girls or children who live away from both of their natural parents have been found to be at increased risk for being sexually victimized. Further, being alone, being unfamiliar with their physical environment increase women's vulnerability to rape. Studies reveal that violet sex offenders are also more likely than other adults to have experienced poor parental child rearing, poor supervision, physical abuse, neglect and separation from their parents (Meyer, 2000).

G. Education level

Women are at increased risk of sexual violence, as they are of physical violence by an intimate partner, when they become more educated and more empowered (WHO, 2002). In a national survey in South Africa, women with no education were found to be much less

likely to experience sexual violence than those with higher levels of education (Jewkes and Abraham, 2002,cited in WHO, 2002). In other study made in Zimbabwe, women who were working were more likely to report forced sex by a spouse than those who were not. This may be because women with a higher education have a greater sense of their own worth and a stronger negative attitude towards violence against themselves. Further, it may show that greater empowerment brings with it more resistance from women to patriarchal norms so that men may resort to violence in any attempt to regain power (WHO, 2002).

H. Attitudes of adolescents towards rape

Adolescent's attitudes regarding rape vary with their demographic and socio-economic characteristics. In studies conducted on high school students and college aged adolescents in the USA, researchers have come to observe that a considerable proportion of adolescent girls and boys believed forced sex is acceptable under some circumstances (Macmahan, 1996). They mentioned that forced sex was acceptable, if the boy spent a lot of money on the girl, if a woman has past sexual experiences, if the man and women are married, if a boy and a girl had been dating for some time, if a girl gets drunk at parties or on dates and the like. These show the early establishment of gender stereotypes in the context of rapes, which are believed to contribute to rape.

2.2.2 Factors Increasing Men's Risk of Committing Sexual Assault

Characteristics of men committing sexual assault are usually agreed to be more important predictors of violence than that of the victim. However, data on sexually violent men are somewhat limited and heavily biased towards apprehended rapists because they are largely based on police and judicial cases. Among the factors increasing the risk of a man

committing rape are those related to attitudes and beliefs as well as behavior arising from situations and conditions that provide opportunities and support for abuse. Some of them have been treated below.

A. Alcohol and Drug consumption

Excessive consumption of alcohol and drugs has been noted as a factor in provoking aggressive and violent male behavior towards women and children. Alcohol has a psychopharmacological effect of reducing inhabitations, clouding judgments and impairing the ability to interpret cues (Koss et al, 1993, Meyer, 2000). It affects men's perception of women's sexual intent and many alcohol-using men perceive alcohol as a sexual cue. Alcohol provides opportunities for some learnt antisocial behavior. Thus, men are more likely to act violently when drunk because they do not consider that they will be accountable for their behavior. It also increases the likelihood that friendliness will be perceived as sexual intent and that a man will fill comfortable enforcing sex after misperceiving a women's cues (Koss et al, 1993). But the links between alcohol and violence are observed to be more complex because researches show that many sexual assaults occur in the absence of alcohol and many people also use alcohol without engaging themselves in violent behaviors (Meyer, 2000).

B. Attitudes and Gender Schema

Some studies on the attitudes of rapists show that sexually violent men have a distorted view of male-female relationships (Alan, 1992, Meyer, 2000). They are more likely to believe myths about rape and use interpersonal violence as an effective strategy for

resolving conflict than non-aggressive men (Alan, 1992). They have coercive fantasies, generally encouraged by access to pornography and overall are more hostile towards women than men who are not sexually violent. Sexually violent men also differ from other men in terms of impulsivity and antisocial tendencies. They tend to have an exaggerated sense of masculinity. These sorts of beliefs may serve as rationalizations for sexual offenders, allowing them to imagine that their victim either desired or deserved to experience forced sexual acts. Especially acceptance of rape myths by men is observed to be strongly related to adversarial sexual beliefs, tolerance of interpersonal violence and gender role stereotyping (Meyer, 2000)

C. Early Childhood Environments

Sexual violence is largely a learnt behavior in violent men that continue into their later life. Childhood environments that are physically violent, emotionally unsupportive and characterized by competition for scarce resources are suggested to have association with sexual violence (Borowsky etal, 1997). Sexually aggressive behavior in young men is also more linked to witnessing family violence as a child, and having emotionally distant and uncaring fathers. Similarly, men raised in families with strong patriarchal structures are also more likely to become violent, to rape and use sexual coercion against women than men raised in homes that are more egalitarian

(Borowsky etal,1997).

D. Sex and Power Motives

Two of the theories of sexual violence, the Biosocial and Feminist theories, assert that men's motives for sex and power underlie all acts of sexual aggression (Ellis, 1989,

Malamuth, 1996). Ellis, who developed the biosocial theory, for instance suggested that for human beings the sex and possession or domination derives are closely linked and both comprise the motivation behind all sexual behavior. But he emphasized that sexist attitudes lead to increased motivation to rape and domination and aggression are tactics used as a means towards a sexual end.

By contrast, most feminist researchers contend that sexual coercion is motivated by a desire to exert control over women and rape is not necessarily a sexual act, but rather an act of dominance and aggression (Powch, 1996, Bronwmiller, 1975). They identify that the male constructed patriarchal society existing all over the world has made men owners of Wealth and power that is used to dominate women. This culture becomes inherent in the manner in which the sexes are socialized. From the beginning, women are taught to be passive and submissive, while men are instructed to be active, dominant and aggressive. Tenderness, sensitiveness and empathy are encouraged for women but discouraged in men (Malamath, 1996). This makes men to develop masculine self-concepts, devalue women and act aggressively against women. Even though both motives are important in promoting sexual aggression the motives of power and anger are more prominent in rapist's rationalization for sexual aggression than sexual desires are (Meyer, 2000).

E. Association with Delinquent Peers

Sexually aggressive behavior among young men has been linked with a gang membership and having delinquent peers (Borowsky etal, 1997). In gang groups, sexual aggression is often taken as a defining characteristic of manhood and is significantly related to the wish to be held in high esteem. Research also suggests that men with sexually aggressive peers

are much more likely to report coercive or enforced intercourse outside the gang context than men lacking sexually aggressive peers.

Gang rape is a form of rape committed by people in-group and is predominantly committed by young men. This is often viewed by the men involved as legitimate in that it is seen to discourage or punish perceived immoral behavior among women – such as wearing short skirts. Thus, peer pressure plays a role in forming attitudes and behaviors that supports sexual assault. Some even suggest that peers are more influential in shaping individual behavior than Biology, personality family, religion or culture (Meyer, 2000, Leech et al, 2001).

2.2.3 Societal Factors Promoting Sexual Violence

Since people's behavior is heavily influenced by the society they live in, socio-cultural factors acting at community and societal levels are equally important to individual level factors. Thus, Laws, cultural values, social structures and family relationships also determine whether the members of a society are violent or not.

A. Social Norms and Expectations

Sexual expectations transmitted by a society's culture encourage men to feel superior, entitled and that they should be always on the lookout for and ready to initiate sex in their relationships with women. At the same time sexual expectations teach women responsible for setting sexual limits and the pace of sexual contact in their relationships with men (Meyer, 2000). Thus, sexual violence committed by men is to a large extent rooted in ideologies of male sexual entitlement. Such beliefs grant women extremely few legitimate options to refuse sexual advances.

Societal norms around the use of violence as a means to achieve objectives are observed to be strongly associated with the prevalence of rape. In Societies where the ideology of male superiority is strong emphasizing dominance, physical strength and male honor, rape is more common (Sanday, 1981). Moreover, rigid gender roles, especially definitions of masculinity linked to dominance, toughness or male honor are highly correlated with violence against women (Heise etal, 1994). It was also observed that violence is prevalent in societies where the use of force is condoned as a means of resolving interpersonal conflicts.

B. Laws and Policies on Gender Equality

Laws and national policies relating to gender equality in general and to sexual violence more specifically are among the important societal factors. Societies and communities with a high prevalence of rape have higher gender inequality in terms of legal status, power and access to resources. Legal systems that discriminate against and fail to protect women, economic structures that disempower women, cultural systems that legitimize violence, male control of female behaviors and political realities that ensure that women's needs and concerns are marginalized in the corridors of power, all conspire to perpetuate violence against women (Heise et al, 1994).

Societies also differ in their approach to sexual violence. Some countries have far reaching legislation and legal procedures with a broad definition of rape that includes marital rape and with heavy penalties for those convicted. Commitment to preventing or controlling sexual violence is also reflected in an emphasis on police training and an appropriate allocation of resources to the problem, and in the resources made available to support

victims and provide medical and legal services (WHO, 2002). On the other hand, there are countries with a weaker approaches to the issue – where convictions of an alleged perpetrator on the evidence of the women alone is not allowed, where certain forms of sexual violence are specifically excluded from the legal definitions and where rape victims are strongly deterred from bringing the matter to the court through the fear of being punished for filling an unproven rape suit.

C. Pornography

Pornography applies to many forms of explicit and non-explicit depictions of human sexual activity. Feminist movements from the beginning opposed this because it is assumed to encourage sexual aggression towards women by portraying them as nothing more than sex objects (Meyer, 2000). It is also observed by some studies that men who see these violent movies are more likely to say that they would commit rape and to endorse rape myths. And while sexual offenders are typically sexually aroused at depictions of rape, even non-explicit sexual scenes have been shown to decrease empathy rape victims. Thus, pornography is viewed as depictions of violence against women rather than sexually graphic material that encourages acceptance of violence towards women. It enhances tendencies of some men to behave aggressively towards women.

D. Schools and other socialization Institutions

School climates contribute to socialization supportive of violent behavior when they reinforce sex role stereotypes and attitudes that condone the use of violence (Meyer, 2000). Since peers are influential in shaping individual behavior, adolescent peer group culture within the school environments encourages male and female pupils to conform to

certain stereotypical behaviors, which make girl's particularity vulnerable to sexual abuse (Leach et al. 2002). Many studies of sexual violence conducted on educational institutions have also observed that sexual exploitation of young girls by school boys, teachers and older men is common in educational institutions. (Bonnie et al. 2000).Other institutions that contribute to the socialization that supports violence include the work place, organized religion and the media (Koss etal, 1993).

E. Community Instabilities

The break down in law and order during war, conflict and displacement leads to an increase of violence. In war situations, rape is often used as a tactical device to accomplish discrete political ends, to intimidate and punish individual women, to destabilize and demoralize communities (Heise et. al. 1995). Mass rape, forced marriages, gang rape, forced prostitution are some forms of violence that result from conflicts or refugee situations (WHO, 1997). For instance, brutal war rapes were reported in Bosnia, Sierra Leone, Peru, Rwanda and Congo during their civil wars (Heise et. al. 1995).

2.3 Consequences of Sexual violence for Adolescents Health

Sexual violence has serious consequences for women's physical and mental health. The World Bank estimated that rape and domestic violence account for 5% of the healthy years of life lost to women of reproductive age in developing countries (World Bank, 1993). For young women, the effects of sexual abuse is more devastating because it is linked, directly or indirectly with the major reproductive health issues of our times-unwanted pregnancy, HIV and other sexually transmitted infections, unsafe abortions and other adverse

pregnancy out comes (Stewart et al, 1996 WHO, 1997, Heise et al. 1995). The psychological and mental effects of rape and other forms of sexual violence are also equally important.

2.3.1 Reproductive Health outcomes

A. Unwanted Pregnancy

Early and unwanted adolescent pregnancy is one of the major consequences of sexual violence. Sexual abuse can lead directly to unwanted pregnancy either through rape or by affecting their ability to negotiate contraceptive use (Heise et al, 1995). Sexual abuse can lead indirectly to unwanted pregnancy by increasing certain risky behaviors such as alcohol use, early sexual initiation and sex without using contraception. In this regard, it has been observed that adolescents who are abused or who have been abused as children are less likely to develop a sense of security than those who are not abused and are thus more likely to engage themselves in these risky behaviors (WHO, 1997, Stewart et al, 1996). For instance, a study of adolescent mothers in the U.S State of Washington found that young women who had been abused during childhood-begun intercourse on average a year earlier than non -victimized ones (Boyer and Fine, 1992). They were also more likely to use drugs and alcohol and less likely to practice contraception. A similar study in the United States confirmed that women survivors of childhood sexual abuse are nearly three times more likely than non-victimized youth to become pregnant before the age of 18 (Zierler et al, 1991, cited in Heise et al, 1995).

However, considerable proportions of unwanted pregnancies are clearly a direct outcome of rape. A study conducted at the maternity Hospital of Lima (Peru) found that 90% of young mothers aged 12 to 16 were victims of rape(Heise et al, 1995). In a study of sexual violence against female high school students in Addis Ababa and Western Shoa, it was observed that 17% of rape victims experienced unwanted pregnancy (Mulugeta et al, 1998).

B. Adverse Pregnancy Outcomes

Sexual violence may also have adverse impacts on pregnancy out comes. It is linked with risks of abortion, miscarriages and premature labor (Global forum for Health research, 2001). In many societies where illegitimate pregnancy is culturally unacceptable, girls try to resolve their pregnancy through abortion. Where the practice of abortion is not legal as in the case of Ethiopia or where safe abortion is difficult to obtain, they resort to unsafe abortions which may have other negative outcomes for their health (WHO, 1997). For instance, a survey of illegal abortion conducted in Addis Ababa about ten years ago showed that 10% of pregnancies of abortion seekers occurred due to rape (Yoseph et al, 1993).

Another risk associated with unwanted pregnancy occurring from rape is the fact that child bearing before the girls are biologically and psychologically mature is associated with adverse health out comes both for the mother and the child. The mother suffers from premature labor, and infants may be premature of low birth weight or be small for gestational age (WHO, 1997).

C. Sexually Transmitted Diseases /HIV/AIDS

Similar multiple pathways are evident in the relationship between sexual abuse and sexually transmitted diseases as with unwanted pregnancy (WHO, 1997). Adolescents are vulnerable to contracting STD's in rape situations because they are not able to use contraception or negotiate safe sex (Heise etal, 1995). Apart from the direct contraction of STDs/HIV AIDS through rape, childhood sexual victimization can also increase their chance of contracting STD's or HIV by affecting their future sexual behavior. As pointed out earlier, childhood sexual abuse increases the practice of high-risk sexual behavior among adolescents.

A more serious concern, with fatal outcomes for survivors of rape is the transmission of HIV/AIDS. The possibility of becoming infected with HIV will be another source of anxiety and fear, which exacerbates the trauma that they experience. The risk of HIV transmission is increased in the context of such coercive sex relative to that of consensual sex since physical trauma, abrasions and cuts are more likely when sex is forced (Global forum for health research, 2001). Condom use is also highly unlikely when sex is forced.

Reports from the joint United Nations program on HIV/AIDS (UNAIDS) show that women are the fastest growing population to be infected with HIV in most regions of the world; sub-Saharan Africa in particular. Further a study by Moreno and Watts (2000) on the linkages between violence against Women and HIV/AIDS, indicated that young women are particularly vulnerable to both coerced sex and HIV/AIDS and that over half of all infection worldwide are occurring among young people between the ages of 15 to 24 (cited in Global forum for Health Research, 2001). In some countries of sub-Saharan

Africa, reports have shown that more young females than males are infected. For instance UNAIDS estimated that HIV prevalence rates among young women and men aged 15-24 is 27.13% and 15.11% in South Africa, 16 and 8% in Malawi and 9.27 and 5.8% in Tanzania (UNAIDS, 2001). Similarly a report from the Ethiopian Ministry of Health indicates that more adolescent females as compared to adolescent males in the age group 15-19 are infected with HIV (MOH, 2000).

D. Risks for other Gynecological Problems

In addition to the aforementioned reproductive health problems, sexual and physical abuse appear to be connected to some common gynecological problems including pelvic pain, vaginal discharges, painful menstruation, pelvic inflammatory disease and sexual dysfunction (difficulty in orgasms, lack of desire). Many of these will be aggravated when sexually transmissible infections occur, (Heise et al, 1999) with fistula cases, and if the women had been circumcised.

2.3.2 The psychological Impacts of Sexual Violence

Apart from the physical (reproductive) health outcomes, sexual violence endures various short term and long-lasting psychological effects. The psychological impact endured after rape or sexual assault by adolescents include feeling vulnerable, unloved and powerlessness, difficulty in distinguishing sexual from affectionate behavior, shame, guilt and fear (Stewart et al, 1996). Some of the long-term consequences of sexual violence include poor self-esteem, chronic depression, eating disorders, substance abuse, suicidal

attempts and sexual risk taking (WHO, 1997). Survivors of childhood sexual abuse often experience repeated sexual violence as adults because the past –traumatic affects of childhood sexual abuse such as poor self-esteem and feelings of powerlessness can increase their vulnerability to repeated violence.

2.4 Legal Aspects of Sexual Violence in Ethiopia

It has been mentioned that legal systems that fail to protect women or discriminate against women, and cultural systems that legitimize violence are among the factors that conspire to perpetuate violence against women. Strong legislation and legal procedures are needed on its side to combat the problem. Laws concerning rape vary tremendously from one country to another. Many countries mostly developed countries, have strict laws that impose stiff penalties for several years, and with penalties increasing sharply in cases where the victim was underage, gang raped or where a gun or other weapon was involved. In some countries, perpetrators may be penalized with a life long imprisonment (ex. Nigeria, South Africa) (Neft and Levine, 1997). In some others, a rapist may be penalized with an imprisonment ranging to 25 years (Egypt, Argentina and the like).

The Ethiopian penal code of 1957 has a set of provisions dealing with some forms of sexual violence against woman; rape, abduction and trafficking in women. The law, however, does not have specific provisions dealing with domestic violence, marital rape, female Genital mutilation and related harmful traditional practices. As to FGM and other harmful traditional practices, the new Ethiopian constitution prohibits them under art 35 (4) as it may result in bodily or mental harm to women. Efforts to discourage such practices are also underway.

Article 589 of the Ethiopian penal code defines rape as the act of compelling a woman to submit to sexual intercourse outside wedlock by the use of violence or grave intimidation or after having rendered her unconscious or incapable of resistance. This offence of sexual assault is punishable with rigorous imprisonment not exceeding ten years (Art 589 (1) of the penal code). The crime is aggravated and the punishment will increase to fifteen years under some situations. These are where rape is committed; on a child under age fifteen, on an inmate of a hospital, asylum, educational establishment, correction, internment or detention by a person in a position of supervision or control and by a number of persons acting in concert (Art 589 (1(a,b,c))).

Regarding rape, it is suggested that the Ethiopian penal law bears a number of shortcomings. Firstly, the definition of rape given by the penal code is somewhat narrow. It recognizes only actual penetration of the vagina (Rakeb, 1997), and for non-virgin victims it comes difficult to prove lack of consent, which is the yardstick for rape. Besides this, it is alleged that the conviction to be penalized to rapists is not implemented appropriately. Rapists can be released within a couple of days or months, because there is no provision in the law for a minimum sentence. The Ethiopian Women Lawyers Association (EWLA) had been making an effort to revise the law regarding rape as well as other laws related to women. With regards to rape, the improvement suggested by the association was to specify the minimum (5 years) and the maximum (20 years) penalties of rigorous imprisonment depending on circumstances (Sara, 2001).

The Ethiopian penal code has not defined sexual harassment specifically, making it difficult to address the issue of harassment legally. But some suggest that the claims of

sexual harassment can be seen under other areas of law that have relevant application to acts constituting sexual harassment (Hillina, 1997, Netsanet, 1999). Articles 590-596 of the penal code deal with sexual offences other than rape. Sexual harassment involves criminal acts such as sexual outrages on persons in hospital, interned or under detention (Art 592), sexual exploitation taking advantage of the distress or dependence of a woman (Art 593), sexual outrage on minors, on infants or young persons (Art 594, 595).

So various cases of harassment can be convicted under these laws. For example, cases of sexual harassment at school and the work place could fall under this article (Hillina, 1997). Most of the acts stated above are punishable with maximum and minimum penalties ranging from five years of rigorous imprisonment to simple imprisonment of one month.

Abduction and trafficking in women are also defined by the Ethiopian penal code. Abduction is recognized by the penal code as the carrying of women by violence or after obtaining her consent to it by intimidation trickery or deceit (Art. 558). The act of abduction is punishable with rigorous imprisonment not exceeding three years. Where the woman has been rendered incapable of defending herself or offering resistance, the crime is aggravated and its punishment raised to five years (Art 559). Further, art 605 of the penal code punishes who so ever for gain or gratify the passions of another traffics in women or infants and young persons, whether by seducing them, by enticing them, or by procuring them or other wise inducing them to engage in prostitution, even with their consent, with rigorous imprisonment not exceeding five years and a fine not exceeding 10,000 Birr.

CHAPTER THREE: DATA SOURCES AND METHODS

3.1 The Study Area

The study was carried out in Jimma town, which is located 335 kilometers South West of Addis Ababa, in Oromia Regional State. Jimma was selected as a study area due to the researcher's familiarity with the area, his earlier observation of the problem understudy in the town and for its convenience for transportation. Moreover, there was a report from Regional (Oromia) police commission that had identified Jimma town as one of the towns in the region where sexual violence against schoolgirls and adolescents is severe.

According to the 1994 population and Housing census of Ethiopia, the town had a total population of 88,867 inhabitants. This makes it to rank among the largest towns in the country. It is in fact, the largest town in the coffee producing region of southwestern Ethiopia, and has currently become a special zone. Of the total population of the town in 1994, adolescents aged 15-24 accounted for 27% (23,914). Female adolescents, who are the study population of this research, constituted 53% (12, 839) of the adolescent's population.

Like other major towns of the country, Jimma consists of people of different ethnic, religious and socio-economic groups. According to the 1994 census, the major ethnic groups residing in the town are Oromo (36.5%), Amhara (22.8%), Kulo (12.7%), Kefa (7%), Guraghes (7%) and Silte (3%). Similarly, Orthodox Christianity and Islam are the two major religions followed by 60.3% and 33.2 %of the population respectively (CSA, 1998). Administratively, the town is divided into three Wereda's comprising a total of 21

urban dwellers associations (Kebeles). The town has one hospital serving as a referral center, one University, one Teacher Training College and two high schools. There are also branches of NGOs like the Family Guidance Association of Ethiopia working on reproductive health in the town.

3.2 Study Design

The study is based on primary data generated through a cross-sectional (household) survey of adolescents living in Jimma town. The study has two components; quantitative and qualitative. The cross-sectional survey was made for the quantitative study. As far as the qualitative component is concerned, two focus groups discussions have been conducted.

3.3 Survey Methodology and Sampling Procedure

Households were the primary sampling unit in this cross-sectional study. To this end, a multi-stage stratified sampling procedure was applied. The town is first subdivided into two administrative units; Weredas and Kebeles. Within the two, the three Weredas were taken as the first sampling unit, and within each stratum or Wereda, one Kebele was chosen. Kebles o3, o5 and 07 were selected from weredas 1, 2,and 3 respectively in a manner that allows adequate geographic distributions of the sample. Then, a list of households obtained from the Kebele Administration was utilized as a sampling frame for the selection of households to be included in the sample. Based on the sampling frame of households in each Kebele, households were selected from each Kebele by systematic random sampling method to determine eligible adolescents for the survey (every fifth household was selected). Each Kebele was represented in proportion to the size of its

households. Accordingly, 178, 140 and 282 samples were assigned to the three kebles (03,05, and 07) respectively. Keble 07 of higher 3 had much larger number of households as compared with the other two and thus a higher proportion of the sample was assigned there. Finally, one adolescent female in the age range 15-24, who will be available at home during the survey period became the subject of the study. Up on the presence of more than one adolescents at home during the interview, willingness to participate in the study was considered. Where there happened to be more than one becoming interested to participate in the survey, enumerators applied a lottery system to select one eligible respondent. Repeated visits were made in cases where a respondent was not available at the time of the interview.

3.4 Sample Size Determination

In this cross-sectional study a sample size of 600 adolescents of age 15-24, was planned to be utilized. This sample size is determined based on the following assumptions and formula.

Assumptions

1. In the absence of previous prevalence data on the population understudy and to obtain the maximum sample size, the prevalence of sexual violence is assumed to be 50%.
2. A precision (Margin of error) of 4% is accepted
3. A confidence interval of 95% is assumed.

Using these assumptions and the following formula, a sample size of 600 is obtained.

Formula

Sample size (n) = $\frac{[(Z * \alpha/2)^2 P.(1-P)]}{D^2}$

Where:

P = 0.5 (50%)

Z= 1.96

D = 0.04 (4%)

The samples are all taken from the three urban Dwellers Associations based on a probability proportionate to size of the kebles. However, the actual number of adolescents successfully interviewed during the survey was 588, giving a response rate of 98%.

For the qualitative study, focus groups comprising of female adolescents, and young men were organized each separately for discussion.

3.5 Data Collection Instruments

A structured questionnaire was prepared (partially adopted) for the survey first in English language and translated into Amharic to collect information for the descriptive part. After the survey, it was translated back to English to ensure its consistency. The questionnaire was pre-tested on samples of adolescents taken from the town and necessary modifications were made on its contents, ordering and clarity of the questions before the survey. For the qualitative study, a semi-structured focus group discussion guide that contained certain points related to the beliefs and attitudes of boys and girls towards rape and pre-marital sexual practice was used. It was believed that supplementing the survey study by a qualitative focus group discussion would be better in studying the adolescent females and

young men's attitudes and knowledge's with regards to the extent and cause of rape and pre-marital sexual practice. Thus, one female and one male focus group discussions were organized.

3.6 Variables

Dependant (Outcome) Variables: - rape as a cause of first sexual debut, rape in adolescents life time and its outcomes, attitudes of boys and girls towards rape are the outcome variables of the study. Moreover, adolescent's knowledge of contraception and HIV/ AIDS was studied.

Independent (Exposure) variables: - For the purpose of the study, socio-demographic and behavioral factors related to rape and other forms of sexual violence were included. Socio-demographic factors included are age, martial status, educational status, occupation, living arrangement, religion, age at first sexual experience, family income and ethnicity of the respondents. Behavioral factors like alcohol and chat abuse and number of sexual partners are included to study their relation ship with sexual violence.

3.7 Data Collection and Management

The data collection process took place between March 8 and March 24, 2003. Fifteen female interviewers who have accomplished their secondary level education conducted the data collection process. The enumerators have had training in reproductive health by the OICE/ PACKARD Foundation, Jimma Branch. Eight of them were also members of the youth club of FGAE, Jimma Branch. For the purpose of this data collection, they were given two days of intensive training on the content

of the questionnaire, interviewing techniques and ethical issues. Moreover, two supervisors were assigned to closely follow the data collection process. At the sample kebeles, informants from each kebele were involved in identifying the selected households. Throughout the survey time, the completed questionnaires were regularly reviewed and checked for errors by the investigator and supervisors. This helped us in making timely corrections during the fieldwork.

At the end, the principal investigator with the selected focus groups conducted the qualitative study.

3.8 Data Processing and Analysis

Once the field operation is complete and questionnaires are edited, data was entered and processed using SPSS PC^{+} version 10.0. Using this package, prevalence rate was calculated; descriptive analysis and frequency distribution of relevant variables were made. A chi-square test and a multivariate logistic regression are used at the Bi-variate and multivariate stages to identify the association of selected independent variables with lifetime rape. The multivariate logistic regression model is used because the dependant variable, lifetime rape, is on a dichotomous scale. It is a model where the natural logarithm of the odds of the dependant variable is predicted by a linear function of the independent variables.

The model is indicated by:

$Ln(p/1-p)= B_o+B_1X_1+B_2X_2---------B_k X_k$

Where; p/1-p is the odds ratio's and

x_1, x_2, x_3 --------x_k are the independent variables used. In the logistic regression, variables were defined as shown below.

Variable order	Variable	Coding categories
X1	Age	Coded into two groups,15-19 and 20-24
X 2	Education	3 categories were identified; No education, (including illiterates and read and write) Primary, and Secondary and above
X 3	Family(own)income	Coded into three categories; No income, below 600 and above 600
X 4	Marital status	also coded into 3 categories; Never married, married and others(widowed, divorced and co-habiting)
X 5	Religion	has three categories; Orthodox, Muslim and others(protestants, Catholic, no religion)
X 6	Living Arrangements	Coded into 5 categories; living with both parents, living with a father or mother only, living with relatives, living alone and being in marital union
X 7	Number of sexual partners	Coded into three categories; those with no partner, those who have one and those who have two and above
X 8	Alcohol drinking	Coded as 1 if drinking, and 0 otherwise
X 9	Chat Chewing	1 if chews chat and 0 otherwise
X10	Age at first sex	Coded into three; 10-14,15-19 and 20-24

Finally, results of the quantitative analysis and the focus group discussions are used in the discussion of the findings of the study.

3.9 Ethical Considerations

The issue under study is a sensitive one that requires ethical considerations. Considering this, care was made following WHO (World Health Organization) guidelines on ethical issues related to violence research to ensure the safety of the respondents as well as data quality. This was implemented as follows.

Prior to initiating the interview, consent was asked and the purpose of the study was described to the respondents. Further, interviewers described what would happen during the course of the study and told them that the study offers benefits to them and all young women in the town. Privacy was promoted and respondents were informed that whatever information they provide would be kept confidential. The interview was also anonymous. Interviewers have been given training in this regard. Participants were also informed that they have the full right to discontinue or refuse to participate in the study. They were given the opportunity to ask questions, and the expected duration of participation in the interview was pre-informed. Moreover, in developing the questionnaire effort was made to make the questions clearly worded, specific and can be easily answered by the respondent.

3.10 Limitations of the Study

The study is not without limitations. Among the main limitations of the study are

1. The sensitivity of the issue as well as the use of long recall period might have underestimated the magnitude of the problem
2. The study had focused on the prevalence and outcomes of sexual violence. In studying the factors that promote sexual violence, it considered only the

female population and the factors that increase their vulnerability. However, factors related to the perpetrators (males) and the society in general, which were hardly covered through this study, would better predict the occurrence of sexual violence. Nonetheless, the FGD conducted is believed to provide some information about these factors.

3. There was only one focus group discussion conducted with each group (boys and girls). This could not enable us to go up to the saturation of information. Moreover in the sampling procedure, which involved a multi-stage procedure, design effect was not considered.

CHAPTER FOUR

RESULTS OF THE QUANTITATIVE STUDY

4.1 Characteristics of the Study Population

A total of 588 female adolescents aged 15-24 participated in the study. The median age of the participants was 18 years. Orthodox Christians comprised the majority, 53.2% followed by Muslims, 33.5 %(table 1). Considering the marital status of the respondents, the never married made up 81.1% of the study population and 12.6% were married at the time of the interview. With regards to education, 52.7% of the respondents are at secondary level, 33.7%at primary level and a further 8.0% have no formal education while current school attendance is 66%. The remaining are involved in some informal and formal activities like waitress, trade, salon work, maid servant, and others, unemployed.

The ethnic composition of the respondents indicates that the majority, 39% are Oromo, followed by Amhara and Guraghe ethnic groups. 67.4% of the participants were born in Jimma town while the remaining 32.6% have moved to the town after being born in other parts of the country. At the time of the interview, 63.5% of the participants were living with their parents (both or with one of the two) 12% in marital union and 9.5% were living alone. Table 1 summarizes the characteristics of the respondents.

The educational attainments of the adolescents' parents indicate that 43% of the fathers and 60% of the mothers had no formal education (table2). For 65.4% of the adolescents participating in this study both their natural parents are still alive. Further, the majorities (61%) of the adolescents belong to low-income families (below 300 birr per month).

Table 4.1: Socio-Demographic Characteristic of Female Adolescents, Jimma 2003

Variable	Frequency	Percent
Age		
15-19	408	69.4
20-24	180	30.6
Religion		
Orthodox	313	53.2
Muslim	197	33.5
Protestants	65	11.1
Others	13	2.2
Educational status		
Illiterate	29	4.9
read and write	18	3.1
Primary(1-8)	198	33.7
Secondary(9-12)	310	52.7
Above High school	33	5.6
Ethnicity		
Oromo	229	39.0
Amhara	108	18.4
Kulo	78	13.3
Kefa	45	7.7
Guraghe	81	13.8
Others	46	7.8
Marital Status		
Never Married	477	81.1
Married	74	12.6
Divorced	26	4.4
Widowed	6	1.0
Others	5	0.9

Current Activity		
Students	390	66.3
Unemployed	31	5.3
Domestic servants	42	7.1
Trade	35	6.0
Waitress	25	4.3
Salon worker	19	3.2
Others	46	7.8
Place of birth		
Jimma	397	67.5
Other towns	125	21.3
Rural	66	11.3
Currently living with		
Parents	373	63.4
Relatives	54	9.2
With spouse	70	11.9
Alone	56	9.5
Others**	35	6.0
Currently enrolled in education		
Yes	390	66.3
No	198	33.7

** others here includes non relatives, employers and Co-habiting with a partner

Table 4.2: Parental Characteristics of Female Adolescents, Jimma 2003

Characteristics	Frequency	Percent
Fathers educational level		
Illiterate	147	25.0
Read and write	106	18.0
Primary (1-8)	126	21.4
Secondary (9-12)	146	24.8
Above high school	63	10.7
Mothers educational level		
Illiterate	219	37.2
Read and write	134	22.8
Primary (1-8)	148	24.3
Secondary (9-12)	70	11.9
Above high school	22	3.7
Family (own) income		
No income	34	5.8
Below 300	359	61.1
300-600	96	16.3
Above 600	99	16.8
Parental condition		
Both alive	384	65.4
Father only	43	7.3
Mother only	103	17.5
Both not alive	57	9.7

4.2 Prevalence and Characteristics of Sexual Violence

Information on sexual activity was asked of all the respondents. Among the 588 female adolescents included in this study, 224 (38.1%) have already initiated sexual activity. The median age at first sexual debut was 16 years and the mean age was 16.4 years. The age range of sexual initiation was 10-22 years. Table 3 indicates the age at first sexual experience of the adolescents by the causes of sexual initiation. Among the 224 sexually active adolescents, 25.9% initiated sexual activity because of rape, 32% of them reported to have started by their own desire, 21% by marriage and 16.4% initiated as a result of promises from partners.

Among the 58 victims who had initiated sexual activity because of rape, 32.8% were victimized between ages 10 to 14 and 65.5% between ages 15-19(table 4). About 90 % of them were victimized before age 18(the age of consent in Ethiopia), can be called statutory rape.

In majority(62%) of the cases , rape was committed by a person well known by the victim; 33% by a boy friend, 12% by acquaintances or relatives, 12% by neighbors (table 4). Rape committed by a stranger accounted for 22.4 % of reported rape cases. In 86.2% of the cases, perpetrators are older than victims, showing that most of the rape was committed by persons older and physically stronger than the victims. The offenders used different mechanisms to intimidate the victims. Verbal threats of harm were used in 31% of the rape cases, physical force (beating up) in 27.6% and making their victims drunk in 24% of rapes (table 5).

Table 4. 3: Age at and Reasons for First Sexual Debut of Female Adolescents, Jimma 2003(N=224)

Variable	Frequency	Percent
Age		
10-14	29	12.9
15-19	177	79
20-24	18	8.0
Reasons for sexual Initiation		
Marriage	48	21.3
Personal desire (love)	72	32.0
Promising words	37	16.4
For exchange of gifts/money	7	3.1
Forced	58	25.8
Other	3	1.3
Total	224	100

Table 4.4: Age at First sex of Adolescents by Causes, Jimma 2003 (N=224)

Causes of first sexual Initiation	Age at first sex		
	10-14 years	15-19 years	20-24 years
Marriage	4	32	12
Personal Desire	1	69	2
Promising words from partner	5	28	3
For exchange of gifts/money	0	7	0
Forced	19	38	1
Other	0	3	0

Table 4.5: Perpetrators of Rape, Mechanisms Used to Rape and Age of Rapists in Relation to Victims, Jimma 2003

	Frequency	Percent
Perpetrators of rape		
Boy friends	19	32.8
Relatives	7	12.1
Neighbors	7	12.1
Strangers	13	22.4
Gangs	5	8.6
Families friends	3	5.2
Others	4	6.9
Mechanisms used		
Beating up	16	27.6
Threats of harm	18	31.0
Making drunk	14	24.1
Pointing a gun/knife	8	13.8
Use of drugs	2	3.4
Age of perpetrators in Relation to victims		
About victims age	6	10.3
Younger than victim	2	3.5
About 5 years older older than victim	24	41.3
5-10 years older	15	25.9
Above 10 years older than victim	11	19.0
Total	58	100

Further questions were asked to identify the adolescent's experience of rape other than rape as a cause of first sexual experience. These helped us to identify 52 rape cases of which 20 were repetitive to the victims who had initiated sexual debut because of rape. Thus, 90 adolescents of the study participants reported that they were victims of rape in their lifetime, 20(22%) 0f them being victimized two or more times. The prevalence of completed lifetime rape was thus 15.3%.

Similar to what has been mentioned earlier, assailants of overall (lifetime) rape are known to the victim in 69% of rape cases. Accordingly, 32% was committed by boy friends and former boyfriends, 19% by neighbors and relatives, 12% by employers and bosses and 5.6% by family's friend (table6). Table 7 further shows some socio-demographic and behavioral characteristics of victims of rape.

Table 4.6: Assailants of Overall (lifetime) Rape Reported, Jimma 2003

Perpetrators	Frequency	Percentage
Boy friends or ex-lovers	29	32.2
Neighbors and relatives	17	18.9
Strangers	15	16.7
Employer/boss/teacher	11	12.2
Gangs	5	5.6
Families friend	5	5.6
Others	8	9.0
Total	90	100

Table 4.7: Socio Demographic and Behavioral Characteristics of Victims of Lifetime Rape, Jimma 2003 (n=90).

Variable	Frequency	Percent
Current Age		
15-19	48	53.3
20-24	42	46.7
Age at firs sex		
10-14	20	22.2
15-19	68	75.6
20-24	2	2.2
Educational level		
No education	13	14.4
Primary (1-8 grades)	27	30.0
Secondary and above	50	55.6
Current activity		
Students	49	54.4
Trade	6	6.6
Unemployed	11	12.2
Maid servant	10	11.1
Waitress	7	7.8
Salon worker	3	3.3
Others	4	4.4
Alcohol drinking		
No	47	52.5
Yes	43	47.8
Chat Chewing		
No	59	65.6
Yes	31	34.4
No. Of sexual partners		
None	28	31.1
One	27	30.0
Two and above	35	38.9

After the rape, only 21(23.3%) have reported to legal bodies like the police (15), women's affairs (4) and Kebele Administrations (2). Those who have not reported gave such

reasons as; being afraid of humiliation (32.1%), fear of parents (36.7%) ,being threatened by the rapist (27.9%) and fear of non-acceptance by the police (2%).

The prevalence of attempted rape in their lifetime was 17.7%. The mechanisms they used to overcome the attempt included giving another appointment (44.2%), fighting back (37.5%), shouting (26.9%) and getting help from other people (22.1%). The magnitude of physical assault (beating) by intimate partners or friends was reported by 28.4% of the study participants. In the twelve months before the interview, 2.7% of the adolescents reported to have been victims of non-consensual sex, and 19% experienced unwelcome or non-consensual kissing in the last year. Information has also been gathered on other forms of sexual violence like female circumcision, abduction and forced marriage (table 8). The table shows that 78.7% of the adolescents have been circumcised, 2.2% had experienced abduction and 3.6 % experienced forced marriage by their families or close relatives.

During the survey, respondents were also asked some indirect questions on the prevalence of rape and forced kissing, "do you know a friend who was forcefully raped and a friend who was forcefully kissed?". Accordingly, 115(19.6%) and 185(31.5%) of the respondents said that they know a friend who was forcefully raped and forcefully kissed respectively.

Table 4.8: Magnitude of the various Forms of Sexual Violence, Jimma 2003 , (n = 588)

Forms of sexual violence **	Frequency	Percent
Completed rape	90	15.3
Attempted rape	104	17.7
Female circumcision	463	78.7
Abduction	13	2.2
Forced marriage	21	3.6
Physical assault (beating)	167	28.4
Non-consensual kissing in the last year	112	19.0
Non-consensual sex in the last year	16	2.7

** Multiple responses are possible

4.3 Reported Outcomes of Rape

The victims have reported various negative consequences of the rape on their physical and mental health. Among the ninety victims who reported to have been raped, 21% reported to have become pregnant, 10% had undergone abortion, 42.2% reported to have had trauma (injury) of the genitalia and 16.7% had unusual discharge from the genitalia (table 9). 20(22.2 %) of these victims reported that they have sought help for their health from health institutions and the Family Guidance Association of Ethiopia (Jimma Branch). Various kinds of psychological outcomes were also reported. In this regard, some 37.8% said they lost interest in sexual intercourse, 53% blame themselves for their victimization,

68% developed fear and anxiety, 41% had a low self-esteem, 8 % had thought of ending their life and 4.4% had withdrawn from school.

Table 4.9: The Reported Outcomes of Rape, Jimma 2003(n=90)

Outcome types**	Frequency	Percent
Physical health outcomes		
Unwanted pregnancy	19	21
Abortion	9	10
Trauma of the Genitalia	38	42.2
Unusual discharge from the Genitalia	15	16.7
Swelling around the Genitalia	9	10
Psychological outcome (after forced sex)		
Bad sleep	40	44.4
Fear and anxiety	61	67.8
Easily frightened	33	36.7
Hate others for what happened	27	30.0
Blame herself for what happened	48	53.3
Feel unhappy	31	34.4
Become addicted to alcohol or substances like chat	7	7.8
Feel that she is a worthless person (low self esteem)	37	41.1
Lost interest in sexual intercourse	34	37.8
Thought of ending your life	7	8
Withdrawn from school	4	4.4

** Multiple responses are possible

4.4 Adolescents Attitudes towards sexual violence

Questions were also posed to the respondents to assess their attitudes towards pre-marital sexual practice and violence. Regarding pre-marital sexual practice, 92% of the girls responded that sex before marriage is not acceptable, although 30% of them have already been involved in sexual activity outside of marriage. The reasons given by these adolescents for disapproving early sexual practice include unwanted pregnancy (63%), HIV/AIDS (79%), pre-marital sex not good for own and family's reputation (11%) and the like. Cultural and religious factors were also given as reasons of disapproving the practice of pre-marital sex. Forcing a girl into sex was almost totally disapproved by the adolescents, 98.1% saying it is not acceptable to force a girl into sex and only the perpetrator is responsible for rape (by 81%) (table 10).

Regarding the current condition of rape in the town, 37% of the adolescents said it is decreasing while 34.4% said it is increasing and a further 24% said they have no idea. As to the legal definition of rape in Ethiopia, 62.9 % said they have no idea about. The remaining 29.3% responded that they have some idea about it. To a question asked about "under which condition is it acceptable to force a girl to sexual intercourse?" 61.6% answered if she is a wife, some 9.4% said if she is a girl friend, and 19% of them said under no condition should a man use force.

Table 4.10: Female Adolescents Attitudes and Awareness towards Sexuality And Violence, Jimma 2003(n=588)

Attitudes/Awareness**	Frequency	Percent
Pre-marital sex		
Not acceptable	541	92.0
Acceptable	47	8.0
Forcing a girl to sex		
Not acceptable	577	98.1
Acceptable	11	1.9
Who is responsible for rape		
The Offender	476	81.0
The victim	29	4.9
Both	79	13.4
Under what conditions can a man force a woman in to sex		
If she is a wife	387	65.8
If she is a girl friend	54	9.2
If both are sexually excited	13	2.0
If he spends a lot of money on her	20	3.4
Under no conditions	113	19.0
Condition of rape in Jimma town these days		
Not changing	27	4.58
Increasing	202	34.4
Decreasing	218	37
Have no idea about	141	24.0
Knowledge of legal definition of rape in Ethiopia		
No Idea	370	62.9
Some Idea	172	29.3
Knows	46	7.8

4.5 Factors Contributing to Rape

Researches conducted in different parts of the world have revealed that there are multitudes of factors that promote rape and other forms of sexual violence against women. These studies showed that there are factors which increase women's vulnerability to violence; there are factors which increase men's risk of committing the violence, and societal factors that promote violence (see the literature review in chapter one). Guided by such literatures and based on the data collected from female adolescents, who participated in this study, an attempt was made to identify some of the factors that increase young females vulnerability to rape in Jimma town. But, as reported by rape victims participating in this study; threats of harm, use of physical force (beating) by the rapist and use of substances like alcohol are the predominant contributing factors of rape.

The associations of some socio-demographic and behavioral factors, with the dependant variable, rape in adolescent's lifetime, have also been tested using some bi-variate and multivariate statistical models. At the bi-variate level, the chi-square is used to examine the relationship between lifetime rape and selected independent variables separately. The results of the bi-variate analysis are shown in table 11. Accordingly, on the bi-variate chi-square test, lifetime rape was associated with number of sexual partners the adolescent ever had, use of alcohol and chat, age, marital status, parental condition, family income, Education, age at first sexual debut and living arrangements of the adolescents (at $P<0.05$). However, no significant association was observed between the religion, ethnicity or place of birth of the adolescents and lifetime rape (at $P<0.05$).

It is observed that the proportion of adolescents who were victims of lifetime rape increased from 11.8% in age group 15-19 to 23.3% among adolescents in age group 20-24. The proportion of raped adolescents varies from 26.5% among adolescents with no formal education, to 13.8% among those at primary level and to 14.6% among adolescents with secondary and above education. Considering marital status, the proportion changes from 14.9% among the never married to 9.5% among married ones, but rose to 32.4% among the others category (including divorced, widowed and cohabiting ones). Regarding the living arrangements of the adolescents, relatively a higher proportion of adolescents living with relatives (20.2%) and living alone (17.9%) were raped as compared to those living with both parents (15.9%) or with a father or mother only (11.3%). Regarding the living condition of the parents, the proportion of raped adolescents increased from 12.2% among those with both parents alive to 28.1% for those without living parents. In the case of religion, the proportion declined from 15% among followers of Orthodox religion to 12.7%among Muslims, but rose to 23.1% for others (like Protestants, Catholic and those with no religion).

Lifetime rape is more significantly associated with behavioral factors like use of alcohol and chat ($P< 0.01$) and the number of sexual partners the adolescent ever had ($P< 0.01$). In the case of alcohol, the proportion of raped adolescents varied from 9.4% among those who do not drink to 49.4% among those drinking alcohol. Similarly, in the case of chat, the proportion increased from 11.4% among those who never chew to 43.7% among those who chew chat. This finding of the higher proportion of rape among adolescents who drink alcohol or chew chat indicates that the use of these substances increases the risk of being raped.

Comparison of the number of sexual partners the adolescents ever had shows that lifetime rape increased from 7.4% among those with no partners to 16.9% among those with a single partner to a further 70% for those who ever had two or more partners. This indicates that the number of partners they have, the more likely that they will be raped (may be by ex-partners). Finally, it is observed in this study that age at first sex is negatively related to the occurrence of lifetime rape: the proportion declining from 69% among those who started sex between ages 10 to 14 to 38.4% among those who started sex between ages 15-19 to a further 11% for those initiating sex in ages 20-24.

Table 4.11: Chi-square Results of Raped and not Raped Adolescents by Socio-Demographic and Behavioral Factors, Jimma town, 2003

Factors	Raped		Not Raped		X^2	P-value
	Count	%	Count	%		
Age						
15-19	48(62.4)	11.8	360(345.6)	88.2	12.89	0.000***
20-24	42(27.6)	23.3	138(152.4)	76.7		
Education						
No education	13(7.5)	26.5	36(41.5)	73.5	5.257	0.036
Primary (1-8)	27(30)	13.8	169(166)	86.2		
Secondary and above	50(52.5)	14.6	293(290.5)	85.4		
Marital status						
Never married	71(73)	14.9	406(404)	85.1	10.388	0.003**
Married	7(11.3)	9.5	67 (62.7)	90.5		
Others	12(5.7)	32.4	25(31.3)	67.6		
Living arrangements						
With both parents	41(39.5)	15.9	217 (218.5)	84.1	4.2428	0.0220**
With father/mother only	13(17.6)	11.3	102(97.4)	88.7		
With relatives	18(13.6)	20.2	71(75.4)	79.8		
Alone	10(8.6)	17.9	46(47.4)	82.1		
In marriage	8(10.7)	11.4	62(59.3)	88.6		
Parental condition						
Both alive	47(58.2)	12.2	337 (325.8)	87.7	10.728	0.0025**
Father/mother only	26(22.1)	17.8	120(123.9)	82.2		
Both not alive	16(8.6)	28.1	41(48.4)	71.9		
Family(own)Income						
No Income	10(5.1)	30.3	23(27.9)	69.7	6.695	0.0176**
Below 600	63(69.6)	13.8	392(385.4)	86.2		
Above 600	17(15.3)	17	83(84.7)	83.0		

Factor	Raped		Not Raped		X^2	P-value
	Count	%	Count	%		
Religion						
Orthodox	47(47.9)	15.0	266(265)	85.0	4.693	0.048**
Muslims	25 (30.2)	12.7	172(166.8)	87.3		
Others	18(11.9)	23.1	60(66.1)	76.9		
Place of birth						
Jimma	54(60.8)	13.6	343(336.2)	86.4	2.7379	0.09800
Non-Jimma	36(29.2)	18.8	155(161.8)	81.2		
Alcohol drinking						
No	47(76.7)	9.4	454(424.3)	90.6	91.693	0.000***
Yes	43(13.3)	49.4	44(73.7)	50.6		
Chat Chewing						
No	59(79.1)	11.4	458(438)	88.6	50.086	0.000***
Yes	31(10.9)	43.7	40(60.1)	56.3		
No. of sexual partners						
None	28(57.9)	7.4	350(320)	92.6	133.87	0.000***
One	27(24)	16.9	133(135.5)	83.4		
Two and above	35(7.7)	70	15 (42)	30.0		
Age at first sex (n=224)						
10-14	20(11.7)	69.0	9(17.3)	31.0	16.554	0.000***
15-19	68(7.1)	38.4	109(106)	61.6		
20-24	2(7.2)	11.1	16(10.8)	88.9		
Currently attending school						
No	41(30.3)	20.7	157(1677)	79.3	6.717	0.000***
Yes	49(59.7)	12.6	341(330.3)	87.4		

** significant at P< 0.05

*** significant at P<0.01

4.5.1 Results of the Multivariate Analysis

The Multivariate statistical technique was employed to determine the relative importance of the background variables on the risk of being raped. Based on the results of the bi-variate analysis, variables that showed significant difference between those raped and not raped were selected for the multivariate analysis. The dichotomous logistic regression model was found to be the most appropriate in this regard because the dependant variable involves two distinct choices; raped or not raped.

Among the socio demographic and behavioral factors considered in this study; age, marital status, income, living arrangements, number of sexual partners the adolescent ever had, alcohol use and age at first sex were the ones that emerged from the regression analysis as significant factors affecting lifetime rape. However, no statistically significant relationship was observed between education of the adolescent, religion and the use of chat. Table 12 shows the results of logistic regression of raped and non-raped adolescents as a dichotomous variable on a set of background variables.

Considering the adolescent's age, lifetime rape was found to be different between the younger and later ages of the adolescents ($P < 0.01$). The multiplicative estimate indicates that adolescents in the age group 20-24 have the odds of being raped 1.667 times higher. This indicates that as age increased the likelihood of being raped increased, may be for the cumulative effect of age.

With regards to marital status and considering married adolescents as a reference group, the chance of being raped is higher for the never married group, the Odds being 1.8272 times higher than married adolescents. It is statistically significant at $P < 0.05$. The regression result also shows the chance of being raped is higher among the others category (including divorced, widowed or co-habiting adolescents) as compared to the married ones. Lifetime rape is negatively related to income on the regression analysis. Adolescents from no income family or from low-income family are found to be more at risk than those who are from better off families.

The living arrangement of the adolescents (with whom she is living) did not show strong association with rape in this study. Considering living with both parents as a reference category, there is higher chance of being raped for those living with relatives and those living alone. The odd of being raped is 1.4 times higher for those living with relatives and 1.7 times higher for those living alone as compared to those living with both natural parents. It shows that adolescents living not with their parents are at increased risk of being sexually assaulted. The absence of parents, by death or separation and the social fragmentation of the adolescents with her family decrease the supervision and monitoring for the adolescent. This increases the likelihood of the adolescent for being raped.

Another significant factor that emerged from the regression analysis as affecting the occurrence of rape is the number of sexual partner the adolescent ever had. Considering those who had no partners as a reference category, the chances of being raped decreased for those who have had only one partner but increased dramatically thereafter (table12). The odd of being raped was found to be 5.2 times higher for those who have had two or

more partners as compared to those who had none. The relationship was highly significant at $P<0.01$. This supports the belief that young women who have many sexual partners are at increased risk of sexual assault. But the reverse can also hold true. Even though it was not possible to identify through this study, having more partners may be the outcome of early sexual abuse. Women who are raped during childhood or early adolescence were found in some studies to have more number of partners in their later life.

Ever use of alcohol by the adolescents is also significantly related to the occurrence of rape ($P < 0.01$). The odd of being raped is 2.23 times higher for those who practice alcohol as compared to those who do not practice it. This goes in line with the idea that alcohol use is involved in up to 75% of acquaintance rapes. Consuming alcohol makes it more difficult for women to protect themselves by interpreting and effectively acting on warning signs.

The other factor to have been significantly related to the occurrence of rape is adolescent's age at first sex ($P <0.01$). It is observed that age at first sex is inversely related to the risk of being raped. Those who had initiated sex early, between ages 10 and 14 are found to be more at risk, the odds being 3.98 times higher as compared to those who stated sex in ages 20-24. With increase in age at first sex, the relationship goes declining. Early age at first sexual activity (forced and /or voluntary) is observed to increase vulnerability to sexual assault in adolescents and young women. This may be because those who start sex early will come into contact with a higher number of potential perpetrators. Particularly, if the girl's first lesson of sexuality is taught through force, violence or trickery, her capacity for self-efficacy is affected. They develop a low-self esteem of themselves and become less

skillful at protecting them selves from further assault. They may also accept their victimization as part of being female.

Table4.12: Logistic Repression Results of the Effects of Adolescents Background Variables on the Risk of being Raped, Jimma, 2003

Variable	Regr. Coeff(B)	S.E	Sig.	Exp (B)
Age				
15-19	RC			
20-24	.5170	.1282	.0001	1.667***
Education				
No education	RC			
Primary	-1469	.1896	.4389	.8634
Secondary &above	-.1759	.1769	.3195	.8387
Income				
No income	RC			
Below 600	-.4274	.1843	.0204	.6522**
Above 600	-.0217	.2400	.9291	.9789
Marital status				
Married	RC			
Never Married	.6028	.2683	.0247	1.8272**
Others	.0666	.3662	.8556	1.0689
Religion				
Orthodox	RC			
Muslims	-.2918	.1782	.1016	.7469
Others	.3931	.2029	.0527	1.4816

Currently living with				
Both parents	RC			
Father/mother only	.1994	.2761	.4701	.8192
With relatives	.3387	.2033	. 0957	1.4032**
Alone	.5335	.2562	. 0381	1.7049**
In marital union	-.6097	.4242	.1506	.5435
No of sexual partners				
None	RC			
One	-0.5371	.1987	0.0069	0.5844**
Two & above	1.6496	0.2465	0.0000	5.2048***
Alcohol drinking				
No	Rc			
yes	.8002	.1829	.0000	2.2259***
Chat use				
No	RC			
Yes	.2090	.2117	.3234	1.2325
Age at first sex (n=224)				
10-14	1.3819	.3696	0.0002	3.9823***
15-19	0.1115	0.3015	0.7114	1.1186
20-24	RC			

** = Significant at P<0.05

*** = Significant at P< 0.01

4.6 Knowledge of HIV/AIDS and Contraceptive Use

4.6.1 Knowledge of Contraception

Information related to Knowledge of Contraception was collected during the survey by posing a question "do you know how you can protect your self from pregnancy?" This is believed to assess knowledge of contraceptive use than questions that ask whether the respondent has heard of methods of contraception. Among the study subjects, 433 (73.6%) reported that they know how to protect themselves from pregnancy. 394 (91%) of them know modern contraceptives and 78 (18%) know some traditional methods of protecting themselves from pregnancy.

Condom was the most popular contraceptive method reported by 88.5% of the adolescents followed by the oral contraceptive pill, 86.4 %. Injectables, safe periods and implants were known to 69.3%, 58.4% and 27.7% respectively (table 13). Respondents who reported that they know how to protect themselves from unwanted pregnancy were asked whether they have used a method during their recent sexual intercourse. Of those who are sexually active and reported to know about contraceptives (n=189), 108 (57%) have used one method of contraceptives during their recent intercourse. Condom was the most popularly used method by 40(37%) of them followed by pills, 30(27.8%), calendar method by 23(21%) and Injectables by 9(8%) respectively.

On the bi-variate chi-square test, knowledge of contraception has a significant association with age, educational attainment, marital status and sexual experience of the adolescents.

As shown in table 11, knowledge of contraceptives is higher among adolescents in ages 20-24(83.9%) as compared to those in ages 15-19(69.1%). Knowledge of contraception is observed to have increased with increases in the level of education of the adolescents. Moreover, knowledge of contraceptive use is higher among the married(86.5%),than never married(70.9%) and among sexually active adolescents(84.8%) than inactive ones(66.9).

Table4.13: Knowledge of Contraceptive Methods by Female Adolescents in Jimma, 2003

Method**	Frequency	Percent
Any method	433	73.6
Any Modern method	394	91.00
Condom	382	88.4
Oral Pills	374	86.4
Injectables	300	69.3
Calendar Period	253	58.4
Implants	120	27.7
LUD/Loop	106	24.6

** multiple responses are possible

Table 4.14:Chi-square Results of Knowledge of Adolescents to Protecting Themselves From Pregnancy by Socio-demographic Factors, Jimma 2003

	Knows methods of protection					
Variable	Yes		No		X^2	P-Value
	Count	%	Count	%		
Age						
15-19	282	69.1	126	30.9	14.039	0.0009**
20-24	151	83.9	29	16.1		
Education						
No education	28	57.1	21	42.9	22.83	0.0001***
Primary (1-8)	128	65.3	68	34.7		
Secondary and above	277	80.8	66	19.2		
Ever had sex						
No	243	66.9	121	33.1	21.86	0.0000***
Yes	189	84.8	34	15.2		
Marital status						
Never married	338	70.9	139	29.1	10.15	0.0032**
Married	64	86.5	14	13.5		
Others	31	83.8	6	16.2		

** = Significant at P<0.05

***= Significant at P<0.01

4.6.2 Knowledge of HIV/AIDS

The survey has also included questions on HIV/AIDS to assess the awareness of the adolescents about the disease. Respondents were first asked whether they heard of AIDS and further questions on the modes of transmission and modes of prevention were asked to

ascertain their depth of knowledge. Knowledge of HIV/AIDS is significantly high among the adolescents as seen in table 12. Among the study population 562 (95.6%) reported that they have heard about HIV/AIDS. Similarly respondents Knowledge of the modes of transmission and of prevention is also significantly high, as shown in table 15.

Table 4.15: Knowledge of Modes of Transmission and Prevention of HIV/AIDS among Female Adolescents in Jimma town, 2003(n=562)

Modes of transmission**	Frequency	Percent
Promiscuity	447	79.5
Blood transfusion	513	91.3
Sharing contaminated Needles	484	86.1
Having sex with infected person	466	82.9
Mother to child	298	53
Sharing toilets	13	2.3
Mosquito bites	5	0.9
Social Kissing	9	1.6
Modes of Prevention**		
Abstinence	491	87.2
Having one faithful partner	444	78.9
Use of condom	353	62.7
Avoid using unsterile needles	426	75.8
Using screened blood	361	64.1
Having sex with in marriage Only	367	65.2
Avoid mosquito bites	21	3.7
Avoid sharing toilets	7	1.2
Avoid kissing	37	6.6

** multiple responses are possible

It is evident from the table that a considerably high proportion of the adolescents report having knowledge about the modes of transmission and prevention of HIV/AIDS. Promiscuity, blood transfusion, sharing contaminated Needles, and having sex with infected person were the important modes of transmission of HIV/AIDS reported by 79.5%, 91.3%, 86.1% & 82.9% of the respondents. With regards to the modes of prevention; abstinence, (87.2%) having one faithful partner (78.9%), avoiding the use of unsterilized needles (75.8%), using screened blood (64.1%), having sex with in marriage only (65.2%) and use of condom (62.7) were identified as important ways to avoid the spread of HIV/AIDS by the study population.

When we compare knowledge of HIV/AIDS among age and education categories, increase in age did not bring about increase in knowledge about HIV/AIDS in this survey. The younger age group (15-19) reported a higher knowledge (96.3%) as compared to the older age groups (93.9% by those in ages 20-24). But knowledge of HIV/AIDS increased with an increase in the level of education of adolescents as indicated in table 16.

Table 4.16: Knowledge of HIV/AIDS among Female Adolescents in Jimma town by Level of education and Age, Jimma 2003.

Variable	heard about HIV/AIDS					
	Yes		No		Total	%
	No.	%	No.	%		
Age						
15-19	393	96.3	15	3.7	408	100
20-24	169	93.9	11	6.1	180	100
Education						
No education	36	73.5	13	26.5	49	100
Primary (1-8)	186	94.9	10	5.1	196	100
Secondary & above	340	99.1	3	0.9	343	100
Total	562	95.6	26	4.4	588	100

Finally, a question was asked on the perceived threats of acquiring HIV/AIDS to examine whether there can be a relationship between rape and perception of acquiring the disease, "do you think that you can get HIV/AIDS?" The majority, 402 (68.4%) answered "no" while the remaining 186 (31.6%) answered yes (table17). The perceived risk of acquiring the disease is higher among sexually active adolescents (45.3%) as compared to those who have not started sexual activity (23.3%) and among adolescents who have been sexually assaulted (56.7%) as compared to those not assaulted (27.1%). Moreover, the perceived threat is higher among adolescents who have had two or more partners (54%) as compared to those who have had one(40.6%) or none(24.9%

Table4.17: Chi-square Results of Adolescents with a Perceived Risk of Acquiring HIV/AIDS by selected Socio-demographic and Behavioral Factors, Jimma 2003

Factors	Risk of Acquiring Count	%	No risk of Acquiring Count	%	X2	P-value
Ever had sex						
No	280(249.5)	76.7	85(115.5)	23.3	30.9907	0.0000***
Yes	122(152.5)	54.7	101(70.5)	45.3		
No. of sexual partners						
None	94(119.6)	24.9	284(258.4)	75.1	25.548	0.000***
One	65(50.6)	40.6	95(109.4)	59.4		
Two and above	27(15.8)	54	23(34.2)	46		
Experience of rape						
Raped	51(28.5)	56.7	39(61.5)	43.3	30.794	0.000***
Not raped	135(157.5)	27.1	363(340.5)	72.9		
Marital status						
Never married	137(150.9)	28.7	340(326.1)	71.3	23.984	0.000***
Married	24(23.4)	32.4	50(50.6)	67.6		
Others	25(11.7)	67.6	12(25.3)	32.4		
Alcohol use						
No	144(158.5)	28.7	357(342.5)	71.3	13.0781	0.000***
Yes	42(27.5)	48.3	45(59.5)	51.7		
Total	186	31.6	402	68.4		

*** Significant at P<0.01

Those with a perception of acquiring the disease mention such reasons as; being sexually active, the existence of non-sexual modes of transmission, having multiple partners, lack of trust in their sexual partner, being a victim of rape and inconsistent use of condoms with a partner. The majority of the participants, however, had reported no threat of acquiring the disease. They have given various reasons for this. Some said they have not initiated sexual intercourse; some have trust in their partners, being married, consistent use of condoms and abstaining from sex.

On the logistic regression analysis too, the perceived threat of acquiring the disease was significantly associated with age, marital status, rape, being sexually active and the number of sexual partners the adolescent had (table 18). Those in ages 20-24 were more likely to report their perceived threat, the odds being 1.1 times higher as compared to those in ages 15-19.With regards to marital status, the perceived threat increased for the never married and those categorized as others, including the widowed, divorced and co-habiting) as compared to the married ones. This may be for the reason that those unmarried divorced or widowed ones lack trust in their sexual partners or they may have multiple partners. The threat of acquiring the disease is also high among raped adolescents as compared to those not raped, the odds being 1.7 times higher. This indicates that rape increases the perceived risk of acquiring HIV/HIDS for the potential transmission of the HIV/AIDS during forced sexual intercourse. Further, the regression result shows that the threat is high among sexually active as well as those adolescents who have had more than one sexual partners.

Table 4.18: Logistic Regression Results of the Perceived Risk of Acquiring HIV/AIDS by Selected Background Variables

Variable	Beta(B)	S.E	Sig	Exp(B)
Age				
15-19	RC			
20-24	.1106	.0949	.2439	1.1170**
Marital Status				
Married	RC			
Never Married	.5628	.1857	.0024	1.5696**
Others	.9975	.2695	.0002	2.7115***
Experience of rape				
Not raped	RC			
Raped	.5501	.1398	.0001	1.7334***
Ever had sex				
No	RC			
Yes	.5016	.0914	.0005	1.6514***
No. of Sexual partners				
None	RC			
One	.0326	.2479	.8954	.3963
Two and above	.3346	.1698	.0488	1.3973**

** Significant at P<0.05

*** Significant at P<0.01

CHAPTER FIVE: RESULTS OF THE FOCUS GROUP DISCUSSION

The focus group discussion was conducted as a supplement to the quantitative study. One female and one male FGD's were conducted. The major theme of the discussion was their awareness of the magnitude of sexual violence, adolescent's attitudes towards pre-marital sexual practice and sexual violence as well as the factors contributing to sexual violence. The aim of the FGD was thus to assess the attitudes and knowledge's of the female adolescents and young men on rape and pre-marital sexual practice. But,analysis of the FGD results has been taken care of in the next chapter on the discussion of findings.

5.1 Male Focus Group

The quantitative study could not capture the male populations who are the perpetrators or potential perpetrators of rape. As to the theory, they are those factors that increase men's risk of committing the rape that can better predict the occurrence of rape. This qualitative study, thus, attempts to examine the attitudes of male young adults towards rape and its causes. The male focus group consisted of 6 young males between ages 18 to 30.Selection of this age group is based on the response of the rape victims in which about 86.2% responded that assailants are older than them.

The initial question posed to this group is related to pre-marital sexual practice, whether they approve it and or practice it. They all frankly responded that they approve sex before marriage and practice it for enjoyment, to be experienced and for love at least with their girl friends. Two have girl friends while others have casual partners. They commented that

after age 18,boys should have a sexual partner since it is not easy to marry and live in Wedlock. Some of them said, it is also worrying for a boy to not have a girl friend when his peers have girl friends. However, they mentioned that many boys find problems with the girls up on forming relationships; the girls will not frankly accept requests made by boys. They prefer to say no, even though they want him. Sometimes, they want to be persuaded more and thus will not give a clear "yes" or "no" response to a boy's request. Others form friendship with boys, accept being a girl friend, but do not like to start sex. This time, they said, the boys use different tactics or behaviors to make the girls involve in sex. Among the behaviors they mentioned are persuasion, deception through promises, verbal insistence and threats and finally use force. For a girl, to begin sex is the most difficult thing as the boys said and once she starts, she will go to like it.

Following such warm up questions, we went on to discuss their awareness of and attitudes towards rape. Majority of them did not consider rape as a problem because they said it happens to few girls who walk alone at night or who will be available at wrong places at the wrong time. When asked about the issue of rape by boy friends or acquaintances as a problem for the girls, the boys argued that it is one way of getting a girl friend for a boy whom girls say no many times. And it is used because in most cases girls are not supposed to admit to wanting sex.

However, many of the boys did not explain their own experiences of raping a girl. They discussed largely what they observed and knew in their society than their own experiences. Some mentioned the experiences of their friends. One of the participants however, mentioned his experience with his girl friend (which he still did not consider it as a rape).

He says;

> " I loved a girl at my neighbor while she was a high school student. When I tell her that I fell in love with her, she was very reluctant to tell me okay or not. After months of holdup, she accepted my request and started our friendship, but refused any kind of sex before she completes her high school education. I thought I could not wait for one and half years. I tried to persuade her but could not. One day, I invited her to our home arranging at a time when other household members are not at home to force her, but felt frightened. Then, I convinced my self, thinking that if maximum I will lose her as a girl friend, locked the door and did every thing. Lastly, after few months of contempt, we became good friends".

Another tells how boys go to use force in sexual relationships with their girl friends.

> " Some girls (girl friends) will be willing to go or have fun with you, drink with you until you are lead to sex, but when you actually want to have sex, she will say no. This time we try to make them drunk, and even if she doesn't want to have sex, she does not feel that much if you force her".

Some of the boys also mentioned conditions in which girls become very ambitious to having a richer, famous or employed man, undermining her earlier partner, "she wants to be popular among her friends by doing so" as the boys suggested. This time boys will go for revenge, penalize her using their peer groups. One said, "it is really a gratification to rape or beat badly such girls who undermine you for your lack".

They also explained conditions in which gang rape may occur. In some parts of the town, there are organized gangs who are threats not only to the girls but also to the population. Especially for girls, it is difficult to be available there after evening. Girls following night school are especially vulnerable to them. They also target girls from rich families for financial matters. Some times the gangs quarrel with each other in groups for girls. But, no body reports to the police, for fear of threats of harm.

Another explained what he observed in his neighborhood;

> "Four boys (peers) rented a room in my neighborhood, to come and chew chat any time they wanted. These boys usually come with girls, who are made to participate in the ceremony by preparing coffee or tea. At the end, the girls are made to have sex with any of the groups. For their deeds, my parents always insult my sister fearing that she may be such a girl"

They were also asked whether they assume that victims of rape are innocent for their victimization or not. It is seen that the boys blame the girls equally for the occurrence of forced sex. They suggested that most rape occurs to girls who say no when asked friendly, who are seductive and dress provocatively up on date, and who stay drinking the night with boys.

5.2 Female Focus Group

The female focus group was made up of eight female adolescents (between ages 15 to 24), five of them currently enrolled in education and three not. Like the male FGD the discussion started by probing into their attitudes towards pre-marital sexual practice. It is seen that, all the adolescents had a negative attitude towards pre-marital sex. They all disapproved sex before marriage saying that it is culturally, and religion wise unacceptable, but more importantly for its negative consequences on the girl. They said that sex before marriage for girls is not much of sexual desire, since it is attached to fear of pregnancy, abortion, HIV/AIDS, stigma and bad reputations. The stigma and blame after experiencing unwanted pregnancy would only be convicted on to the girls.

Further, they suggested that the boys with whom girls form their relationship would not be committed to have sustained romantic relationships. They explain that many girls go

into pre-marital sexual experience without their interest and before they plan or want to do it. Some begin by false promises, some by peer influence, some to be in love and form good relationships with their partners, some for expectations of material and financial assistance from the partner and others are forced to start sex at early ages. Once they start sex and participating in unwanted sexual activity, the girls group cite such reasons as pressure from a boy friend and the desire to please or keep a sustained relationship with a boy friend.

They were further asked whether rape is a problem to girls in the town or not. They believed that rape is a problem that many girls experience and is worrying to their health these days for the potential transmission of HIV/AIDS. On the issue of rape, the girls participating in the discussion however, described more of what they heard and observed in the town than their own experiences. Only one disclosed that she experienced an attempted rape two years ago while she was coming back home from a night school.

Regarding who and how girls are raped, the participants admit in saying that most perpetrators of rape they know are not strangers to the victims. Boy friends or neighbors are the main ones to have been heard regarding rape. They pointed out that rape by boy friends happen to a girl who denied accepting a boy's request for sexual relationships. The boy in collaboration with his peers will intimidate her on her ways to school, in school or somewhere else. Verbal abuse and beating are common behavior they use initially, until they find a condition to rape her. One of the girls in the focus group described her own experiences of withdrawing from school for fear of humiliation and threat by a boy with his peer group, whom she said no to his request for relationships. She said;

"Every day when I walk to school, I had to look for ways where he will not see me fearing his verbal assault and threat, but finally I couldn't continue and withdrew from school. Later I changed to another high school in the town". It seems to me that a girl can not say no to a request from a boy, what evidences can we give other than lack of interest in it?''

Another suggested how girl's usual relationship with boys changes to sexual coercion. "Some boys become friendly to invite you to Cinema's, movies and drinks, then ask you to have sex with, if she says no they will beat her up". The girls further suggested that boys do not like to approve a girl's intention to choose a boy friend she preferred for her self. Their own friends or peers also influence to put a girl into intimidation in this regard. They bring letters or gifts from a boy, but do not know that it will be followed by requests for sexual relationships, which if she does not accept turns to violence and intimidation. They also go onto disseminate bad rumors on the girls.

One of the participants mentioned a case of her own classmate raped by a boy living in her neighbor. She said;

" The girl failed twice in her grade nine education and asked for assistance from a boy as she thought that he would be better, (the boy was following his diploma courses in the evening program). He took advantages of this opportunity and persuaded her to have sex with. Many times she expressed her reluctance. But, one day at the moment she went to study with him in his room, he raped her. She thought to scream for help, but she was in his room to be easily blamed by the people who hear the incident".

Another mentioned a case where a girl was raped by her stepfather (in the absence of her mother) and was later forced to leave home before becoming pregnant.

The girls mentioned men's lack of enough knowledge related to reproductive health problems as a factor contributing for rape. That is the reason the girls give for absence of

attitudinal change among the boys towards early sexual practice or sex outside of wedlock. When asked why they did not bring attitudinal change the girls suggested;

> " this may be because various NGOs like the FGAE and governmental organizations working on reproductive health have focused more on girls than boys. But, in our culture, females can not decide on having or not having sex even though they know the problems"

They have also mentioned some conditions in which the poor become more victimized. They mentioned cases in which housemaids are raped by their employers. One of the participants also mentioned the case of a girl from a poor family who was raped while she was collecting fuel wood in the forest near to the town.

More of what the girls mentioned is related to rape that occurs by acquaintances like boy friends. When asked whether they know how stranger rape occurs, one of the cases they raised was that of gang rape committed to girls following night school. Another one, however, mentioned a case in her kebele where there is a military camp. She said that some members of the military put off their uniforms at night and move into the villages. Incase they find a girl or women alone, they will rape even in-groups. But, no body identifies them.

The girls were also asked whether they assume that victims of rape are innocent for their victimization or share some of the responsibility for the attack. The girls group do not accept any kinds of blame related to their share of being guilty for a girl's sexual attack. They disapproved the myth by citing cases in which children of 6 or 8 years have been raped, who have not dressed provocatively. One of the girls also mentioned a case of

attempted rape that happened to a 55-year-old woman at night while coming home from her neighbor.

The girls rather mention other causes for rape. Men's sexual urge, their attitudes for dominance, attempts for revenge, lack of knowledge of reproductive health problems, unemployment, drunkenness, peer pressure, lack of strict law enforcement related to sexual violence and poverty of women are the major ones they perceived as causes for rape.

CHAPTER SIX: DISCUSSIONS

Knowledge of the magnitude and characteristics of sexual violence against women is very limited in Ethiopia because of the absence of population-based researches in the area. Hence, this study was made with the major objective of exploring the magnitude of sexual violence, factors associated with it and its outcomes on health using a sample of adolescents from Jimma town of the Regional state of Oromia. The study utilized a cross-sectional survey among female adolescents and a focus group discussion comprising of girls and boys groups each separately.

The quantitative study has helped us to estimate the magnitude of different forms of sexual violence, some characteristics of the perpetrators, out comes of rape and the awareness of adolescents on Contraceptive use and HIV/AIDS. The qualitative study was made to strengthen the results of the quantitative study on matters such as adolescent's attitudes towards sexual violence, factors related to it and the awareness of the problem. In this chapter, we will review the main findings of the study, compare the findings of this study with the findings of other (similar) studies conducted in Ethiopia or elsewhere and give some explanations of the findings.

The study utilized a total sample of 588 adolescents and found that 38.1% of the adolescents participating in the study were sexually active. Of these sexually active adolescents, 25.8% started sexual activity as a result of rape. This prevalence rate (of rape as a cause of first sexual experience) lies with in prevalence rates found in different studies, ranging from 7-62% (Heise etal, 1994). It is lower than the prevalence rate estimated by a study made on the Bameda town of Cameroon, in which 37.3% of the

sampled adolescents between ages 12 and 25 reported forced sexual initiation (Rwenge, 2000). Ours is nearly similar to the results of a South African study of the city of Transkei (1994/1995) in which 28.4% of adolescents aged 15-18 reported forced sexual initiation and a Tanzanian study of 1996 in which 29.1% of adolescents aged 12-19 reported forced sexual initiation (Matasha et al,1998,Cited in WHO,2002). However, the prevalence rate observed in this study is still lower than the rate observed in a study of female street Adolescents in Addis Ababa, in which 43% of the participants reported forced sexual initiation(Mitike,2000). The high rate reported here may be attributed to the nature of the study population, streets being more at risk of rape. However, a caution should be made in such comparisons because differences in age and sample size bring about different prevalence rates. A further 16.4% and 3.1% of the sexually active adolescents had begun sexual activity because of false promises and for exchange of gifts or money respectively. Thus, it is observed that for a considerable proportion of the adolescents, sexual initiation is a traumatic occurrence done by force, coercion or deceit.

The age range of sexual initiation reported was 10-22 years, the median being 16 years. It is seen that of those who initiated sex early or before age 14, 65.5% of them started by rape. Further, about 90% of those who initiated sex by rape were victimized before age 18. This is of statutory type (since it has occurred to adolescents under the legal age of consent in the country, 18 years) and can be considered as child abuse according to the convention of the rights of the child. If we include those who started sex by false promises, the proportion rises to 82.5%. Thus, our first hypothesis saying the younger the girl is at the time of the first sexual debut, the more likely that it will be forced or coerced proves acceptable.

The fact that most of the rape is statutory may have undesirable social consequences on the girls. In societies such as that of Ethiopia, where virginity is considered as an essential element in marriage, statutory rape is associated with the defloration of the girl and is taken very seriously because it is a dishonor to the family and it may also spoil the future possibilities of the girl's marriage (Andargatchew, 1996).

The prevalence of lifetime rape against the adolescents was found to be 15.3% or 40.2% of the sexually active adolescents. This also lies in the range of prevalence of life time rape obtained in different studies, where 5-29% of women are observed to have experienced rape in their lifetime (Heise, 1994). It is also similar to the finding of studies conducted in Switzerland and Australia which indicated that between 20-30% of young girls and adolescents experienced sexual assault (Russel, 1986, Bouvier etal, 1999). But, it is lower compared to the prevalence of rape obtained by a study made among female street Adolescents in Addis Ababa, where the prevalence of rape in 3 months recall period was observed to be 15.6%(Mitike, 2000). Again the latter is attributed to the nature of the study population, streets being more at risk of rape.

Perpetrators are known to the victims in 69% of cases in this study; 32% of rapes committed by a boy friend or former lover, 19% by neighbors and relatives, 12% by employers and bosses and 6% by family's friend. This is again similar to the findings of studies made in Lima (Peru), Mexico City, Guatemala City and the USA in which attackers were known to the victims in 60% to 80% of the cases (Heise, 1993, see Literature review in this study). It is contrary to most popular beliefs that rape takes place

between strangers. Further, the perpetrators are older than the victims in 86.2% of the cases. This issue of age difference between victims and perpetrators has been supported by the findings of various studies.

In this study, it was found that 76.7% of the rape victims have not reported to any legal body. Major reasons given for not reporting were; being afraid of humiliation, fear of parents, being threatened by the rapist and fear of unacceptance by the police. It is also observed in various studies that only a minor proportion of rape victim's report to the police. For instance, in the rape in America survey made in 1992, 86% of rape victims have not reported to the police (Kilpatrick et al, 1992). It is the characteristics of rape, where majorities of assailants are acquaintances. This may indicate that victims do not report the incidence to legal bodies to maintain their privacy.

An attempt to find the number of rapes reported to the town police was not successful because of the absence of compiled statistics (it was difficult to count cases from daily reports). But few cases referred to Wereda courts for which the victim had enough evidences of witnesses or medical proof to sue the rapist were available. Accordingly, there were 12,9,12, and 20 rape cases the police referred to district court in 1998/99,1999/2000,2000/01 and 2001/02 for conviction respectively (Jimma town police report).

The prevalence of attempted rape reported was 17.7% and non-consensual kissing was 19%. In the twelve months before the survey, 2.7% of the adolescents reported having an unwanted (non-consensual) sex. Physical assault (beating) by intimate partners or friends

was reported by 28.4% of the adolescents, abduction by 2.2%, forced marriage by 3.6% and Female Genital Mutilation by 78.7%.

The health outcome of rape as reported by the adolescents is of serious concern. In this study 21% of rape victims became pregnant, and 10% had practiced abortion. It is similar to the prevalence of unwanted pregnancy reported in the study made among female streets in Addis Ababa and high school students in Addis Ababa and Western Shoa, 23% and 16% of rape victims reported unwanted pregnancy respectively (Mitikie, 2000, Ermias et al, 1998). In a study in Bombay, India, 20% of all pregnancies of adolescent's abortion seekers occurred because of forced sex, 10% from rape by male domestic servants, 6% from incest and 4% from other rapes (WHO, 1997). In the USA, the adult pregnancy rate associated with rape is estimated to be 4.7% and of STD's, 40% (Holmes et al, 1996). However, the problem in countries like Ethiopia where abortion is not legalized is that girls who have been raped are forced to bear the child or else will put their lives at risk with unsafe abortions.

42.2% of the rape victims in this study reported trauma (injury) of the genitalia, 16.7% had unusual discharges from the genitalia and 10% had swelling around the genitalia. The fact that some proportion of rape victims report vaginal discharge may imply a possible transmission of STD's as well as the occurrence of gynecological problems. Further 56.7% of the rape victims reported their perceived risk of acquiring HIV/AIDS. Thus such reproductive health out comes as well as the possibility of transmission of HIV/AIDS during rape should be a major cause of concern. The figures further show the role of forced sex on the health hazards of adolescents.

The mental (psychological) outcomes they experienced after rape is also equally important. 68% developed fear and anxiety, 53% blame themselves for their victimization, 41% had a low self-esteem and some 37.8% had lost interest in sexual intercourse.8% had thought of ending their life and 4.4% had withdrawn from school after the incident. In the study made among high school students of Addis Ababa and Western Shoa, 35% blamed themselves for their victimization, 33% faced social isolation, 31% experienced anxiety and a further 19% had fear and phobia (Ermias et al, 1998). These mental outcomes are mostly long lasting and reflect the subsequent trauma victims faced after the assault.

The attitude of adolescents towards pre-marital sexual practice and rape has been examined, both through the survey as well as the FGD conducted. It is observed that boys and girls have different attitudes towards sexual practice and rape as seen in the focus group discussion. For the girls, pre-marital sexual practice is attached more to fear of pregnancy, abortion, HIV/AIDS, stigma and bad reputations for the girl and her family. Thus, 92% of the survey participants disapproved the practice. Moreover, most girls begin sex before they plan or want to do it. But, in the male focus group discussion, it is seen that sex before marriage is welcomed and is practiced for enjoyment, experience or love with their partners. Rape is a problem for the girls, even worrying because of its impact on their health and men are almost always responsible for the occurrence of rape. But, to the boys rape is not a problem because it happens only to bad girls who will be available at the wrong time and place. Some of the boys in the focus group also believed that forcing a girl to begin sex is one of the ways of finding or having a girl friend for boys who find a problem in getting a girl friend.

It should be noted at this juncture, however, that the young girls also consider forced intercourse acceptable under certain conditions and are not immune to conservative attitudes about forced sex; majority saying it is acceptable if she is a wife (66%) and few (9%) if she is a girl friend. Such attitudes show the early establishment of gender stereotypes among the girls and are believed to contribute to the occurrence of violence(Macmahan,1996). But, about two thirds of the girls participating in this study, have no idea about the legal definition of rape in Ethiopia.

The discussion with the boys group showed that the boys blame the girls to be equally responsible for their attack by saying no when asked for a friendship, leading him into sex by being available and drinking with, wearing seductively and communicating provocatively upon dates. In various studies, this kind of thinking has been observed to be rationalizations or myths men use as a cause for rape (Alan, 1992, Koss et al, 1995). It tries to shift the blame from the attackers to the victim, faulting her for her behavior, dress or acts. In actual sense however, it is seen that the boys tend to subscribe to a belief in their dominance over girls, gender stereotypes and a tendency to perceive girls as sexual objects. This can be observed from the boy's discussion that they punish (revenge) girls who say no to a boy's request by rape, or by beating up. Girls who want to choose another boy friend they preferred are also victimized, some of the boys said "it is a gratification to rape or beat badly such girls who undermine you for your lack". For a girl not accepting a boy's request for relationships, rape is seen as a means of relief from his feelings of anger or of inadequacy to control and dominate the girls.

Making the girls drunk up on date is also another mechanism they described to coerce into sex a girl who says no to having sex, the boys arguing as "even if she does not want to have sex, she does not feel that much if you force her to have sex after having alcohol". Moreover, the influence of peer groups in an attempt to intimidate girls at school or on streets, the occurrence of gang rapes in some situations have been mentioned as factors related to rape in Jimma town. It is observed in this study that the major mechanisms used by the boys to rape a girl are threats of harm, physical assault (beating) and making the victim drunk.

The girl's focus groups also mention men's use of physical force, intimidation and threat to coerce girls into sex. A girl saying no to a boy's request will be victimized for revenge. From their discussion, it seems that they attribute their vulnerability to their lack of sexual rights, such as the right not to have intercourse if they do not want it, the right to choose any partner they liked and so on. This reveals the boy's dominance and controlling behavior upon the girls. Further, the girls mention how the girls dependence contributes for sexual victimization. Asking for assistance on education, being a housemaid at somebody's house, going out of the town to collect fuel wood were examples of girl's dependence and poverty they described as conditions contributing to sexual assault.

The major perceived causes of rape as suggested by the girls include men's attitudes for dominance, their attempts for revenge, lack of enough reproductive health information, peer pressure, drunkenness, lack of strict law enforcement related to such crimes as rape and dependence of women. The girls groups do not accept any kinds of blame related to their share of being guilty for a girl's sexual attack.

On the logistic regression analysis, lifetime rape was significantly associated with age, marital status, family income, living arrangements, number of sexual partners, use of alcohol and age at first sex. The association between age and rape showed that the likelihood of being raped increased as age increased. This association was also observed in the study made among high school students of Addis Ababa and Western Shoa and many other studies (Meursing et al, 1995,Ermias etal, 1998). As to marital Status, the unmarried, and those categorized as others (including divorced, widowed and co-habiting) tended to be more victimized than the married ones. The relation with income showed that those adolescents from the lowest family income or no income category experienced higher rate of rape. Education of the adolescents did not relate significantly to the risk of rape. However, the relationship has turned to be negative. The risk of rape declined as education increased. This finding contrasts with a South African study in which women with no education were found to be less likely to experience sexual violence than those with a higher level of education (Jewkes and Abraham, 2002, cited in WHO, 2002).

Considering the living arrangements of the adolescents, the likelihood of being raped is higher among those living alone ($p<0.05$) and those living with relatives as compared to those living with both of their natural parents. This relationship between lifetime rape and living alone and living with relatives has also been observed in the study made among high school students in Addis Ababa and Western Shoa (Ermias etal, 1998) and in a study conducted among street adolescents in Addis Ababa (Mitikie, 2000). It shows that adolescents living not with their parents are at increased risk of being sexually assaulted. The absence of parents, by death or separation and the social fragmentation of the

adolescents with their family decreases the supervision and monitoring of the adolescent. This increases the likelihood of being raped.

The likelihood of being raped is higher among girls who tend to have multiple sexual partners. The relationship is highly significant at $p<0.01$, showing that those who have had many sexual partners are at increased risk of sexual assault. This has also been observed in the male focus group discussion. They suggested that girls who want to choose another boy friend, better or richer as they mentioned would be beaten badly or raped for revenge. This also supports the belief that young women who have many sexual partners are at increased risk of sexual assault.

As observed in several studies (Koss etal1993, Rickert andWeinmann, 1998,Mitikie, 2000), in this study too, the use of alcohol increased the likelihood of being raped. This is also supported by the male focus groups discussion; the boys coerce their dates into sex after getting them drunk. Consuming alcohol makes it more difficult for women to protect themselves by interpreting and effectively acting on warning signs. Under alcoholic conditions, women will have reduced coping responses and will be unable to ward off a potential attack (Rickert & Weinmann 1998, See literature review).

Age at first sexual activity has also a significant association with rape (at $p<0.01$). In various studies it is observed that early age at first sexual activity (forced or voluntary) increases a girls vulnerability to sexual assault in her later life because it is believed that those who begin dating early come into contact with a higher number of potential perpetrators (Rickert and Weinmann, 1998). Particularly, childhood sexual abuse is observed to result in low self-esteem of girls making them less skilful at protecting

themselves from further rape. This was seen in a study made in the USA (Tjaden and Thennes, 2000) in which women who were raped before age 18 were twice as likely to be raped as adults. Forced sexual initiation has also been among the significant risk factors to rape in the study of street adolescents in Addis Ababa.

In this study, adolescent's knowledge of contraception and HIV/AIDS was assessed assuming that their awareness in this regard may be important if they can negotiate for contraceptive use or HIV/AIDS preventive mechanisms during rape. Knowledge of the adolescents in this regard was found to be high. 73.6% of the study participants have reported that they know how to protect themselves from pregnancy. However, this level is lower as compared to the findings of the Ethiopian Demographic and Health Survey, where 86.2% of all women aged 15-59, 78.9% of those aged 15-19 and 85.4% of those in ages 20-24, reported knowing any method (CSA, 2001).

The lower figure obtained in our case is attributed to the way the question has been posed "do you know how you can protect yourself from pregnancy?" unlike the DHS which asked whether the woman has ever heard of a method. Condom, Oral pills, injectables, safe periods and implants were the most popular methods known to 88.5%, 86.4%, 69.3%, 58.4% and 27.7% respectively. Of those who are sexually active and know about contraceptives, 57%reported to have used one method of contraceptives during their recent intercourse. Condom and oral pills were the most popularly used methods.

Knowledge of protecting one self from pregnancy is associated with age, level of education, sexual experience and marital status. Considering age and educational level of

the adolescents, Knowledge of contraception increased with increases in age and level of education. This is consistent with the findings of various surveys like the Ethiopian DHS of 2000.

Among the study population 95.6% reported that they have heard about HIV/AIDS. This level is high but should have been universal. For instance, in a study made on high school adolescents in the town two years ago, almost all of the respondents (99.6%) have heard about HIV/AIDS, 90.3% reporting that they learnt about HIV/AIDS at school (EYOB, 2000). Thus, there might have been an intentional underreporting by the study subjects or the fact that a considerable proportion of them are out of school has influenced the result.

Their knowledge about the modes of transmission and prevention of HIV/AIDS is also high as compared to results of the Demographic and health survey of 2000. Promiscuity, blood transfusion, sharing contaminated Needles, and having sex with infected person were the important modes of transmission of HIV/AIDS reported by 79.5%, 91.3%, 86.1% & 82.9% of the respondents respectively. With regards to the modes of prevention abstinence, (87.2%) having one faithful partner (78.9%), avoiding the use of unsterilized needles (75.8%), using screened blood (64.1%), having sex with in marriage only (65.2%) and use of condom (62.7) were identified as important ways to avoid the spread of HIV/AIDS by the study population. This may show the successes of Information, Education and communication made in relation to HIV/AIDS.

When we compare knowledge of HIV/AIDS among age and education categories, increase in age did not bring about increase in knowledge about HIV/AIDS in this survey. The

younger age group (15-19) reported a higher knowledge (96.3%) as compared to the older age groups (93.9% by those in ages 20-24). As these younger adolescents are more enrolled in education, this may show the influence of schools in teaching or communication information about HIV/AIDS. But knowledge of HIV/AIDS increased with an increase in the level of education of adolescents.

When asked whether they think that they can get HIV/AIDS, the majority, 68.4% answered "no" while the remaining 31.6% responded having a perception of acquiring the disease. The perceived risk of acquiring the disease is higher among sexually active adolescents and among adolescents who have been sexually assaulted and among adolescents who have had two or more partners. On the logistic regression analysis too, the perceived threat of acquiring the disease was significantly associated with rape, being sexually active and the number of sexual partners the adolescent had. The threat of acquiring the disease is high among raped adolescents as compared to those not raped, the odds being 1.7 times higher. This indicates that rape increases the perceived risk of acquiring HIV/HIDS for the potential transmission of the HIV/AIDS during forced sexual intercourse.

Being a victim of sexual violence and being susceptible to HIV shares a number of risky behaviors. Forced sex in childhood or adolescence for instance, increases the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work and substance use(WHO, 2002). Moreover, sexual coercion among adolescents is also associated with low self-esteem and depression, which are known to be among the factors associated with many of the risky behaviors for HIV infection. It is also observed in this

study that having multiple sexual partners increases the perceived risk of acquiring the disease. This risky sexual behavior is commonly practiced among the adolescents. In a study conducted on HIV/AIDS related Sexual behaviors among high school students in Jimma town (Eyob, 2000), it was observed that one third of the sexually active students had multiple sexual partners (lifetime) and one fourth of those who had sex in the year before the survey reported engaging in sexual activity with more than one partner.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

This study has shown that sexual violence against female adolescents is a serious problem, yet a less reported and less recognized one. It revealed a high prevalence of different kinds of sexual violence perpetrated against female adolescents. Rape was reported by 15.3%of the study participants (40% of the sexually active adolescents), attempted rape by 17.7%, non-consensual unwelcome kissing in the last year by 19%, Physical assault (beating) by 28.4%, forced marriage by 3.6%, abduction by 2.2% and female circumcision by 78.7%. Moreover, in the twelve months before the interiew, 2.7% of the adolescents had experienced non-consensual sex.

Rape is the most extreme of all these forms of sexual violence for its severe consequences on adolescent's physical and mental health. It was found in this study that 21% of rape victims became pregnant, 10% had practiced abortion and 16.7%had unusual discharge from the genitalia, the latter being an indication of the possible transmission of STD's. Moreover, as forced sex can increase the risk of transmission of HIV, about57% of the rape victims reported their perceived risk of acquiring HIV/AIDS. These outcomes show that sexual violence is one of the major contributing factors for health problems adolescents face nowadays, including unwanted pregnancy, abortion and STD's like HIV/AIDS.

Apart from these, there were various short term and long-lasting psychological outcomes reported by the victims. These include; fear and anxiety, self blame, low self esteem , bad

sleep , suicide attempt, and withdrawal from school and the like. These further shows the subsequent trauma victims faced after the assault.

Most of the rape (69%) reported in this study was committed by a person known to the victim; like boy friends or ex-lovers, neighbors and relatives and those in positions of authority like employers and bosses. The problem in line with this was that victims do not report the incidents to legal bodies. In this study, 78% of rape victims have not reported to any legal body for fear of humiliation, fear of parents (that they may hear the incident), and fear of threats by the rapist. Majority of the rapists are older and physically stronger than the victims.

The fact that more than two-thirds of the adolescents lack knowledge of the legal definition of rape in Ethiopia might be another contributing factor.

Examination of the attitudes of the adolescents on pre-marital sexual practice and rape showed that there is a gender difference in relation to beliefs and attitudes related to rape and sexual practice. The girls see pre-marital sexual practice in relation to pregnancy, abortion, stigma and bad reputations. Thus, they disapprove the practice. Rape is also a serious problem for such and other undesirable outcomes. But, for the boys, pre-marital sexual practice is accepted and practiced for enjoyment, experience or love with their partners. Rape is not a problem for the boys because they believe that it happens only to bad girls who will be available at the wrong place and wrong time, who undermine requests and who wear provocatively and act seductively on dates.

The major causes of rape as observed in this study are men's use of physical force, threats of harm, use of alcohol, men's controlling and dominance behaviors and their beliefs in

rape myths. On the logistic regression analysis, early sexual initiation, having multiple partners, being unmarried, living alone, living with relatives and use of alcohol are the main risk factors that increased the girls vulnerability to rape. Further, as suggested by the girls, lack of enough reproductive health information (of men), peer pressure, unemployment, lack of strict law enforcement and dependence of women are among the contributing factors for sexual violence.

7.2 Recommendations

Based on these findings, the following recommendations are made

1. Education should be the foremost step to reducing the magnitude of sexual Violence. A Comprehensive education on aspects of sexual and reproductive health and rights, gender and gender-based violence that address facts about the magnitude of sexual violence and its outcomes should be integrated into the school curriculum, and should be implemented by the Ministry of Education. For those out of school youth, interventions must be made through youth groups and at work places.
2. Life skills that can help young girls to prevent sexual assault and become sexually assertive should be taught. For instance, skills that enable them recognize warning signs of inappropriate sexual advances, controlling and abusive relationships as well as a sense of empowerment is essential. Moreover, for those who choose to be sexually active, skills on how to protect themselves against the risk of pregnancy, HIV and other STD's are needed. Understanding their sexual rights and developing a sense of

empowerment to force them is important in negotiating safe sexual relationships. This can be implemented by Women's Organizations, NGOs and related Government Organizations.

3. Improving law enforcement on issues related to sexual violence. This Should include improving the speed and sensitivity of the processing of cases by the courts as well as identifying mechanisms to encourage victims to report incidents of sexual violence to the police. This also requires giving sensitization training to court personnel, police officers, the adolescents, the media and other related groups.

4. Counseling and screening for HIV infection of rape victims is essential.

5. Training of health care professionals in a way that they can be able to detect and handle Cases of sexual abuse.

6.It is known that social belief systems that posits male superiority over women , and views women as inferior is among the root causes of violence against women. Thus, eradicating violence against females will require changes at the most fundamental levels of society; changing the underlying patriarchal beliefs and practices. The changes must eliminate practices (or policies) that sexualize women, demean their value, and restrict their rights over their own bodies. To this end, the media should play a key role in advocacy, IEC that promotes moral values of safety, equality and justice for women and girls and create awareness about the problems of sexual Violence and its preventive mechanisms.

7. Further research using longitudinal studies of victims and a Qualitative approach on men's attitudes is recommended.

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Appendex

Appendex I

Participants Consent Form

Hello sister! My name is _____. I am working for Addis Ababa University and we are now conducting a survey in selected kebles in Jimma town to learn about sexual violence against female adolescents. You have been chosen to participate in this study by chance and you will help us by answering the questions we ask you. We assure you that whatever answers you give us is kept strictly secret. We do not need your name and address. We also inform you that you have the right to stop the interview at any time or skip any questions that you do not want to answer. You may find some of the questions too personal and difficult to talk about, but your experience could be very helpful for other adolescents in the country. The interview takes approximately 30 minutes. Do you have any questions, you can ask.

The respondent agrees to be interviewed (----------)
She did not agree to be interviewed (----------)

Thank you!

Appendex II - Questioniare

A questionnaire prepared to study sexual violence against female adolescents in Jimma town, Dec. 2002

Part I, Section on Socio – demographic data			
Questions		Coding categories	
1	Respondents age in year	[ ]	
2	Religion	1. Orthodox 2. Protestants 3. Catholic 4. Muslim 5. No religion 6. Others [ ]	
3	Marital status	1. Never married 2. Married 3. Divorced 4. Widowed 5. Others [ ]	
4	The respondent's level of education	1. Illiterate 2. Read and write 3. Primary (1 – 8 grade) 4.Secondary (9 – 12 grade) 5.Above high school level	
5	Are you currently attending school?	1 .No 2. Yes	
6	If you are not attending school, what is your current occupation	1.trade 2. Construction work 3. Assistant driver/driver 4. House servant 5. Waitress 6. Professional 7. Barber (beauty salon) 8 . Others ( )	

7	Ethnicity	1. Oromo 2. Amhara 3. Kulo 4. Kefa 5. Guraghe 6. others (specify)_____	
8	Place of birth	1.Jimma 2. Other towns 3. Rural	
9	How long did you live in Jimma town	_____	
10	Mothers educational level	1. Illiterate 2. Read and write 3. Primary (1 – 8grade) 4. Secondary (9 – 12 grade) 5. Above high school level	
11	Fathers level of education	1.Illiterate 2.Read and write 3.Primary (1 – 8grade) 4.Secondary(9 –12 grade) 5.Above high school level	
12	Parental condition	1.Both are not a live 2.Mother only 3.Father only 4.Both are a live	
13	With whom are you currently living?	1. Married 2.Both parents 3.Father only 4.Mother only 5.Step parents 6.Grand parents 7.Other relatives 8 Alone 9. Others( )	

14	What is your family's (your) monthly income	1.Below 150 2.150 – 300 3.300 - 600 4.600-1000 5.1000-1500 6. Above 1500	

Part II. section on sexual violence			
1	Have you ever had sexual intercourse?	1. No (skip to no.26) 2. Yes	
2	Age at first sexual intercourse	[ ]	
3	What made you have your first sexual debut(if other than no.5 skip to question 10)?	1. Marriage 2. Personal desire 3. Deceived by promising words 4. For exchange of property or money 5. Forced 6. Others [ ]	
4	If it was forced, who forced you?	1. Close relative 2. A brothers friend 3. Neighbors 4. A boy friend 5. An unknown person 6. Family's friend 7. Employer/boss 8. Other ( )	
5	Age of the perpetrator	1. About your age 2. Younger than you 3. About 5 years older than you 4. About 5 to 10years older than you 5. More than 10 years older than you	

6	What mechanism did he use to force you?	1. Threats of harm 2. Hit you 3.Pointed a knife at you 4.Pointed a gun 5.Made you drunk 6.Made you use some drugs 7.Others ( )	
7	When you were forced to have sexual intercourse, were have you been living.	1.With both parents 2.With relatives 3.Alone 4.Other [ ]	
8	Where did this incident happen to you	1.At your home 2. Neighbor 3. At school 3. Hotel 4.On street at night 5. Other [ ]	
9	At the time of the rape did you take any of the following 1. Did you drink alcohol? 2. Chew chat 3. Did you use any kind of drugs?	No Yes 1 2 1 2 1 2	
10	Other than what you have already mentioned, in your lifetime, have you had sexual intercourse when you did not want to because a man used his position of authority (boss, teacher, and supervisor) to make you?	1. No 2. Yes	
11	Have you had sexual intercourse when you did not want to because a man gave you alcohol or drugs?	1. No 2. Yes	
12	Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force(twisting your arm, holding you down, etc) to make you?	1.No 2.Yes	
13	How many times in your lifetime did these things happen to you?	1.once 2. 2-4 times	

		3.more than five times	
14	What was your relationship with the perpetrator?	1. Boy friend/ex-friend 2.Co-habiting 3.a stranger 4.neighbor 5.boss/supervisor 6. Family's friend 7. A teacher 8. Other ( )	
15	As result of any of the above incident, did you seek help for your health?	1.No 2.yes	
16	Where did you seek help for your health?	1. Hospital 2. Health center 3. Traditional/country /Medicine 4. NGO' s 5. Other [_____]	
17	Did you make sex in the last year	1.No 2.Yes	
18	Did you face a nonconsensual sex in the last year	1. No 2. Yes	
19	If your answer is yes, how many times	1.once 2. 2-4 times 3. More than five times	
20	In the last twelve months, did you have sex in exchange of money?	1. No 2. Yes	

21	To which legal body did you report after the event?	1. Did not report 2. To the police 3. To kebele administration 4. Women's affairs 5. Other legal bodies [ ]	
22	Action taken by legal bodies on the perpetrator	1. None 2. Imprisonment 3. Financial penalty 4. Forced to marry 5. Others ( )	
23	If your answer for #21 is did not inform any body,		

	why did you keep the secret with you? 1. Do not know what to do 2. Afraid of parents 3. Afraid of humiliation 4. Threatened by the rapist 5. The police will not listen to me 6 Others	No Yes 1 2 1 2 1 2 1 2 1 2	
24	Did you experience any of the following after you were raped 1. Pregnancy 2. Abortion 3. Ulcer in the genitalia 3. Unusual discharge from the genitalia 4. Swelling around the genitalia 5. Others (specify)	No Yes 1 2 1 2 1 2 1 2 1 2	
25	Which of the following did you experience after a forced sex 1. Often have headaches 2. Poor appetite 3. Bad sleep 4. Easily frightened 5. Blame yourself for what happened 6. Hate others for what has happened on you 7. Feel unhappy 8. Cry more than usual 9. Lost interest in sexual intercourse 10. Become addicted to alcohol or substance like chat 11. lost interest on things 12. Feel that you are a worthless Person 13. Thought of ending your life 14. Tried to take your life 15. Fill tired and depressed all the time	No Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 2	

	16. Faced problems in your education 17. Withdrew from school	1 2 1 2	
26	Other than the incidents you already mentioned, in your life time, has any one (a boy friend, ex-lover, or others) attacked or threatened you in any of the following ways 1. With a gun or knife 2. By some thing thrown at you, such as a rock 3. By beating up 4. By face to face threats	No Yes 1 2 1 2 1 2 1 2	
27	Did you face nonconsensual unwelcome kissing in the last year?	1. No 2. Yes	
28	If yes, how many times	1. Once 2. 2-4 times 3.more than five times	
29	Have you ever faced an attempted rape? If yes how did you manage to escape the attempt? 1. Did not face an attempted rape 2. By giving appointment 3. By fighting 4. By shouting 5. By getting help from other persons 6. By running 7. By frightening 8. Others (_____)	No Yes 1 2 1 2 1 2 1 2 1 2 1 2	
30	Do you know a friend who was raped in the last 12 months	1. No 2. Yes	
31	Do you know a friend who was kissed forcefully in the last 12 months?	1. No 2. Yes	
32	Do you know a friend who had an abortion after a forced sex in the last one year?	1. No 2. Yes	
33	Do you know a friend who had died of causes related to pregnancy?	1. No 2. Yes	
34	How do you rate the extent of rape and harassment in your area these days?	1.not changing 2. Increasing	

		3.decreasing 4. Have no idea about	
35	Do you have any idea about the legal definition of rape in Ethiopia?	1.No idea 2.some idea 3. Know very well	
36	In some parts of Ethiopia, there is female circumcision. Have you ever been circumcised	1. No 2. Yes	
37	Did any body try to abduct you?	1. No 2. Yes	
38	Any experiences of forced marriage by your family or relatives?	1. No 2. Yes	
39	Did some one older than you force you to have sex or force you to do something sexual before the age of 12?	1. No 2. Yes	
40	If yes, how many times	_____	
41	In a family or between a husband and a wife sometimes physical fights may occur. Have you ever observed a fight between your parents?	1.No 2.Yes	
42	Did your parents punish you for your wrong deeds during your childhood?	1.No 2. Yes	

Part III, Section on adolescents attitudes towards sexual violence and behavior Related to substance use			
1.	In your view, is pre-marital sex acceptable?	1.No 2.yes	
2.	If your answer is no, why do you say is it not acceptable?	_____	
3	Do you believe that it is acceptable to force a girl to have sexual intercourse?	1.No 2.Yes	
4.	Among the following conditions, on which one do you think it is 'acceptable' to force a girl to have intercourse	1. If she is a wife 2. If she is a girl friend 3. If both are sexually aroused 4. If a boy or a man spends a lot of money on a girl 5. Under no conditions	

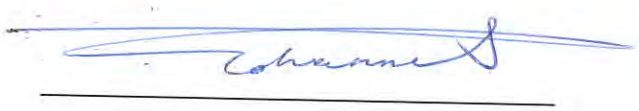
		6. Other ( )	
5	Who do you think is responsible for a rape	1. The offender (man) 2. The victim (the girl) 3. Both of them	
6.	If you say the girl, can you give a reason	_____	
7	What do you think is the cause of rape?	_____ _____	
8.	Do you drink alcohol?	1.No 2.Yes	
9	If yes, how often do you drink?	1.Never 1. Every day or nearly every day 2. 3 – 4 times a week 3. Every week 4. Every month 5. Only on holidays and public holidays	
10	Do you smoke?	1. No 2. Yes	
11	Do you chew chat	1. No 2. Yes	
12	Do you take drugs	1. No 2. Yes	
13	Why do you use these things?	_____	
14	What are your biggest worries about your health?	_____	
15.	Do you have a boy friend or a sexual partner?	1. No 2. Yes	
16	How many such partners did you ever have in your lifetime?	1. One 2. 2-4 3. More than five	

Part V, section on awareness of contraceptive use, and HIV/AIDS			
1.	Do you know how you can protect your self from pregnancy?	1. No 2. Yes	
2	If the answer is yes, mention some methods of preventing pregnancy	1. By using contraceptives 2. By traditional medicine 3. By natural and traditional methods 4. Others( )	
3	Which type of contraceptives do you know? 1. Condoms 2. Diaphragms 3. Pill 4. Injectables 5. Implants 6. IUD/Loop 7. Safe period 8. Regulating body temperature 9. Coitus interrupts 10. Abstinence 11. Other (_____)	No Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
4	Did you use contraceptives, in your last sexual intercourse? If so which one did you use? (If your answer is other than 1 skip to #6)	1. Did not use 2. Condoms 3. Diaphragms 4. Pill 5. Injectable 6. Implants 7. Loops 8. Calendar method 9. other(_____)	
5	If the answer is no, what is the reason? 1. Causes infertility 2. Causes cancer 3. To have many children 4. Not good with poor nutrition 5. Do not know where to get 6. Do not believe it will help 7. Do not know about it 8. Others (specify)	No Yes 1 2 1 2 1 2 1 2 1 2 1 2	

6	Have you heard about HIV/AIDS?	1. No (skip to no.9) 2. Yes	
7	Which are the ways of transmission of HIV/AIDS? 1. Promiscuity 2. Blood transfusion 3. Sharing contaminated needles 4. Having sex with infected person 5. Mother to child 6. Mosquito bites 7. Sharing toilets 8. Shaking hands 9. Social kissing 10. Others (specify) [ ]	No Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
8	Do you know any preventive methods of HIV/AIDS? 1. Abstinence 2. Condom use 3. One faithful partner 4. Avoid using unsterile needles 5. Avoid mosquito bites 6. Having good nutrition 7. Avid sharing toilets 8. Using screened blood 9. Having sex after and within in marriage only 10. Others (specify) [ ]	No Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
9	Have you used condom during the last sex with your partner?	1. No 2. Yes	
10	Do you think you can get AIDS?	1. No 2. Yes	
11	Why do you say no? Or why do you say yes?		
12	Have you ever made an HIV test	1. No 2. Yes	
13	Do you want to have HIV testing and counseling?	1. No 2. Yes	

Declaration

This thesis is my original work and all sources of materials used for the thesis have been duly acknowledged.



Yohannes Dibaba

Addis Ababa University

June, 2003