Addis Ababa University
School of Graduate Studies

SEXUAL VIOLENCE AMONG FEMALE STREET ADOLESCENTS IN ADDIS ABABA

By

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List of abbreviations

AIDS- Acquired Immunodeficiency Syndrome

AA- Addis Ababa

DCH- Department of Community Health

HIV-Human Immunodeficiency Virus

STD-Sexually Transmitted Disease

FGD- Focus group discussion

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Abstract

A cross-sectional survey among 654 female street adolescents and a qualitative study among 32 male street adolescents were undertaken to determine the magnitude of rape, attempted rape and its consequences, to describe life skills of escaping the attempt and to describe attitudes of male street adolescents towards rape in Addis Ababa. The quantitative study revealed that the prevalence of rape among female street adolescents in the last 3 months was 15.6%, (using the definition of rape as the penile penetration of the vagina), attempted rape 20.4% and unwelcome kiss 16.4%. The most popular way of escaping the attempt was yelling, running, negotiating, and fighting back. Raping a girl in the street as reported by the male focus group study was used as a means of penalizing a girl for adultery or for refusing a sexual advance. The boys report showed that the girls are blamed for their victimization, as "being in the wrong place at the wrong time" and being provocative by talking in a sexual manner. Rape was significantly associated with living alone and low self-esteem of girls due to early childhood sexual abuse. Unwanted pregnancy, abortion, STDs, and psychological, problems were reported to prevail as consequence of rape. After their victimization 80% of the victims did not report the event to legal bodies. Awareness of street girls towards contraceptive use and STDs were significantly associated with increase in age. This study has showed girls in the street are at a higher risk of rape and its consequences. It is recommended that though tackling the root cause i.e., streetism is a long-term issue, establishing a rape crisis center in health institutions with standard STDs treatment and counseling service, wide spread public education, law protection, training of life skills in protecting girls from rape, night shelter for girls are some of the many to be undertaken. Further more a longitudinal study on the impacts of childhood sexual abuse is recommended.

INTRODUCTION

Gender based violence is endemic in most communities all over the world (1). Rape is one of the common crimes of violence, in which a man uses sex as a weapon to exercise power over women (2,3). Rape and other forms of sexual assault are not recent phenomena in any society but have been part of the history of civilization (4). Among some American Indian tribes rape was a prescribed punishment organized by an offended husband against an adulterous wife. In Africa rape was considered as a serious property right, since women were considered as the property of their fathers first and their husbands after they got married. In patriarchal societies of the past and the present a socially accepted rape exists (5).

The types of rape may be classified into three categories as statuary rape, forcible rape and marital rape. A statuary rape is a condition in which sexual intercourse occurs with a female under the age of consent, usually 12-18 years (with or without her consent). Sexual intercourse with a person who is mentally deficient or unconscious and therefore incapable of giving consent is also sometimes considered as statuary rape. Forcible rape is sexual intercourse/penetration with a non-consenting victim through the use of force or threat of force or fraud. Marital rape is a situation where a husband forces his wife to have sex without her will, but this is a controversial case in many cultures (5,6,7). With respect to public health importance sexual violence includes several harmful behaviors that are directed towards women and girls, including date rape, marital rape,

harassment, assault by a stranger, child sexual abuse, gang rape, prison rape and war rape (8).

Women were considered by law to be less competent than men and were denied educational, economic and political rights. The violation of women's rights is highly influenced by the norms of the society in which women live (4).

In many societies two cultural features mark the relation between the sexes relevant for rape. These are inequality between the sexes and a tendency for men to view women as actual or potential property. In periods of community instability like war, mass raping of women was used as a tool of controlling the enemy (1,2,4).

Female-targeted violence has not been acknowledged until December 1993 when the United Nations General Assembly adopted the Declaration on the Elimination of Violence Against Women. The declaration defined violence against women as follows: *Violence against women includes any act of verbal or physical force, coercion or life threatening deprivation, directed at individual women or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty and that perpetuates female subordination* (9). However, even after the 1993 UN declarations, little attention has been given to the problem as a broad social issue, or as one relevant to public health. As a result, less effort has been devoted to tackling the underlying cause of abuse (9).

Information about women's health problems is scarce in the third world countries, and the existing studies emphasized only on the reproductive health problems of women. Little attention has been given to impairments that are not directly related to women's

reproductive capacities resulted from sexual violence (1). Violence against women is an important health problem not only because of physical injury that may result but also because of potentially harmful health behaviors that may be triggered in response to violence, such as substance abuse and other psychological problems. The health consequence on women due to gender-based violence is a serious problem world wide, which has devoid of women from participating in socio-economic development (10). Women can not lend their labor or creative ideas fully while they are burdened with the physical and psychological problems of abuse (9,10,11).

Sexual violence is pervasive at every stage of women's lifecycle. However adolescents have higher rate of rape victimization compared to other age groups; there are only few studies that have examined predictors of rape-supportive attitudes among adolescents (12). This has become worse with the development and expansion of cities, which has created a new socio-medical problem i.e. streetism among children. There are an estimated number of 60-80 million street children in the world. These children are obliged to live in the street for different reasons and somehow they have found the street to be habitable than their home for different reasons. In the street, adolescents despite their young age are marginalized and isolated. They hardly receive any kind word from other individuals and are chased by authorities. They live in the subculture of violence; the slightest disagreement may cost a life or may result in severe injury. This problem is worse in the female street adolescents who are vulnerable to every type of violence especially sexual violence (13). Street adolescents though do not exhibit emotional

debility like that of old street people, are nevertheless dependent upon the environment of the street for their physical well-being and emotional development (14).

In Ethiopia, decades of war, draught, ethnic conflicts, migration from rural to urban areas, loosing family ties, and search for better life have produced over 100,000 street children nation wide, and in Addis Ababa there are an estimated 40,000 of which a third of them are estimated to be female. The urban nature of the city as a major economic center draws the attention of many people to come to the city looking for jobs (15,16,). Though the problem of street children especially that of female adolescents is prominent, there is a paucity of studies on street adolescents in general and on sexual violence in particular in Ethiopia. Hence, undertaking a study in this area is believed to benefit decision makers, those who are interested to work on gender based violence, the female activists and the study population at large. In this study the magnitude of sexual violence among street adolescent, the health effects of sexual violence among the victimized, awareness towards contraceptive use, awareness and attitudes towards HIV/ AIDS, self esteem towards prevention of further sexual victimization, and life skill in escaping attempted rape, and attitudes of male street adolescents towards rape were determined.

Literature review

Magnitude of sexual violence

Violence against women can occur at any point in their lifetime. The extent of abuse is more directed to sexual attack at adolescent: whereby dating and courtship violence, sexual abuse at workplace, forced prostitution and trafficking is perpetrated by men (9). The collection of data on sexual violence against women is complicated and commonly under reported by the hidden nature of the problem. Many of the victims may be reluctant to report to authorities due to fear of being stigmatized, or may not think of the offenders as criminal, in part because of self-blame. Further more, many women will not classify what has occurred to them as rape because of the still prevalent cultural/traditional notion that " real" rape involves attacks by strangers. This can be seen from studies and reports of many countries. In South Africa where rape is common among girls and women, it has been estimated that in urban areas fewer than one in twenty rapes are reported to the police, with even lower rates of reporting in rural area (1).

However studies around the world indicate that sexual violence is common in the lives of women and girls. A study in Germany indicated that one in seven women is raped or harassed once in her lifetime, but only 5% of them report to the police and 52% of the suspects were prosecuted at last (17).

Several studies in the United States indicated that between one in five and one in seven women would be victim of completed rape in her lifetime. Cross-national research on

the prevalence of sexual assault among college-aged women also revealed, remarkably high rates of violations that range between 19 and 27.5% of the women surveyed in Canada, Korea, New Zealand, United kingdom and the United States (9). In South Africa a police report in March 1997 has indicated rape crime as increasing nearly by 20% between 1994 and 1996 that was equivalent to one thousand rapes occurring monthly (17). Another well-structured longitudinal study among 3031 US adult women showed that 413 women experienced 616 completed rape incident at some time during their lifetime resulting in a prevalence of 13.6% (18).

Child and adolescent sexual abuse

Because of the sensitivity of the issue there are only very few population based studies from which prevalence rates can be estimated. However, many other indirect evidences support the claim that sexual abuse of children and adolescents is wide spread (9). In the USA, 27-62% of women recalled that they were raped at least once before they were 18 years of age. According to a survey in Barbados, one woman in three and one to two men in hundred reported to have been subjected to behaviors constituting childhood or adolescent sexual abuse. In Canada, a government commission estimated that one in four female children and one in ten male children were sexually assaulted before the age of 17 (9).

Indirect evidence from study conducted in Nigeria, showed that in 1988 16% of female patients seeking treatment for STDs were children under the age of five, and 6% were between ages of six and fifteen (8). The Genito-Urinary Center in Harare reportd that

they treated 907 children under the age of 12 for STD in 1990 and in 1992 59% of all rapes constitute children less than 16 years of age (19).

According to a study undertaken in Uganda 40% of the 400 randomly selected primary school students who were sexually active reported of being forced to have intercourse (20). A survey conducted in Australia among college students, reported that vaginal penetration accomplished or attempted by a perpetrator with a finger and or by an object was the common type of unwanted sexual act experienced by the subjects in this survey. The prevalence of sexual abuse (using the broad definition) was 19% for males and 45% for females. The mean age of abuse was 10 years (21).

Factors predisposing to sexual assaults

Community instabilities: During war times, women are subjected to repeated rape, though recorded rape events were not available previously. The commitment of the Japanese Government in compensating rape victims after the Second World War has made the number of reported cases to rise (22). As a result, repeated and brutal war rape has recently been documented in Bosnia, Cambodia, Peru, Somalia, and Uganda (17). A European community fact-finding team has estimated that more than 20,000 Muslim women were raped in Bosnia since the war began in 1992. Many have been kept in "rape camps" where they have been raped repeatedly and obliged to bear Serbian children against their will (9).

Abusive partners: Women who live with abusive partners are at high risk of marital rape, though non-consensual sex in marriage is not considered as rape even in affluent

countries. It is assault by strangers that is usually considered as rape and this may disproportionately reduce reporting of marital rape. Even among international human rights organizations, marital rape is hardly mentioned except within the broader context of domestic violence (1). However, according to prevalence studies in the United States, 14% of wives have reported non-consensual sex with their husbands and this prevalence may exceed 40% among North American women who are battered. Similarly, studies in Mexico, Bolivia, Porto Rico, Colombia, Philippines and Guatemala have indicated forced sex with husbands was a common experience (1).

Deviant behaviors: Studies of specific deviant groups revealed the occurrences of frequent experiences of sexual abuse. A large proportion of drug and alcohol addicts, prostitutes and runaways are victims of childhood sexual abuse. They may often be abused double and triple times over extended period of time (23). Among these deviant groups, the street children are the ones that are devoid of any type of family protection. Street girls are obliged to engage in survival sex in order to fulfill their needs. According to the Brazilian study, sexual initiation occurred at an early age, and was frequently the result of coercion, particularly of girls. The mean age of first sexual experience reported by the respondents was 11-12 years. Girls whose first sexual experience occurred before or after age 12 report that their first partner was an adult man (36.4%vs 46.7%) (24). A study conducted among Seattle street youth in 1979 indicated that 75% of Female Street prostitutes were abused sexually (25).

Early childhood sexual victimization: Prevalence studies in The US showed early childhood sexual victimization as resulting in low self-esteem of women and girls making them less skillful at protecting themselves from further rape. They are usually less sure of their worth, their personal boundaries and accept their victimization as part of being female. These factors may increase the chances of further victimization. In a community based survey, 49% of childhood sexual abuse victims reported being battered in adulthood relationships. Russell in 1986 found that 68% of incest victims as reporting to have been victims of rape or attempted rape (excluding incestuous rape) later in their lives, compared with 17% of non-abused controls (9,19).

Dependence and lack of information: The social and economic dependence and the hierarchical gender relation predispose women for sexual assault. Different studies show that sexual assault often comes from the same population of men, whom women depend for support and protection. Economic independence and self-reliance may not totally prevent assault, but they do help women to deal more effectively with it (8).

Inaccurate and incomplete knowledge about sexual assault prohibit the victims from being prepared to deal with it. Furthermore, access to the right information about when assaults occur and who are the major perpetrators is usually lacking (8).

Social fragmentation: Sexual abuse is common in a society where there is an increasing isolation. Isolation facilitates sexual abuse into two ways: It reduces the intensity of general social supervision, so that all socially sanctioned forms of support

and intimacy may turn to forms that are taboo. Sexual abuse is a symptom of pervasive loneliness (23).

Health consequences of rape (sexual assaults)

The World Bank estimate shows that rape and domestic violence account for 5% of the healthy years of life lost to women of reproductive age in developing countries. In countries such as China whose maternal mortality and poverty related conditions are under control, the healthy years of life lost as a result of rape and domestic violence accounts for more than 6% of the total burden (1,9).

The psychological and physical impacts of rape on women can be severe. Even many years after the event, victims of sexual assault are significantly more likely than non-victims to be diagnosed as having mental health disorders including major depression, alcohol abuse, drug dependence, generalized anxiety, obsessive compulsive disorder and post traumatic stress disorder. Such outcomes are even more likely among women who have been repeatedly victimized (2,26).

Research in the United States has shown that about one fifth of child sexual abuse victims experience serious long-term psychological effects. Different researches support the correlation between childhood sexual abuse and low self esteem, which includes: feelings of isolation and stigma, anxiety and tension, depression, self harm behaviors, fear, difficulties in interpersonal relationships, parenting difficulties, lack of trust, vulnerability to re-victimization, sexual dysfunctions, substance and alcohol abuse, unprotected sex with multiple partners, teen pregnancy and prostitution (9, 26,

27, 28). In addition the victims may become pregnant, have induced abortion or contract sexually transmitted diseases, including HIV/AIDS. Rape crisis centers in Mexico reported that 15-18% of their clients became pregnant because of rape. It is estimated that the chances of becoming pregnant from rape in the United Sates is 5% per rape or 6% per victim. The same study estimated that 32,101 rape related pregnancies occur per year (2,18). In a study conducted in Bombay, 20% of pregnancies of adolescent abortion occurred as a result of rape of which 10% occurred following incest (29).

Ethiopian Situation

In Ethiopia though much is not done in this area police report and some of the existing studies show that the magnitude of the problem cannot be underestimated. Six years police report of Addis Ababa showed that the number of rape victims in the city had grown by four fold from 116 in 1994 to 493 in 2000 (30).

Among the few existing studies a study conducted in Addis Ababa and Western Shoa among high school students, sexual harassment was reported by 74.3% of female students. A prevalence rate of completed rape and attempted rape among female students were 5.2% and 10.1% respectively. The age range of rape victims in the study was 9-23, 40% of the victims being below the age of 15. Among the factors contributing to sexual violence, previous history of sexual abuse, false promise and verbal threats, physical force, substance use and living alone were the major contributors. Unwanted pregnancy and different forms of psychiatric disturbance were

reported among rape victims (31). Another high school based prevalence study among 376 students conducted in Addis Ababa to determine childhood sexual abuse indicated 11.4% of the students were sexually abused at childhood; the mean age of students was 13.36 (32). In a study undertaken by Chelchesa in 1995-1997 to assess the incidence of child abuse in four woredas in Addis Ababa, it was found that only in one woreda (woreda 5) there were 24 (3.7%) reported rape cases and 0.2% attempted rape case (33).

In a survey conducted to assess streetism and its determinants on street children in four selected towns of Ethiopia in 1993, out of 32 girls who were interviewed 12 of them had been raped and nine reported to have had attempted rape. One of the victims reported to have become pregnant as a result of rape (16). The Ethiopian Women's Lawyers Association report from 1996-1998 indicated, the magnitude of the problem to be significant, around (8%) of their clients were raped and abducted (34).

Conventions, and legal provisions on the rights of women and children.

Ethiopia has ratified the UN convention of 1989 on the rights of children. In the convention, article 19[1] states that, parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, negligent treatment, maltreatment, or exploitation including sexual abuse. Article 34 concentrates on sexual abuse and protection of children (35).

With regard to women's rights towards sexual violence the earliest mention dates back to the middle of the 15th century in the "Fethanegast, the law of the Kings" which was adopted from Egypt and translated into "Ge'ez" (the earliest Ethiopian church language). The penalty set for rape in this book was: "If a layman (not a priest) who carries off a virgin not betrothed to him and uses violence with her, he shall be separated, and shall not marry another. He shall marry her just as he loved her, even if she is ugly or poor" (36). The currently applicable penal Code of 1957 holds several articles that address various types of sexual offenders (Annex 1) (37). But this law was enacted 43 years back and no update is made up to now. In addition though the existence of this law is good it is not adequate, since the yardstick for rape is the use of violence or lack of consent. Further more acts without vaginal penetration are not addressed and for non-virgin victims it is difficult to prove lack of consent. Besides these shortcomings, the application is even worse since it needs evidence. Even if proved guilty the penalty imposed is usually low (38).

Sexual assault prevention strategies

The best way to deal with the possibility of sexual assault is to prevent it from happening in the first place. Preventive efforts require the elucidation of risk factors, which predispose women for being raped and men for perpetrating rape. Prevention of rape can be exercised depending on the status of the women i.e. different actions to prevent rape when the woman is at the work place, dating with abusive partners, with strangers on the road and so on (Annex 2). The other aspect of prevention deals with a

continuum of developing skills that are important to protect one self from being a victim of rape in the life cycle of a woman (8,39).

Prenatal care: Prenatal care provides an opportunity to talk with the pregnant women, and her partner if possible about promotion of the healthy growth and development of the child. Issues concerning decision making, stress and non-violent resolution of conflict may be explored. In doing so things like sex role stereotyping beliefs must be discussed. This will decrease the stressful situation of pregnancy and arrival of a new child (8,39).

Well childcare: The provision of well-child care allows the opportunity to reinforce previous discussions concerning parenting, sex roles and conflict resolution skills in a structured fashion. Teaching of parents about child sexual abuse and strategies that are effective for prevention is very important. Parent-child communication on this issue is also necessary. Health promotion strategies during childhood encourage the physical and emotional well being of youngsters. Primary care providers should teach flexible sex role behaviors and encourage girls to be sportive and physically strong (8,39).

Childhood and adolescence: Children should be empowered to have control over their body and to inquire the care provider not to touch their body parts without permission. At adolescence and young adulthood, parents or adolescents shall be taught with example of " what if " exercise i.e., like " you are in a party with a guy whom you think is nice but you hardly know him, but he tries to kiss you what would you do?" This exercise helps teens to think ahead of time about confusing or compromising situations

(39). Health promotion for young people should incorporate strategies for resisting peer pressure, assertiveness training, self-defense, and leadership skills building. Methods of successfully including discriminations of causes of impending coercion, early and active resistance and use of multiple assertiveness strategies of resistance like yelling, kicking, fleeing, and fighting back should be thought. Training methods of non-violent resolutions of conflict are also very important (19,39).

Conceptual framework of sexual violence

Various models have been developed to describe the sources of gender-based violence, of which sexual violence is one of the serious types. A brief account of some of the models is given below.

Interpersonal model: This model underlines that violence originates from the subject's psychological abnormalities. For instance, the characters of men that abuse their wives include jealousy, partners control and isolation, explosive temper, legal problems, and history of family violence. The same authors characterized the abused women as having low self-esteem, as accepting male supremacy, and the traditional sex roles (40).

The Socio-structural model: This approach emphasizes social structures, norms and values in a certain community as causal variables of violence. In many of these studies maltreatment is seen as arising from changes in traditional ways of life (40).

In some African cultures having sex with very young girls, usually the clients own daughter is believed to bring about luck in business like farming or in any monetary activities (19).

The social learning model: This emphasizes the influence of variables such as occupational status and parental modeling on the onset of violence. Studies showed that an unsatisfactory employment status strongly increased the likelihood of violence in young subjects (aged less than 40 years). Older subjects endure several strains simultaneously. Men who were abused as a child or witnessed violence will be more likely to involve in violence than those who do not have this experience (40).

Sex role stereotyping: This has been strongly associated with family violence through a stereotype of both genders, devaluation for women's work inside and outside the home and socially condoned family violence. As a result of societal beliefs and values girls learn to be passive, gentle, dependent, nurturing, kind, soft and polite, where as boys learn to be aggressive, dominant, tough, independent, adventurous and forceful. Such sex role stereotyping strengthens the way of thinking that tolerates and rewards aggressive male behavior and passive female behavior (4, 40)

Theories of self-blame: These argue that victims blame themselves for their victimization. Research on the attributes made by victims of crime suggests that they tend to blame themselves for their victimization. This is associated with the myth of rape that argues rape does not occur to "good girls" and the like. Accepting this myth, girls tend to blame themselves for their victimization. Theories of self-blame developed from victims of sexual assault discussed that self-blame restores the victim's control over the environment but does not help to prevent further victimization (40).

Male dominance: Sexual victimization is based upon its degree of male supremacy. It is one way in which men, the dominant status group control women. To maintain control men need a vehicle by which women can be punished, brought into line and subordinated status. Sexual victimization and the threat of it are useful in keeping women intimidated. Inevitably the process starts in childhood with victimization of the girl child (23).

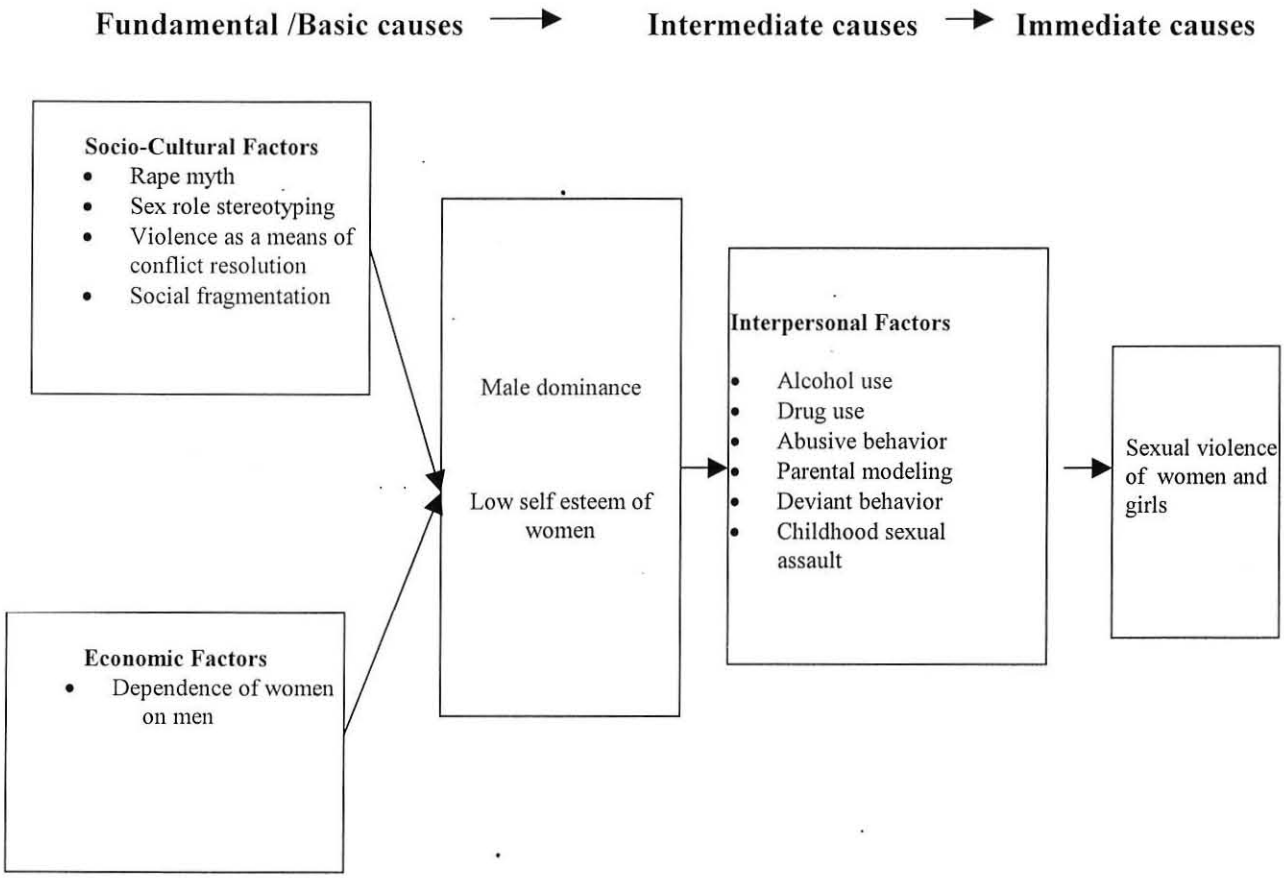
In society where male dominance is prevalent usually male dominance is restricted to the two general types of behaviors. First, the exclusion of women from political and economic decision-making, second, there is male aggression against women, which is measured here by the following five traits: the expectation that males should be tough, brave and aggressive; the presence of men's houses or specific places where only male may congregate; frequent quarrelling, fighting or wife beating; the institutionalization or regular occurrence of rape (41).

In this study a combination of the six models discussed above have been utilized. The main reason for the combination of these models is the assumption that no one model will fully address the factors that are believed to cause violence in women.

In the combined model, socio-cultural and economic factors are assumed to be the basic causes of violence, which will cause the economic dependence of women on men, accepting of sex role stereotyping and rape myths.

Male dominance and low self-esteem of women are stated in this combination as intermediate causes resulting from the fundamental causes. The immediate causes that are believed to result from the intermediate causes are interpersonal factors such as, alcohol use, drug use, abusive behaviors, parental modeling, deviant behavior like streetism and prostitution, directly cause sexual violence against girls and women. Though the relationships are depicted as unidirectional, the factors outlined can interact in more complex multiple dimensions (Fig 1).

Figure 1: Combined conceptual framework of sexual violence



Objectives

General Objective: The general objective of this study was to assess magnitude of sexual violence and its determinants among female street adolescents of age 10-24 years in Addis Ababa.

Specific objective:

- To determine the prevalence of sexual violence and its consequences among female street adolescents in the last 3 months recall period.
- To describe the life skills that female street adolescents use in preventing sexual violence.
- To describe beliefs of street adolescent boys regarding sexual violence on girls
- To assess the level of awareness of female street adolescents towards sexually transmitted diseases and contraception.
- To assess the factors associated with sexual violence among female street Adolescents

Subjects and Methods:

Study design: The survey utilized a cross-sectional design with complementary focus group discussion to determine the prevalence of sexual violence and-its determinants among street adolescent in Addis Ababa.

Study area: The study was conducted in Addis Ababa. Addis Ababa has an area of 540 square kilometers, an altitude of 2200-2800 meters above sea level with a temperate climate; it is divided into six administrative zones, twenty-eight Woredas[1], and 328 Kebles[2]. The total population is 2,624,524 with a male to female ratio of 1:1.041. The population growth rate is 3.79% per annum, with net in migration of 2.97% and a rate of natural increase of 0.82%. From the economically active population, 30% are unemployed (42).

Study population: The source population for the study was street adolescents in Addis Ababa. The inclusion criterion is all female street girls of age 10-24 years, who can speak and listen Amharic language. The exclusion criterion is all disabled street girls and women, age less than 10 years and more than 24 years. This is because the chance of being raped in disabled and very young girls is believed to be higher than the others and it needs a separate study.

Sampling procedure: Areas were stratified into two based on previous studies undertaken by Ministry of Labor and Social Affairs.

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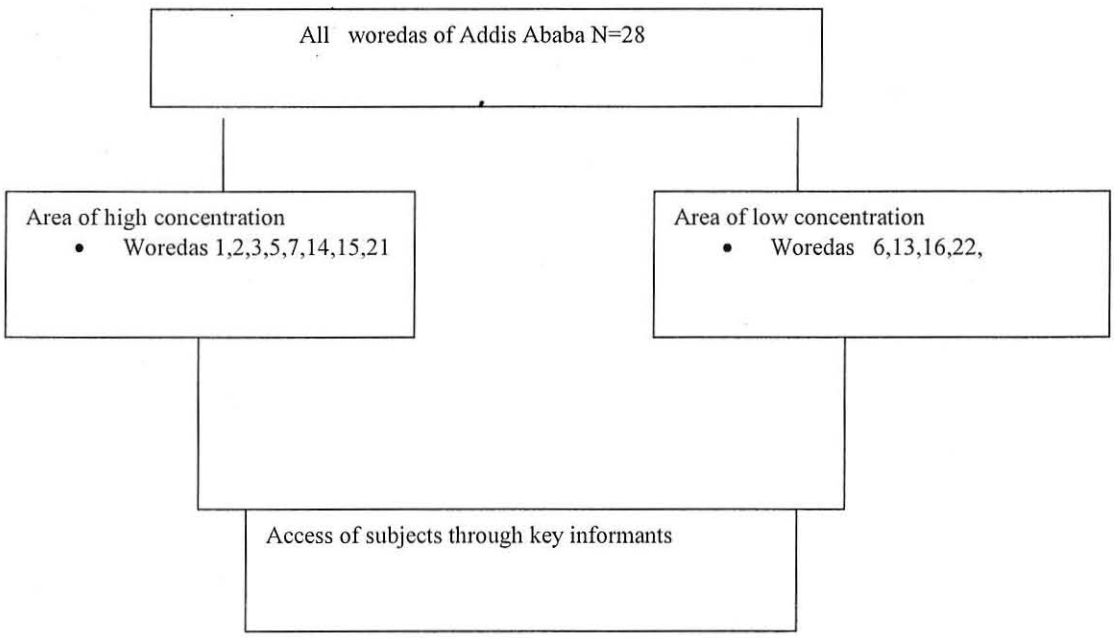
[1] Woreda is the equivalent of a district with an estimated population of 70-80 thousands
2.Kebele is the smallest unit of a woreda with an estimated population of 8-10 thousand

Woredas which are believed to have high concentration of street adolescents especially the hard core (those who live and work on the streets) and woredas of low concentration were selected by purposive sampling method. As a result Woredas 1, 2,3,5,7,14, 15 and 21 were selected as high concentration areas and Woredas 6, 13,16 and 22 were selected as low concentration area, making up a total of 12 woredas.

The selection of high concentration and low concentration does not imply the existence of medium concentration area; these areas are known for the existence of street adolescents in their respective magnitude. Most of these areas are market places, center of the city or bus and train terminals. The subjects from each woreda were identified using key informants on the day of the survey. Those adolescent, who were eligible for the study, were selected for the interview.

Fig. 2 Sampling procedure



Sample size calculation:

Considering the absence of previous data on the specific study population and to obtain a large (conservative) sample size, this study assumed the prevalence of sexual violence to be 50%, with a precision of 4% and 95% confidence interval a sample size of 600 was obtained. Contingency of 10 % was added to compensate for non- responses. After the conduct of the survey a prevalence rate of 15.6% was found, and replacing this prevalence in the formula other things being the same, a sample size of 316 was obtained.

Formula used to calculate sample size:

Sample size: $n = \frac{[(Z\alpha/2)^2 * P.(1-P)]}{d^2} + 10\%$ Contingency

Where:

p= 0.5(50%)

Z=1.96

d=0.04(4%)

Additionally four male focus group discussions each with 8 participants were conducted to identify the beliefs of boys towards rape.

Data collection

A structured questionnaire was used to collect data in the survey. It was prepared in English and then translated to Amharic, and then back translated to English, to ensure its consistency of translation. The questionnaire had four parts, part one dealt with socio-demographic features part 2 dealt with substance abuse, part 3 dealt with sexuality and rape, Part 4 dealt with awareness and use of contraceptive as well as awareness about HIV/AIDS and STDs. Data were collected by 20 female enumerators, the

majority of whom had experience in street survey and supervised by three supervisors. They were given a two-day training and pretest was done on 20 study subjects in woreda 27, which was not included in the study. Based on the pretest some questions that were redundant were taken out and some questions that were not included were added. Before the actual data collection appropriate government agencies like the Woreda and Keble Administration, were consulted and requested to let us use their premises for the study. A coordinator, in addition to the principal investigator, was participated from the Bureau of Labor and Social Affairs.

Data were collected between April 8-11, 2000. Adjacent woredas were surveyed on the same day. During subsequent days different sets of adjacent woredas were surveyed. Information concerning the next days' survey area was kept confidential to minimize double counting. Each interviewer interviewed an average of 10 subjects per day. After interviewing the subjects fingernails were painted with 3% Gentian-Violet solution to avoid double interview.

Focus group discussion: A semi structured discussion guide was developed that contained certain points believed to explore the beliefs of boys towards rape. The adolescents were selected purposively in age groups of 14-24 years. The reason for selecting this age group was based on the survey result of the female group, i.e., since most of the adolescents who were victims of rape claimed the perpetrator to be older

than them. The other reason was that those who are in the adolescent age group of 10-13 were believed to be too young to explain their feelings about rape.

The participants were selected from two major woredas of the city, (Woreda 3, and Woreda 21) those who work and live around stadium and train-terminal and those who worked and lived around the main market, "Markato" (the largest market place in Addis Ababa), "Teklehymanot Church", and "Somali Tera" (a place where old cars are cannibalized for spare parts). The main reasons for selecting these areas were first, the area has higher concentration of street people, and second accessing them through the woreda administration was easy. A total of four focus group discussions (two for adolescents "of" the street and two for adolescents "on" the street) were conducted, where each group was comprised of eight participants that made the total thirty-two.

The focus group discussions (FGD) were conducted in the Woreda 21-Administration Office in anticipation of difficulty of sharing their views elsewhere in an area, which was not familiar to them. The focus group discussion was conducted on July 14, and an average of an hour was used with each focus group. An experienced public health person who has an experience in dealing with adolescent sexual behavior moderated the FGD assisted by a recorder who took notes. The discussion was tape recorded after getting a verbal consent of the participants, which was then transcribed completely into Amaharic, and fully translated in English and described

Exposure variables: Behavioral factors related to rape, such as alcohol, khat and drug abuse, physical violence, socio-cultural and personal factors like self blame and low self esteem of girls for their victimization, socio-demographic variables such as age, type of street life, educational status, current living conditions, marital status, duration of street life and former residence were included as exposure variables.

Outcome variables: Rape as a cause of first sexual debut, rape in the last three months and its consequence, unwelcome kiss, attempted rape, and life skill of girls to escape the attempt. In addition to the above knowledge and attitudes towards contraceptive use and STDs are out come variables. A three months recall period was used in expectation of high prevalence rate of rape and to avoid recall bias of repeated rape.

Method of Analysis: Quantitative data was entered, cleaned and processed using EPI-INFO version 6 statistical package. Analysis of Association for selected exposure variables was done with the outcome variables. Logistic regression was performed using SPSS (Statistical Package for Social Sciences) version 10. The results were presented using absolute numbers and proportions, odds ratio and confidence interval. Certain categories in the demographic variables such as marital status, were re-categorized whereby cohabitation and having a steady boyfriend are specified as married, widowed, divorced and separated are considered as single.

All substance users regardless of their frequency of consumption were classified as users. Knowledge of prevention and transmission methods of HIV/AIDS and STDs

were scored by giving 1, to those who correctly answered the question and 0, to those who did not answer the question correctly. The focus group discussion was transcribed into Amaharic, then to English; the findings are then described and presented in English.

Ethical consideration: Ethical problems were envisaged due to the sensitivity of the issue, hence appropriate training was given to the interviewers and informed consent was obtained from all participants (annex 3). A minimum fee was given for the time lost in responding to the interview and for the index person that helped to access the street adolescents. Ethical clearance for the study was received from Addis Ababa University Medical Faculty.

OPERATIONAL DEFINITIONS

Adolescent: Is the transitional age from childhood to adulthood 10-24 as included in this study.

Adolescent "of" the street: Adolescents who work and sleep on the street whereby the street is their principal home.

Adolescent "on" the street: Adolescent who depends on the street for their subsistence, but usually return home at night.

Sexual Violence: Is defined in this study as the use of force to have sexual intercourse and or unwelcome kiss on a woman or a girl.

Completed rape: is defined as any non-consensual penile penetration of the vagina by physical violence or by threat of body harm, or when the victim is incapable of giving consent due to drug or intoxication of alcohol.

Unwelcome kiss: Kissing perpetrated to a girl/women without her will with or without the penile penetration of the vagina

Attempted rape: Is an attempt\trial to have non-consensual sexual intercourse with a woman where by the woman was having a chance of escaping the attempt.

RESULTS

Socio-demographic characteristics

A total of 654 female street adolescents participated in the survey. Half, 331 (50.6%) of the adolescents were "on" the street and the remaining half were "of" the street type. Forty four percent of the respondents live alone. The median age of the participants was 16. Orthodox Christians comprised the majority 82.9% and never married comprised 76.8%. With regard to educational status, 49.5% were at the elementary level, and over all current school attendance was 27.5% (Table 1)

Twenty eight percent of the study subjects came to Addis Ababa for different reasons; the major one being looking for work 77 (42.7%) followed by displacement 23 (12.9%), and being orphaned 9 (5%). Three hundred sixty eight adolescents had left their home for different reasons. The majority 191 (51.9%) left home at the age of 10-14 and the median age at leaving home was 12 years. Among the reasons for leaving home, physical violence by parents or guardians was reported by 93 (25%), economic reasons by 64 (17%), bribed by an adult by 64 (18%), orphaned by 38 (10.3%), and school failure was reported by 33 (9%) of the respondents.

The majority 301 (46%), of the street adolescents are involved in businesses like vending. Some of the street adolescents engage in multiple activities (Table 1).

The average daily income was less than 5 Birr for 79.2% of the respondents. Both parents were alive for 32.9% street adolescents. Seventy five percent of the street

adolescents got at least one type of support from parents or guardian. With respect to parental education 45.3% of the fathers and 60% of the mothers were illiterate (Table2).

Table1: Socio-demographic characteristics of female street adolescents, in Addis Ababa, April 2000. (n=654)

Variable	Frequency	Percent
Type of street life		
On the street	331	50.6
Of the street	323	49.4
Age in years		
15-19	333	50.9
10-14	215	32.9
20-24	106	16.2
(Median16, Mean16.2 ± 3.3)		
Religion		
Orthodox	542	82.9
Muslim	102	15.6
Others	10	1.5
Marital status		
Never married	502	76.8
Divorced	71	10.9
Married	65	9.9
Widowed	8	1.2
Others	8	1.2
Educational status		
Primary (1-6) school	324	49.5
Secondary (7-12) school	160	24.5
Illiterate	144	22.0
Read and write	26	4.0
Occupation*		
Vending	301	46.0
Begging	281	43.0
Prostitution	72	11.0
Others	4	0.6
Currently living		
With parents/guardian	363	55.9
Alone	291	44.1

* More than the total n since some girls engaged in more than one occupation, like begging and survival sex.

Table 2: Parental characteristics of female street adolescents, in Addis Ababa, April 2000. (n=654)

Variable	Frequency	Percent
Alive parents		
Mother only	219	33.5
Both are alive	215	32.9
None	147	22.5
Father only	63	9.6
Do not know	10	1.5
Fathers' educational level		
Illiterate	296	45.3
Read and write	128	19.6
Secondary (7-12) School grades	104	15.9
Primary (1-6) School grades	62	9.5
Do not know	53	8.1
Above high school	11	1.7
Mothers' Educational Level		
Illiterate	392	59.9
Read and write	87	13.3
Primary (1-6) School grades	61	9.3
Secondary (7-12) School grades	80	12.2
Do not know	30	4.6
Above high school level	4	0.6
Supports given by parents*		
	236	36.1
None	190	29.1
Food	165	25.2
Clothing	273	41.7
Shelter	109	16.7
School fee	10	1.5
Others		

* Multiple responses were possible; therefore percentages may be more than a hundred percent.

Sexual Debut

Half of the participants i.e., 328 (50.2%) have already initiated sexual activity. The median age at first intercourse was 14 years and the mean age was 15 years. The age range of initiation was 6-24 years; where the majority was in the age between 10 and14 (Table 3).

Magnitude of completed rape, attempted rape and unwelcome kiss

Among the study subjects who were sexually active, 141 (43%) initiated sexual activity as a result of forcible rape (Table 3). The perpetrators used different tools to intimidate the victims such as beating in 69 (48.9%) cases and threatening with pointing a knife in 29 (20.6%) of the cases. Verbal threat of harm was used to intimidate the victims on 27(19%) of the street adolescents. More than one tool was used in 11 (8%) of the respondents (Table 4). The perpetrator was a stranger for 94 (66.7%) of the victims and older than the victim in 128 (90.8%) of the respondents.

Table 3: Age and reasons for first sexual debut of female street adolescents, in Addis Ababa, April 2000. (n=328)

Variable	Frequency	Percent
Age range		
6-9	11	3.4
10-14	158	48.2
15-19	148	45.1
20-24	5	1.5
Do not know	6	1.8
(Median age =14 years) (Mean 15.4 ± SD10)		
Reason for sexual initiation		
Marriage	55	16.8
Personal desire	77	23.5
Peer influence	21	6.4
Promising words	16	4.9
For exchange of money	15	4.6
Coerced*	141	43.1
Others	3	0.9

* Sexual initiation with out the consent of the girl either by physical force or by threat of force

Table 4: Mechanisms used to intimidate female street adolescents to initiate sexual intercourse forcefully in Addis Ababa, April 2000. (n=141)

Mechanism	Frequency	Percent
Beating up	69	48.9
Pointing a knife	29	20.6
Threats of harm	27	19.1
Make drunk	17	12.1
Use drugs	5	3.5
Pointing a gun	3	2.1
Others	3	2.1

Multiple responses were possible; therefore percentages may add more than a hundred percent.

The prevalence of rape in the last 3 months period was 102 (15.6%) and that of unwelcome kiss was 107 (16.4%). When the prevalence of rape is computed from the sexually active it is 31%, and the median age of the victims of rape was 17 years. The sexual assault (rape) was repetitive in 61 (60%) of the victims (Table 5). Of those who survived repeated attack 41(40.2%) were victimized 2-4 times, while 20(19.6%) reported to had been victimized more than five times. Among the victims who suffered repeated attack; the perpetrator was the same person for 12 (19.7) of the victims and a different person usually in gangs for 49 (80.3%) respondents.

Among the reasons given by the victims for their re-victimization, sleeping in unsafe place (on the streets) was reported by 34 (55.4%) of the respondents while being female and physically weak were reported by 11 (21.3%). The rest 16 (26.3) reported working and staying on the street for a longer period and living and sleeping in the same area and other reasons for their victimization.

After victimization only 53 (52%) inform to somebody such as their friends. The majority i.e., 82 (80.4%) did not reported to any legal body while 19 (18.6%) report to the police, and 1(1.0%) reported to the street chief. Among the perpetrators who were accused 6 (30%) were sentenced to imprisonment, no action was taken against 7 (35%) of them, 1 (5%) was penalized by fines, and 4 (20%) disappeared. Other actions were reported to have been taken on the rest two.

Of the reasons given for either not sharing their experiences to someone or reporting to legal bodies, the majority 38 (42.%) said that they did not know what to do, 20 (22.5%) stated that they were threatened by the perpetrator, and 32 (36%) claimed that fear of non acceptance by the police.

The magnitude of attempted rape was 134 (20.5%). Of those who escaped the attempt, the majority i.e., 70 (52.2%) did so, by yelling (Table 5).

Among the study subjects, 151 (23%) reported that they knew friends who were raped and 131 (20%) knew girls who were forcefully kissed in the last 3 months period. Ninety-five (14.5%) of the study subjects knew a friend who was raped and prosecuted the perpetrator of whom 55 (57.9%) reported that the perpetrator was imprisoned, 9 (9.4%) reported the rapist was obliged to marry the victim, while 18 (18.9%) were released free, 7 (1%) disappeared, and 4 (0.6%) faced other penalties.

Table 5: Prevalence of sexual violence among female street adolescents in the last three months period in Addis Ababa, April 2000. (n=654)

Out come	Frequency	Percent
Rape	**102**	**15.6**
On the streets n=(331)	13	3.9
Of the streets n=(323)	89	27.6
Un welcome Kiss	**107**	**16.4**
On the streets n=(331)	19	5.7
Of the streets n=(323)	88	27.2
Attempted rape n=(552)	**134**	**20.5**
Life skills used to escape the attemp		
Yelling	70	52.2
Seeking help from others	56	41.6
Running away	37	27.6
Fighting back	27	20.1
Giving appointment	27	20.1
Forming a gang	18	13.4
Threatening	6	4.5

*Multiple responses were possible; therefore percentages may be more than a hundred percent.

Perceived self efficacy of victims of rape, about rape prevention

Among the victims of sexual violence, 67 (65.6%) reported positive self-efficacy in preventing further rape, while 35 (34.3%) reported negative self-efficacy in preventing it. Of those who reported positively, 28 (41.8%) reported that they can escape further attempt by reporting it to the police, if police is around. Twelve (18%) reported they would yell and ask help, 10 (15%) said that they could prevent it by sleeping in a safe place. Whereas 22 (25.4%) said that they can prevent it by negotiating, getting home early and other means. Of those who reported negative self efficacy 17 (48.5%) claimed that they are helpless and female, while 15 (43%) claimed that boys usually come in groups (gang rape) and they are stronger than them therefore the chances of escaping is very little.

Consequences of completed rape

Among adolescents sexually victimized during the last 3 months 23 (22.5%) had unwanted pregnancy, 15 (14.7%) had induced abortion [1], 26 (25%) had trauma of the genitalia, 45 (44.1%) had unusual discharge from the genitalia and 13 (12.7%) had swelling on or around the genitalia.

With regard to psychological problems, 74 (72%) blamed themselves for their victimization, 71 (69%) had fear and anxiety, 68 (66.7%) had headaches more frequently, 62 (60.8%) had lost sexual interest, 60 (59%) had low self-esteem and 35 (34%) became drug addicts [2].

Among the total study subjects 160 (24%) stated that they knew a friend who had abortion in the last one year 118 (18%) who died of pregnancy related causes, and 51 (8%) who had disability from pregnancy related causes such as delivery and abortion.

Factors contributing to sexual violence

Among the female street adolescents being raped was significantly associated with type of street life (OR=9.3, 95% CI: 5.0,18.5), older age, the association being strongly associated with age group 20-24 (OR=6.0, 95% CI: 2.7, 14.1), living alone (OR=10.81,95%CI: 5.18,20.41), forced sexual initiation (2.4, 95% CI: 1.5-4.0) and duration of street life (OR= 2.8, 95%CI: 1.2, 6.9)(Table 6).

Substance use was reported as being practiced among the population. Khat is consumed by the majority 123(19%), followed by alcohol [115(18%)], cigarette smoking [109 (16.7%)], smoking Marijuana [22(3.45%)] and benzene sniffing 10(1%). The prevalence of any substance use was found to be 29%. Substance uses were significantly associated with rape, cigarette smoking (OR= 6.0, 95% CI, 3.7, 9.9), alcohol drinking (OR=6.4, 95% CI, 3.9,11), khat chewing, (OR=6.7,95% CI, 4.1,10.8) drug use, (OR=4.9,95% CI, 1.8,12.7) and benzene sniffing (OR=5.3, 95% CI, 1.8,14.7) respectively. On logistic regression rape was found to be significantly associated with living alone (OR=8.5, 95% CI: 2.0, 3.6) and forced sexual initiation (OR=1.8, 95% CI: 1.0, 3.3) only.

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[1].The prevalence of abortion may not be from the same pregnancy

[2]. Multiple answers were possible percentages may be more than a hundred percent

Table 6: Comparison of socio-demographic factors and behavioral factors associates with sexual violence among Sexually victimized and non-non victimized street adolescents in Addis Ababa, April 2000.

Factors	Raped (102)	Non-Raped (552)	Crude OR CI	Adj. OR CI
Type of street life				
On the street	13	318	1.00	
Of the street	89	234	**9.3 (5.0, 18.5)**	1.933 (0.5, 7.4)
Age				
10-14	11	204	1.00	
15-19	65	268	**4.5 (2.3,9.7)**	1.6 (0.5, 5.0)
20-24	26	80	**6.0 (2.7,14.1)**	0.9 (.3, 2.7)
Marital status				
Married	12	57	1.00	
Single	90	495	0.8 6 (0.4, 1.8)	.9(.3, 2.7)
Educational status				
Secondary	22	138	1.00	
Illiterate	21	123	1.1 (0.5, 2.2)	1.4 (0.6, 3.3)
Read and write	4	24	1.1 (0.2, 3.5)	3.6 (0.7, 18.6)
Primary	55	269	1.3 (0.7, 2.3)	1.7 (0.8, 3.7)
Currently living with				
With relatives	14	349	1.00	
Alone	88	203	**10.8 (5.8,20.4)**	**8.5 (2.0, 36.5)**
Forced initiation n=(328)				
No	43	144	1.00	
Yes	59	82	**2.4(1.5, 4.0)**	**1.8 (1.0, 3.3)**
Smoking				
Never	57	488	1.00	
Yes	45	64	**6.0 (3.7, 9.9)**	1.09 (0.5, 2.2)
Alcohol drinking				
Never	54	485	1.00	
Yes	48	67	**6.4 (3.9,1.5)**	1.7 (0.9, 3.2)
Khat chewing				
Never	51	480	1.00	
Yes	51	72	**6.7 (4.1,1.8)**	1.9 (0.9, 3.9)
Drug use				
Never	92	540	1.00	
Yes	10	12	**4.9 (1.8, 12.7)**	1.1 (.4, 3.2)
Benzene				
Never	93	542	1.00	
Yes	9	10	**5.3 (1.8, 14.7)**	1.5(0.5, 4.9)
Duration of street life				
Less/equal to one year	8	57	1.00	
More than one year	84	217	**2.8 (1.2, 6.9)**	1.4 (.6,3.4)
Former residence				
Addis Ababa	68	408	1.00	1.00
Out side of Addis Aba	34	144	1.4 (0.8,2.3)	1.1(.6, 2.0)

Knowledge and attitudes of street adolescents towards HIV/AIDS, STDs and contraceptive use

Contraceptive use: Among the street adolescents, 394(60.2%) reported that they know how to protect themselves from pregnancy. Of those who reported to know different methods of protecting from pregnancy, 225(57%) reported to have heard the information from health workers, from friends 204(51.8), from media 291(44%), and from readings 82(20.8%).

The oral contraceptive pill was the most popular contraception method reported to be known by 358(90.9%) of adolescents followed by condom, which was reported by 351(89.1%) of the respondents. Injectables, implants and calendar methods were familiar to 305 (77.4%), 171(43.4%), and 143(36.3%) of the respondents, respectively.

Among those who were sexually active and reported to know about contraceptives, 221(77.5%) used at least one type of contraceptive during their most recent intercourse. The most popularly used method was condoms by 110(38.6%), followed by oral contraceptive pills 65(27%). Injectables 45(15.8%), and 10(9.1%) used both condoms and pills together.

Though in less proportion other modern contraception methods were also used. Of those who did not report contraceptive use during their recent intercourse at the time of the survey, 27(42%) reported to have been abstaining, while the rest gave different reasons.

Knowledge of protecting oneself from pregnancy was significantly associated with age and educational status (Table 7).

Knowledge about HIV/AIDS and STDs: Among the study participants, 579(88.5%) reported that they have heard about HIV/AIDS. Knowledge of HIV/AIDS was significantly associated with age, and educational level. The association was stronger with age group 15-19 compared to the others (OR=4.7, 95% CI 2.6, 9.1) while education there is a direct association with increase in educational level (Table 8).

Of those who reported to have heard about the disease 124 (21.4%) had the highest score by answering all the questions about the transmission of the disease correctly, 157 (27%) answered 10 questions correctly, and the mean score was 9.1 ± (SD 3.9) reflecting a 91% knowledge of preventive methods.

Knowledge about prevention of HIV/AIDS scored the highest by 70 (12.1%), of the participants answering all the 9 questions correctly. One hundred and nine (18.8%) answered 8 questions correctly. The mean score was 6.7±(SD1.5) reflecting 74% knowledge of the prevention methods. Among the commonly prevalent STDs, gonorrhea was familiar to 451 (69%), syphilis was familiar to 444 (67.9%), chancroid to 331(50.6%) and LGV was the least familiar STD reported only by 221 (33.9%) of the study subjects.

Knowledge about transmission of STDs scored the highest by 185 (28.3.1%) of the participants answering 4 questions out of 5 correctly. The mean score was 2.6 ±(SD 1.4) reflecting 51.6% knowledge of STDs among the study subjects.

From those who reported to have heard about AIDS, 182(32.4%) reported to have perceived threat of acquiring the disease. The main reasons for such perception were: the existence of non sexual mode of transmission for 55 (29%), the possibility of confronting rape 26(14%), that they are sexually active 26 (12%), that they have more than one partner 30 (16%), that they were raped 15 (8%), condom breakage 11(5%), men refusal to use condom 9(5%), the fact that AIDS is an epidemic 12(6%) and 7(4%) gave various different reasons such as my friends have it.

Those who did not have the perceived threats were the majority 391 (68%). Among the reasons for their perception of not getting the disease included: not initiated sexual intercourse 130 (33%), could protect themselves using different methods 112 (29%), using condom 53 (14%), being married 28 (7%), abstaining 28 (7%), and having a single partner 23 (5%). Others report AIDS does not exist 2 (1%), God will protect them 4 (2%), do not know the reason 9 (5%), and the rest reported every body do not have it. Perceived threat was significantly associated with increase in age, older age groups were more likely to have the perceived thereat of acquisition. There is no significant association between perceived threat and educational level (Table 9).

Table7: Knowledge of female street adolescents towards protecting themselves from unwanted pregnancy in Addis Ababa, stratified by age and educational level, April 2000. (n=654)

Variable	Knowledge of Protection		Crude OR	Adj. OR
	Yes	No	(95% CI)	(95% CI)
Age				
10-14	77	138	1.00	
15-19	237	92	4.5 (3.1, 6.8)	8 (2.6, 5.8)*
20-24	80	26	5.5 (3.2, 9.7)	4.9 (2.8, 8.7)*
Educational				
level	67	77	1.00	
Illiterate	10	13	0.7 (0.3,1.8)	0.8 (0.3, 2.0)
Read and wr	190	134	1.6 (1.1, 1.6)	2.0 (1.3, 3.3)*
Primary	127	33	4.4 (2.6, 7.6)	6.1 (3.4,11.0)*
Secondary				

*Significant association

Table 8: Awareness of HIV/AIDS (n=654) and Perceived threat (n=579) among female street adolescents in Addis Ababa stratified by level of education and age, April 2000.

Variable	Awareness of HIV/AIDS		Crude OR (95% CI)	Adj. OR (95% CI)
	No	Yes		
Age				
10-14	165	50	1.00	
15-19	315	18	5.3 (9.0,9.9)	4.7 (2.6, 9.1)*
20-24	99	18	4.9 (1.8,11.6)	3.8 (1.6,10.4)*
Educational status				
Illiterate	108	36	1.00	
Read and write	23	3	2.56 (0.7,14)	2.9 (0.79,16.6)
Primary (1-6)	293	31	3.15 (1.8, 5.5)	3.7 (2.06, 6.7)*
Secondary (8-12)	115	5	10.3 (3.8,34.6)	13.5(4.9,146.8)*
Perceived threat of acquiring HIV/AIDS				
Age	Yes	No		
10-14	23	142	1.00	
15-19	122	193	3.9 (2.3, 6.7)	3.5 (2.1,6.7)*
20-24	39	60	4.0 (2.2,7.7)	3.1 (1.7,6.4)*
Educational level				
Illiterate	38	71	1.00	
Read and write	4	19	0.4 (0.09,1.3)	0.5 (0.1, 1.6)
Primary (1-6)	84	209	0.77 (0.5, 1.28)	0.9 (0.6, 1.6)
Secondary (7-12)	59	96	1.2 (0.7, 2.0)	1.5 (0.9, 2.7)

***Significant association**

Results of the focus group discussion

The focus group discussion was conducted after creating a conducive environment among the pears from the same area. It dealt with the most sensitive issues of sexuality, the major theme being attitudes, practices, knowledge, consequences and prevention of rape. The experience of both the "on" the street and the "of" the street boys were almost similar and both groups were free to discuss their experiences. Some discussed the experiences of their friends and what they knew and observed, while others discussed their own experiences of forcing girls in to sex and their frank attitudes towards rape.

There is a consensus among the four groups as to the existence of rape among the street population. Majority believed that rape occurs to girls usually because they are at the wrong place in the wrong time and they are also drug and alcohol abusers. It is the girls that initiate the boys by speaking provocative words or by showing acts that invite boys. It was discussed that rape on the street was used as a means of penalizing misbehaved girls. One of the boys shared his experience by saying " a girl who was cohabitating with their friend started an affair with another man secretly, their friend heard about it and when she came back they raped her in group of more than five". They also stated that girls who refused when they are invited for sex would love it when they are forced. One boy described his experience as follows: "I loved the girl very much but she had a friend, when I approached her the boyfriend gave me a bump on my cheeks and I lost my front tooth. Then one night I went to where she slept, she was sleeping on her back I

got closer to her quietly and torn her pants and started having intercourse, she woke up, called my name and hug me. She liked it and I was very happy because I got her at last." Some of the participants reported that it happened to lonely (friendless) girls who are usually new comers and substance users. Boys who are drug and substance users are also reported to commit rape.

Some of the boys almost in all groups reported that girls are inferior to boys, and on the street girls usually live either depending on boys or begging. Their dependence predisposes them for their victimization. To avoid the use of force girls should accept the sexual advances afforded by men otherwise they will be bitten or torn on the face with blade and will be raped so that they would not forget it.

Some of them explained that rape is not a good thing and shall be avoided, but others believe it is a good penalty for "bad girls" (those who refused to do it when they are asked peacefully). Raping a girl was reported by eight of the participants. It was usually happened in groups of 5-11. One of them who had experienced gang rape described his experience as follows " It was mid night and I was asleep when my friends brought one girl and every one was raping her turn by turn, I woke up and joined them."

Among the participants who have heard about rape, they said that it usually occurred by groups of 10-25 boys. One boy reported, "The woman was mentally sick and she was walking at mid night, the boys took her to a park while she was screaming. Later her

voice went down. I called a police and when we reached there she was not responding, we took her to a mission hospital then she was not able to walk for the next few days."

Summary of the focus group discussion

Reasons for a street adolescent girl to be raped

- Girls/women are inferior to boys/men
- They are there at the wrong time
- They are raped for revenge
- Girls being drug and alcohol addicts
- Loneliness and being new to the street

Attitudes towards raping of a girl:

- Girls are shy and do not ask for it, so one has to force them
- Once you start it they will like it.
- Raping a girl is not interesting but girls sometime initiate it by using provocative words and being drunk.

Practice: Eight of the boys reported their own practices while 12 reported what they witnessed. Personal practices included raping by force either by oneself and or in-groups. Rape usually occurred at night, if a girl sleeps on the street her chance of being raped is very high. Even in the daytime there is a chance of being raped if they sleep in a hidden place. Threats of harm and physical violence are the major mechanisms used to intimidate the girls. Among the mechanisms of violence, incising with a knife/blade on the face to create an unforgettable mark and slapping were reported as common tools. Rape happens to girls and women of all age groups. One boy witnessed a girl of 10 years

age being raped by a 20 years old young man and another boy reported his own practice of raping an older woman who was passing by his sleeping place.

Consequences of rape

As reported by the boys in the focus group discussion, the commonest consequences to females include STDs, unwanted pregnancy, uterine problem, suicide, and other psychological problems. There are also problems for the boys. One of the boys reported contracting chancroid after raping a girl.

Prevention

As a method of preventing rape the boy's group suggested the following: Educating girls and boys about the problem, employing both boys and girls in some kind of activity that makes them busy, and night shelter for girls. Penalizing those who rape by imprisoning for longer period will also be a lesson for the others.

DISCUSSIONS

Information about street children in general and rape in particular is scarce in our country. The unstable lifestyle of street children follow; lack of trust and the inconvenience of interviewing on the street and the difficulty of age classification could be stated as major reasons for the scarcity of systematic research in this area (24). This study has utilized a cross-sectional quantitative survey among female street adolescents and a qualitative study among boys. Due to methodological differences and variable population selection direct comparison of findings was difficult, but some how comparisons are made with the available studies. Such as studies from the US and Australia were used.

As examined in the study the predictors of sexual violence as basic causes such as rape myths, sex role stereotyping, deviant behaviors, loneliness, (social fragmentation) on the one hand and economic dependence of women on men on the other hand were clearly seen. In the street both boys and girls are poor but girls are more dependants on men either as means of protection from violence or as a means of subsistence. The belief that men are stronger and girls are weaker is highly prevalent in this population. As a result the aggressive nature of boys and the low self-esteem of girls is seen profoundly in the FGD, which predisposes and intimidate girls for easy submission. Further more the substance use of both boys and girls to ease their problem, and the belief that non-acceptability of prosecution of perpetrators by police, makes the girls accept the risk of violence. Hence the fundamental causes, the intermediate causes and the immediate causes are seen here to be the risk factors of violence.

The quantitative study has identified the major reasons for streetism to be economic in the majority of the cases followed by displacement, war and being orphaned (like everywhere else) (15).

In this study, it was found that 50.2% of the study subjects have initiated sexual intercourse, 43% of the respondents initiated it as a result of rape. This prevalence lies with in the prevalence rates in the literature 7-62% (9,19). The age of the victims ranges from 6-24 and the mean age of first sexual debut was 15 years. This is higher than the age of initiating of the Brazilian study, 11 years. One possible explanation for this could be that the upper age group included in the Brazilian study was 18 years (24). Rape as a reason of sexual initiation is similar to that of the Brazilian study, whereby the majority initiated as a result of coercion. In a South African study of adolescent sexuality, 31% of pregnant teenagers and 18% non-pregnant teenagers started sexual intercourse as a result of coercion (43).

The perpetrator was older than the victims in 88% of the victims in this study, which is higher than the Brazilian study i.e. those who initiated sex before the age of 12 initiated it with an older person in 53% of the cases; this can be explained by the late sexual initiation pattern of boys than girls (24).

The prevalence of rape in the last 3 months recall period was 15.6%, which is comparable with that reported in a US study of 13.6% (18). Since result is of only 3 months it can be explained as higher. The prevalence in this study is also higher than the study conducted among high school students in Addis Ababa and Western Shoa,

whereby the life long experience of rape was 6%(31). This can be explained by the nature of the study population.

Unwanted sexual advance like kissing was reported in 107(16%) of all the participants. This finding was comparable to the Queensland studies in absolute percentages only where 17-19% of all females experienced unwanted kissing in their lifetime (21). But ours is still higher for the reasons mentioned above.

Unlike other studies, which underline that (60-78%) of the perpetrators were known to the victims, this study revealed that 66% of the victims did not know the perpetrators. This finding is also supported by the male focus group discussions, which showed that rape usually happens to new girls and boys usually do it in-groups of more than 5. The other explanation as mentioned by the focus groups was that the perpetrators in the street were usually young boys who came from villages and are usually drunk. As a gang the street boys refer these types of boys as "Findata"(new and hot tempered). These are also reported to be a threat for the street boys if they interfere to stop the assault.

Naturally if a woman is raped repeatedly, the attack is deemed to be by a family member or by an intimate partner as found in other studies (18,19). However in this study different individual usually in gangs perpetrated 83% of the victims of repeated rape. This can be explained by the nature of the study population.

In this study, 80% of the victims did not report to the police after the assault. This proportion is higher than the results found in other studies whereby, up to 50% of

women might not tell to anyone (39). This might be explained by the reports of the victims them selves as fear of un-acceptance by the police.

There is a significant association between increase in age and rape in the last 3 months period but this significance was lost after controlling for confounding using logistic regression. Other studies showed the likelihood of being raped is increased as the age increases (19,31). This difference can be explained by the life style of the street adolescents whereby age is not a risk factor and it is also seen in the focus group discussion that the possibility of being raped is there for all age groups. Living alone is significantly associated with rape. This fact is supported by the reasons given in the survey by the female group whereby being helpless was mentioned as a major cause for their victimization. The male FGD also mentioned that loneliness and being new was the predictor factors of rape among girls. The findings of this study is consistent with the study undertaken in Addis Ababa and Western Showa among high school students whereby living alone was one of the factors contributing for rape (31).

Forced first sexual debut (can be considered as child hood sexual assault since the lower age range of the victims was 6years and 70% of those who were victimized were in the age group of 13-18 years of age) is significantly associated with rape in the last 3 months period. This is comparable with other studies elsewhere (8, 25). The reasons given by the girls for their victimization as being female is consistent with literature. Girls who had survived child hood sexual assault accept victimization as part of being female, and in their future life they are unable to protect themselves (25).

The prevalence of any substance use in contrast to their living status is relatively small. This may be as a result of underreporting due to the fact that substance use is a taboo among females and especially drug use is illegal in Ethiopia. However substance use like alcohol, smoking, khat chewing benzene sniffing and drug were significantly associated with rape, while after adjustment with logistic regression none of the these factors were significantly associated with rape in the last 3 months.

The prevalence of attempted rape was (20.4%), which is higher than the (10%) prevalence of the high school study in Addis Ababa and Western Showa. This implies that there is high risk of rape on the streets, and the life skills that girls used in escaping the attempt is found to be useful. In violent situation effective self-defense was reported by 123 (66%) of Nicaraguan women against domestic violence (44). The same can be used on the street as reported by the respondents yelling for help, fighting back, getting home early and sleeping on a safe place were the life skills that helped them to escape the assault. This was also supported by the focus group discussion that girls who are quite during an attempt were reported to be vulnerable to completed rape, and those who did not shout are considered to like it.

As a consequence of rape, the prevalence of unwanted pregnancy was 23% and induced abortion was 15%. This is comparable with the Bombay study whereby 20% of abortion seekers got pregnant as a result of rape (29). This result was higher than the high school study undertaken previously in Ethiopia whereby 16% of the rape victims were pregnant (31). Forty-five percent had unusual vaginal discharge and 13% had

swelling around the groin; this can be stated as having STDs, this is comparable with the US study of rape related pregnancy whereby up to 40% of the victims had STDs (18). Genital trauma was reported by 26% of the victims, which was higher than the US study of 19-22% and that of the Ethiopian study; this might be due to the gang rape occurring in this population.

Rape victims in this study reported to have had several psychological problems. A large proportion of the victims reported to have blamed themselves for their victimization 72%, had low self-esteem 58%, have become drug and alcohol addicts 35.3%, have had attempted suicide 45.1%. The reported prevalence of suicide was higher than the study undertaken in Addis Ababa among high school students in which the prevalence of suicide ideation was 8% (31). This can be explained due to the nature of the population. This is comparable with the results of the New Zealand study that 35% Childhood sexual assault victims were reported as a case of posttraumatic depression, 24.5% of them were drinking alcohol at a hazardous level, and 26.4% had an attempted suicide in their lifetime.

The attitude of boys towards raping girls was similar to other studies, in which the boys groups blame the girls for their victimization. If the girl is at the wrong place at the wrong time, if she is provocative by communicating in a sexual manner, if she is drunk or used drugs, the likelihood of being raped is very high. She will also be penalized by rape usually in-groups, if she did "adultery"(if she had an affair with another person while she had a street boyfriend or cohabitating with some one on the street) or if she

refused sexual advance. The notion of penalty was consistent with the Brazilian street youth "ronda" which was described as a way of making girls available sexually to the group as well as to punish transgressors (24). The practice of raping girls was supported by the male focus groups discussion where by, some of the participants reported they have individually or in-groups raped girls. This is comparable to the study conducted by Kilpatrick among male college students where some admitted sexual aggressive acts and 7.7% of the men admitted to have been involved in rape or attempted to rape. This is also comparable with the Canadian and Californian studies whereby 20% of males reported to have high likelihood of raping (3 or more in the scale) and 33% some likelihood of raping two or less on the scale (39). In the Los Angeles study the acceptance of rape was described by the following phrases: "when the girl gets a guy sexually exited", "When she changes her mind after agreeing to have sex" and "when she led him on". In that study 56% of the girls, and 76% of the boys believed that force was acceptable. The other reason reported by the male group, in our study for the victimization of girls was their sex; they described it, as they are female and weak. The female group in the survey also supported this and also the use of force by male. This is comparable with the Brazilian study of street youth where girls needed to find a way to survive on the streets, unless they had someone to protect them when they were away from home (24).

A 60% knowledge of protecting oneself from pregnancy was reported. This knowledge of protecting oneself from pregnancy was significantly associated with age whereby the

association was stronger with increase in age. Of those who are sexually active (n= 328) contraceptive use in the last sexual intercourse was 212 (77%); this was the highest among the "of" streets, this is because of their lifestyle. This knowledge is comparable to the knowledge of contraception methods among women at reproductive age that was 62.2% and age group 20-24 had the highest knowledge. Compared to the Indian study of adolescents knowledge, ours is lower since they know at lest one method of contraception (28,45).

With regard to knowledge of HIV/AIDS, 88 % of the adolescents had heard about HIV/AIDS, which is comparable with out of school youth of Addis Ababa whereby almost all have heard about the disease (46). Beliefs about prevention of HIV/AIDS were the lowest (38%) among street adolescent in the study at hand when compared to the perceived threat of vulnerability of out of school youth of Addis Ababa, which was (53%). Knowledge of HIV/AIDS was strongly associated with increase in age and educational level. This can be explained by some of the activities undertaken by different non-governmental and governmental agents and their information sharing life style. Perceived threat had a significant association with age, whereby age group greater than 14 had the highest threat. This is as a result of their susceptibility to rape and or they are sexually active. This association was the highest among the "of" the street adolescents.

A 91% knowledge of transmission methods and a 74% knowledge of prevention methods may signify an overall knowledge of HIV/AIDS among this population. This

can be comparable to the overall knowledge of runaways in New York City (47). Four out of six questions were correctly answered as to the knowledge of transmission of STDs by 28.3% of the respondents. This is higher than the Bombay study among adolescents whereby only 10%of both girls and boys heard about STDs and none of the 85 girls could name at least one STD (31).

STRENGTH AND LIMITATION OF THE STUDY

The study is not without limitations; lack of reference material for comparison was one of the limitations of the study. The use of short recall period (three months), the sensitivity of the issue and the use of interview, might have under estimated the magnitude of the problem. However the use of focus group discussion and relatively large sample are believed to provide reliable and accurate findings. The other strength of the study was the short time frame and the collection of data in adjacent woredas in the same day that is believed to minimize double counting.

CONCLUSIONS AND RECOMENDATIONS

The findings of this study indicated that the street adolescents are at high risk of sexual violence (rape). History of childhood sexual abuse, living alone, and alcohol drinking, low self–esteem of girls and the dominant nature of boys are the major contributing factors of rape in this population. Their awareness of STDs and contraceptive use is high despite their life style. But using contraceptive and protecting themselves from STDs including HIV/AIDS is beyond their control since they are always at high risk of being raped due to both their young age and lack of family protection. Alleviating this problem requires a major socio-economic change, but recommendations that can be implemented in the short run in order of priority are:

- Introduce a rape crisis center in the health institutions and prepare a standardized treatment for STDs including anti-retroviral prophylaxis, emergency contraception and counseling to alleviate psychological problems.
- Wide spread public education and efforts to protect girls and women against unwanted sexual acts and rape.
- Law enforcement to protect girls and women against rape.
- Training of girls on life skills of preventing sexual assaults.
- Providing night shelter for girls who are already on the street.
- Efforts in protecting girls from going out to the streets and family reunion for those who have parents shall be enforced with the collaboration of all who are concerned.
- Further longitudinal studies in the consequences of early childhood sexual assaults and a systematic study on the attitude of men towards rape.

REFERENCES

1. Heisie LL, Rakes A, Watts CH, Violence Against Women, A Neglected Public Health Issue in less Developed Countries. Soc. Sci. med, 1994 November; 39(9): 1165-1179
2. Chaundhary S, Sangani B, Retrospective study of alleged sexual assault. East Africa Medical Journal. 1993 March; 72(8): 200-202
3. Clarck L, Lewis D. Rape the price of Coercive sexuality. Toronto: Women educational press, 1977
4. Porteous T, Alexander C. Sexual Assault in our society. In: Flora Macieod editors. Victim support handbook. British Colombia: Justice institute 1989: 3-14
5. Encyclopedia Britannica. 5thed volume 9. USA. University of Chicago, 193:941
6. Academic American Encyclopedia. Volume 16, 16thed. USA. Grolier Incorporated, 1986: 10-11
7. Encyclopedia Americana. Volume 23.USA. Grolier Incorporated, 1995:255.
8. Shirley P. and Janet T. Types of sexual assault. In: A book about Sexual Assault. Montreal Health Press Inc. 1987: 4-22
9. Heise L, pitanguay J, Germain A. Violence Against Women the Hidden Health Burden. World Bank discussion papers. 1994 (255): 1-38.
10. Finklhor. K. Gender Domestic Violence and Sickness in Mexico. Soc. Scie. Med. 1997November; 45(8): 1147-1160.

11. Sandra L, Kathleen TE, Kathryn A. Clark, Dorothy C. Violence and substance use among North Carolina pregnant women. American Journal of Public Health, 1996 July; 7(86): 991-998.

12. Marcinainika CM. Adolescents Attitudes towards Victim Perception of Rape. Violence and victims.1998; 13(3): 287-300

13. Ebrahim G J, Street Children a pediatric concern of growing proportions TropicalPediatrics.1984; 30(8): 130-1

14. James A. Farrow, Robert W, Deisher, Richard B. Journal of Adolescent Health 1991; 12:497-499

15. Tycoon P. Protection Respect and Opportunity for Street Children of Ethiopia: Consolidated report to UNICEF representative; 1991 Addis Ababa.

16. Ministry Of Labor And Social Affair/UNICEF/UCC: Study On Street Children In Four Towns In Ethiopia, 1993.

17. Royal Tropical Institute Sexual Exchange. Prevalence of and attitudes towards abuse. Asexual exchange report 1998:1-3

18. Holmes MM, Heidi S, Renick, Dean G, Kilpatrick, Rape related pregnancy estimates and descriptive characteristics from a national sample of women. Am J Obstet Gynecol 1996; 175(2): 320-5.

19. Meursing K, Vos T, Countinn o, Moyo M, Mpofus, Oneko O, and etal. Child sexual abuse in Matabeland Zimbabwe. Soc. Scie.Med. 1995; 41 (12) 1693

20. Hesie L, Kanti M, Nahdi T, Sexual coercion and women's reproductive health: A focus on research.1995: New York, Population Council.

21. Goldman J. The prevalence and nature of child sexual abuse in Queensland, Australia. Child Abuse and Neglect.1997; 21(5): 489-498

22. Women 2000, United Nations Division Of The Advancement Of women. Sexual Violence and the Second World War. 1998 April: 3-4

23. Finkholer D. In: Sexually victimized children. Consequences to the victim 1981:1-30 Macmillan publishers.

24. Raffaeilli M, Campos R. Merritt P A, Siqueira E, Antunes MC, Parker R,and et al, Sexual practices and attitudes of street youth in Belo Horizonet, Brazil. Soc. Sci. Med.1993 Sept; 37(5): 661-670.

25. Deisher R W, Rogers Ii, William M. The medical care of street youth. Journal of Adolescent Health special issue 1991 Nov; 12(7): 500-503.

26. Mullin PE. Martin JL, Anderson JC, Roamans SE, and Herbison GP. The long-term impacts of the physical emotional and sexual abuse of children a community studies. Child Abuse And Neglect 1995; 19(2): 261-264

27. Moncerief J, Coline DD, Candy B, Checinski K, and Farmer R. Sexual abuse in people with alcohol problems. British Journal of Psychiatry 1996; 169:355-360

28. Gibbons J. Services for adults who have experienced child sexual assault: Improving Agency. Soc. Sci. Med. 1996; 44(12): 1755-64

29. Jejeebhoy S J. Adolescent sexual and reproductive behavior: A review of the evidence from India Soc. Sci. and Med.1998: 46(10): 1275-1290.

30. Extracted from records of Addis Ababa City Administration Police Commission, 1994-2000.

31. Mulugeta E. Prevalence, attitude and factors related to sexual violence among high school students in Addis Ababa and West Showa. [Dissertation]. Addis Ababa Ethiopia: Addis Ababa University, 1996.

32. Daniel G. Child sexual abuse in Addis Ababa High Schools. Addis Ababa Ethiopia: Forum for Street Children, 1998.

33. Chelhesa D. Incidences of child abuse in four woredas in Addis Ababa. The Ethiopian Journal of education 1998 June; 18(1): 19

34. Ethiopian Women's Lawyers Association Activity Report. 1999 Oct: 12

35. United Nations Convention of The Rights of The Child. New York.

36. Assal IF. Corporal and Spiritual Punishment For Fornication. In: Peter L, Strauss editors. The Ftha Nagest the law if the kings. Addis Ababa, Haileselassie The First University, 1968: 297-301

37. The Ethiopian Penal Code. 1957 Addis Ababa: Brhanena Selam.

38. Woldegiorgis O. Rape and abduction in Ethiopian law. Addis Ababa.

39. Schwartz Il, Sexual Violence Against Women. Prevalence, Consequences, Societal Factors, and Prevention. American Journal of Preventive Medicine 1991; 7(6): 363-371

40. Kornbalt AL. Domestic Violence: An emerging health issue. Soc. Sci. Med. 1994 Nov; 30(9): 1181-1188.

41. Peggy RS. Female power and male on the origins of sexual inequality. University of Pennsylvania Cambridge University Press, 1984.

42. Federal Democratic of Ethiopia Office of Population and Housing Census Commission Central statistics authority. The 1994 population Census of Ethiopia. Results for Addis Ababa April 1996.

43. Wood K, Maforh F, Jewekes R. " He forced me to love him" putting violence on adolescent sexual health agendas. Soc. Sci. Med. 1998; 47(2) 1233-242

44. Mary E., Anna W. Women's strategic responses to violence in Nicaragua. In: Mary E. editors. Candies in hell research and action on domestic violence against women in Nicaragua: Epidemiology Department of Public Health and Clinical Medicine, Umea University, Sweden, 2000: Part IV .

45. Tekalenge A. Barriers to access to modern contraception in Addis Ababa, Ethiopia [Dissertation]. Addis Ababa: Addis Ababa University, 1988

46. Abate S. Determinants of High Risk Sexual Behaviors for HIV/AIDS among out of schools youth in Addis Ababa, Ethiopia [Dissertation]. Addis Ababa: Addis Ababa University, 1999.

47. Rotheram MJ, Kopman C. Sexual risk behaviors attitude knowledge and beliefs among runaways. American Journal of Public Health 1991 Feb; 81(2): 209-210

Annex (1) Ethiopian penal code 1957

Article 589 states that (1) Who so ever compels a woman to submit to sexual intercourse outside the wedlock, whether by the use of violence or gave intimidation, or after having rendered her unconscious or, incapable of resistance, is punishable with rigorous imprisonment not exceeding ten years. Rigorous imprisonment shall not exceed fifteen years where the rape is committed:

(a) On a child under 15 yeas age; or (b) on an inmate of a hospital, alms-house or asylum, or any establishment of education, correction, internment or detention, who is under the supervision or control of or dependant upon the accused person; or (c) by a number of persons acting in concert (30).

Articles 590, 594(2), 595(2) stated different

Article 590. Sexual outrages accompanied by violence: who so ever, by the use of violence or grave intimidation, or after having in any other way rendered his victim incapable of offering resistance, compels a person of opposite sex, outside wedlock, to perform or to submit to an act corresponding to sexual act, or any other indecent act, is punishable with rigorous imprisonment not exceeding eight years, or with simple imprisonment for not less than six months (30).

One of the elements of article 589 states that the man and women must be tied in wedlock; the husband's rape of his wife is thus excluded. This is the traditional

definition of rape in many countries, but some countries are revising their low especially when the spouses are separated. The issue of marital rape is a difficult one because of the duty of spouses to have sexual relations with each other. The generalization of marital rape is also opposed on the ground that it would create resentment and destroys family harmony (31)

Article 594(2): ``who so ever cause on infant or young person under fifteen years of age, other than his own child to have sexual act with him, is punishable with rigorous imprisonment not exceeding 5 years (30).

Article 595(2): who so ever has sexual intercourse or performs sexual intercourse or performs analogues act with minor of the opposite sex of more than fifteen and less than eighteen years of age, is punishable with simple imprisonment (30).

The above distinction for punishment with in the two age groups reflect the country's traditional stance as to who is a child with age 15 often being taken as marriageable age for girls (32).

Annex.2

RAPE PREVENTION METHODES [1]

Feeling yes, Feeling no

Feeling yes is a positive feeling that is not always having sexual connotation and a feeling of caring about a person. Feeling no is a feeling that is indicating a possible sexual assault situation, such as a nagging feeling that some thing is not right and the like. Once we can recognize the no feelings we have to learn to act on them.

There is no single, correct way to handle an assault situation. The actions one takes depend on the how well you know the man, how frightened you are and how dangerous you consider the situation to be. However there are some reactions to assault situations that do not work in a woman's favor. Recent research shows that crying and pleading usually make rapists more determined. Rape is an act of power and hostility and rapists usually pick people who look easy victims. Effective fighting back both verbal and physical greatly increases your chance of getting away.

Assaults by some one you know: If a woman is seeing some one she barely knows arranging to meet him in a public place minimizes the risk.

[1] Source: A Book About Sexual Assault Montreal Health Press Inc. 1987

On-going sexual relationships: This violence is often accompanied by sexual coercion. As with any dangerous situation it is advisable to avoid one self from the scene until tempers have cooled. The best long-term strategy to deal with sexual assault

in an on-going relationship is to immediately acknowledge that it has occurred. Speak to some one who will take your concerns seriously and will help you explore your options.

On non-sexual relationships: prevention of sexual coercion in a friendship depends on open, frank communication. A discussion of how sexual involvement could affect the relationships.

On employment: If an employer teacher or doctor makes sexual comments or suggests inappropriate encounters, make your discomfort known from the very beginning. As institutes have some policies towards harassment, make your harasser know that you are aware of this polices.

On the street: Being alert and attentive to ones environment is an important skill to women especially for walks alone. Pick a route, which allows you to be near activity. Try to avoid streets where there are no lights. If you are followed cross the street and go opposite. If following continued shout and ask him what he is looking for. This may throw him off balance and may convince him that he is choosing the wrong person for victimization.

Self-defense: A good strategy for sexual assaults prevention is to take a woman's self–defense course. Self –defense courses given by women are specifically designed to deal

with the helplessness many women fell when confronted with an assault. Research clearly shows that women who verbally and physically resist their attackers are much more likely to avoid rape and much less likely to experience depression after the attack.

Annex 3:

Scoring instrument

Transmission of HIV/AIDS

Promiscuity	Yes=1 No=0
Unsafe blood transfusion	Yes=1 No=0
Using contaminated needless	Yes=1 No=0
Unsafe sexual Intercourse	Yes=1 No=0
Mother to child	Yes=1 No=0
Mosquito	Yes=0 No=1
Sharing toilet	Yes=1 No=0
Shaking Hands	Yes=0 No=1
Welcome kiss]	Yes=0 No=1
Curse	Yes=0 No=1
Others	Yes=0 (since all the answers in the others sections were not correct) No=1

Prevention of **HIV/AIDS**

Abstinence	Yes=1
	No=0
Condom use	
	Yes=1
	No=0
One faithful partner	Yes=1
	No=0
Unsafe sexual Intercourse	
	Yes=1
	No=0
Avoid using unsterile needles	Yes=1
	No=0
Avoid mosquito bites	
	Yes=0
	No=1
Avoid sharing toilet	
	Yes=0
	No=1
Having good nutrition	
	Yes=0
	No=1
Using screened Blood	
	Yes=1
	No=0
Having sex after and with in marriage only	
	Yes=1
	No=0
Others	Yes=0 (since all the answers in the others sections were not correct)
	No=1

Annex 4.

Questioner and discussion guides

Discussion guide to Asses attitude knowledge and practice of male street adolescents towards rape

Theme of the focus group

Introduction

Introduction of the moderator and note takers with the participants

Introduce the aim of the study

Obtaining consent

Warm-up discussions

How is life on the streets?

How are your relations with the girls on the street?

Have you heard about rape on the street? Probe; probe.

Any practices or witness of rape on the streets? Probe; probe.

Why do you think girls are raped? Probe; probe.

Any consequence of rape you may think of?

What do you think can be done to stop rape on the streets?

INDIVIDUAL CONSENT FORM

Dear sisters`

Hello my name is ----------. I work for Addis Ababa university. We are conducting a survey in selected areas of Addis Ababa to learn about problems of adolescents, you have been chosen to participate in this study by convenience.

We want to assure you that all your answers will be kept strictly secret. We will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you do not want to answer. There are no right or wrong answers. Some of the questions are personal and difficult to talk about, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary but your experience's could be very helpful to other adolescent in the country.

Do you have any question?

The interview takes approximately 45 minuets and will pay for the time lost in our interview.

Note whether respondent agrees to interview or not

[ ] Does not agree to be interviewed

[ ] Agrees to be interviewed

Thank the participant for her time and end,

To be completed by the interviewer
I certify that I have read the above consent procedure to the participant.

Signed:

A questionnaire prepared to determine sexual violence and its determinants among street adolescent in Addis Ababa March 2000

RECORD THE TIME		Hour [ ] Minutes [ ]	
PART I, SECTION ON SOCIO - DEMOGRAPHIC DATA			
QUESTIONS & FILTERS		**CODING CATEGORIES**	
1	Respondents age in years	[ ]	
2	Religion	1. Orthodox 2.Other Christians 3. Muslim 4. No religion 5. 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. church school 3. Koran school 3. Primary 1-6(grade) 4. Secondary 7-12(grade) 5. Above high school level	
5	Are you currently attending school?	1. No 2. Yes	
6	Where was your permanent residing area before coming to Addis Ababa?	1. Addis Ababa urban(skip to 9) 2. Addis Ababa rural 3. Urban outside of Addis Ababa 4. Rural outside of Addis Ababa	
7	If your answer for number 5 is outside of Addis when did you come to Addis ?	[ ]	
8	Why did you come to Addis Ababa?	1. Looking for work. 2. Influenced by a friend. 3. Following a stranger. 4. Attracted by city life. 5. To find a lost relative 6. Pregnancy 7. School failure 8.Rape by a guardian/close relative 9. Any other reason specify	
9	Number of siblings (Make an + if mom or dad, otherwise fill number	**1.Father[ ]** **2.Mother[ ]** **3.Sister [ ]** **4.Brothers[ ]** **5.Others[ ]**	

10	Mothers educational level	1. Illiterate 2. Read and write 3. Primary 1-6(grade) 4. Secondary 7-12(grade) 5. Above high school level	
11	Fathers level of education	1. Illiterate 2. Read and write 3. Primary 1-6(grade) 4. Secondary 7-12(grade) 5. Above high school level	
12	**Parental condition**	**1.Both are not alive** **2.Mother only** **3.Father only** **4.Both are alive**	
13	With whom are you currently living?	1. Married 2.Both parents 3. Father only 4. Mother only 5. Step parents 6. Uncle /Aunt 7. Grand parents 8. Other relatives 9. Organization 10. Alone 11.Others	
14.	What supports do you get from parents/guardian or organizations (more than one answer is possible) 1. None 2. Food 3.Clothing 4. Shelter 5. School fee 6. Others	**No Yes** **1 2** **1 2** **1 2** **1 2** **1 2** **1 2**	
15	Age at leaving home?	[ ]	
16	What was the reason for leaving home?	1.Forced out by parents 2. Influenced by peers 3. To be free from family control 4.Physical violence by parents/family members 5.Sexual abuse by members of the family 6. Influenced by a boy friend 7.Bribed by an adult 8. To stand by myself 9. Marriage 10. Pregnancy 11.School failure 12.Others (specify) [ ]	

17	Where do you sleep at night?	1. On the streets 2. By paying overnight 3. Plastic houses 4. Relative house 5. Others (specify)	
18	What is your main source of income?	1. No income at all 2. vending 3. Changing sex for money 4. Begging 5. Others (specify) [ ]	
19	What is your daily income on the average	1. none 2.Less than 5 birr 3. 5-10 birr 4. 11-15 birr 5. Greater than 15 birr	

PART II. Section on substance use			
1	Do you smoke? If yes: on the average how many cigarettes did you smoke in a day	1.Never 2. Less than 10 3. 10 to 20 4. more than 20	
2	Did you drink alcohol ? If so how often do you drink?	1. Never (skip to # 5) 2. Every day or nearly every day 3. 3-4 times a week 4. Every week 5. Every month 6. Only on holidays and public holidays	
3	On the days that you drunk in the last three months how many drinks did you usually have in a day?	Usual number of drinks [ ]	
4	Why do you drink alcohol?	1. Do not know 2. Because my friends do it 3. To be happy 4. To get warmth 5. To avoid misery 5. Others specify	
5	Do you chew chat? If yes how often?	1 Never (skip to # 7) 2. Every day 3. 3-4 times a week 4. Every week 5. Every month 6. Some times	

6	Why do you chew chat?	1.Peer influence 2. To be happy 3. To get warmth 4. To avoid misery 5.Others (specify)[ ]	
7	Do you take drugs like Marijuana? If so how often?	1. Never(Skip to #9) 2. Every day 3. Every other day 4. 3-4 times a week 5. Every week 6. Every month 7. Some times 8.Others	
8	Why do you take these stuff?	1. Because my friends do it 2. To be happy 3. To get warmth 4. Help to forget misery 5. Others (specify) [ ]	
9	Do you sniff Benzene? If yes, how often?	1 Never[Skip to # 1, part III) 2. Every day 3. 3-4 times a week 4. Every week 5. Every month 6. Some times 7. Others (specify) [ ]	
10	Why do you sniff Benzene	1. Because others do it 2. To be happy 3 . To get warmth 4. Help to forget misery 5. Others (specify) [ ]	

PART III SECTION ON SEXUAL VIOLENCE			
1	Have you ever had sexual intercourse?	1 No (Skip to #7) 2 Yes	
2	Age at first sexual debut	[ ]	
3	What made you have your first sexual debut? (If your answer is other than # 6 skip to# 7)	1. Marriage 2. Personal desire 3. Persuaded by friends 4. Promising words from partner 5.For exchange of property or money 6.Forced 8. Others (specify) [ ]	
4	Who was the perpetrator?	1. Close relative 2. A brothers friend 3.Neighbors 4. A boy friend 5 An unknown person 6. Other (specify) [ ]	

5	Age of the perpetrator?	1.About your age 2. A bit older than your age 3. Very old person 4. Others {specify}}[ ]	
6	Mechanism used to force you?	1.Hit you 2.Pointed a knife 3.Pointed a gun 4.Threats of harm 5.Made you drunk 6.Made you use some drugs 7.Others (specify) [ ]	
7	Did you face anon consensual sex in the last 3 months.	1. No 2.Yes	
8	If the answer for #7 is yes, how many times was it?	1. Once 2. 2-4 times 3. More than five times(Specify)	
9	Did you face non consensual unwelcome kissing the last three months?	1 . No (If the answer for #7, and 9 is no skip to #23) 2. Yes	
10	If the answer for #8 and is yes, how many times was it?	1. Once 2. 2-4 times 3. More than five times (Specify)	
11	If it was repeated was it by the same person?	1. No 2. Yes	
12	If the perpetrator was the same person, what was your relation with him.	1. Boy friend 2.Co-habituating 3.A stranger 4.neighbor 5.Others	
13	If it was repeated, what do you think the reason is.	_____	
14	Do you think you can prevent farther rape?	1. No 2. Yes	
15	If the answer for # 13 is yes how do you prevent it ?	_____ _____ _____	
16	If the answer for # 13 is no, what is the reason ?	_____ _____	
17	Whom do you share the event after you were raped?	1. No one 2. A friend 3. A sister/brother 4. Health professional 5. To parents 6. Others (specify) [ ]	
18	To which legal body did you report after the event?	1. Did not inform 2. To the police 3. To kebele administration 4. Other legal bodies[ ]	

19	Action taken by legal bodies on the perpetrator	1. None 2.Imprisonment 3.Financial penalty 4.Financial compensation levied by elderly 5. Forced to marry 6.Others.	
20	If the answer for # 17 and 18 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 (specify). [ ]	**No** **Yes** 1 2 1 2 1 2 1 2 1 2 1 2	
21	Did you have any of the symptoms following rape? 1.Pregnancy 2.Abortion 3.Ulcer in the genitalia 4. Un usual discharge from the genitalia 5. Swelling around the genitalia 6. Others	No Yes 1 2 1 2 1 2 1 2 1 2	
22	which of the following did you experience after a forced sex in the last three months ? 1. Often have headaches 2. Poor appetite 3. Bad sleep 4. Easily frightened 5. Hands shake 6.Blame yourself for what happened 7. Hate others for what has happened on you 8. Feel unhappy 9.Cry more than usual 10. Loose interest in sexual intercourse 11.Become addicted to alcohol or substance like chat, marijuana and so on. 12. Daily life suffering 13. Lost interest on things 14. Fell that you are a worthless person 15.Thought of ending your life 16 Tired to take your life 17. Fell tired 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 1 2 1 2 1 2	

23	Have you faced an attempted rape? If yes how do 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. By forming a gang 9. Others (specify) [ ]	No Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
24	Do you know a friend who was raped in the last 3 months	1 . No 2. Yes	
25	Do you know a friend who was kissed forcefully in the last three months?	1 . No 2. Yes	
26	Do you know a friend who had an abortion after a forced sex in the last one year?	1.No 2. Yes	
27	Do you know a friend who had died of causes related to pregnancy ?	1. No 2. Yes	
28	Do you know a friend who had died of causes related to pregnancy ?	1. No 2. Yes	
29	Do you know a friend who went to the police and accuse the rapist? If yes what happened to the rapist?	1. Do not know 2. Released free 3. Imprisoned 4.Others (specify) [ ]	

PART V, SECTION ON AWARENESS OF CONTRACEPTIVE USE, STDs INCLUDING HIV/AIDS			
1.	Do you know how you protect your self from pregnancy?	1. No(skip to #7) 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 specify	
3	Where do you get the information 1. A friend 2. Family member 3. Health professionals 4. Printed materials 5. Radio 6. TV	No / Yes 1 2 1 2 1 2 1 2 1 2 1 2	
4	Which type of contraceptives do you know? 1. Condoms 2. Diaphragms 3. Pill 4. Injectable 5. Implants 6.IUD/ Loop 7. Safe period 8. Regulating body temperature 9. Coitus interruptus 10. Abstinence	No / Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
5	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 #7)	1. Did not use 2. Condoms 3. Diaphragms 4. Pill 5. Injectable 6. Implants 7. Loops 8. Calender method	
6	**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** **1 2** **1 2**	

7.	Have you heard about HIV/AIDS?	1. No (skip to 11) 2. Yes	
8.	Which are the modes 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. Curses and bewitches 11. Others (specify) [ ]	No Yes 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
9	Do you think you can get AIDS? If yes why?	1. No 2. Yes _____	
10	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 with 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 1 2 1 2	
11	Which of the STDs do you know? 1. gonorrhea 2. Syphilis 3. chancroid 4. Others (specify) [ ]	No Yes 1 2 1 2 1 2 1 2	
12	Do you know how you can get STDs 1. Promiscuity 2 Poor health 3. Having sex with infected person 4. Mother to child 5. sharing toilets 6. Others (specify) [ ]	No Yes 1 2 1 2 1 2 1 2 1 2 1 2	

የግለሰብ የስምምነት ፎርም

ውድ እህቴ

ጤና ይስጥልኝ ስሜ _____ ይባላል። በአሁኑ ወቅት ለአዲስ አበባ ዩኒቨርስቲ ነው የምሰራው በአዲስ አበባ በተመረጡ ቦታዎች በወጣት ሴቶች ዙሪያ ያተኮረ ጥናት በመስራት ላይ እገኛለሁ አንቺም ለዚህ ጥናት በአጋጣሚ ተመርጠሻል።

ለጥያቄዎቹ የምትሰጫቸው መልሶች ለጥናታችን ጠቀሜታ ስላላቸው የራስሽ የሆነና እውነተኛ ምላሽ እንድትሰጭን እንጠይቃለን። ማንኛውም የመለሽው መልስ ለጥናቱ ጥቅም ብቻ የሚውል ሲሆን ስምሽንም ሆነ አድራሻሽን በጥያቄው ወረቀት ላይ አንመዘግብም። ሚስጥራዊ ቁጥር ነው የምንጠቀመው።

ይህንን ጥያቄ በሙሉ መተው ወይም በከፊል መመለስ ወይመ በፈለግሽ ጊዜ ማቋረጥ መብትሽ ነው።

ይሁንና የአንቺ ምላሽ መስጠት አንቺን መሰል ለሆኑት ሴቶች ሁሉ ሊጠቅም ስለሚችል እውነተኛ የሆነ አስተያየትና ምላሽ እንድትሰጭን በአዲስ አበባ ሴቶች ወጣቶች ስም እንጠይቃለን።

ጥያቄ ካለሽ እንመልሳለን

ጥያቄና መልሱ ቢያንስ 45 ደቂቃ ይፈጃል። ለሚባክነው ጊዜ እንከፍላለን።

ተጠያቂዋ መስማማት አለመስማማቷን መዝግቢ

እስማማለሁ	[ ]
አልስማማም	[ ]

ተጠያቂዋን ለሁሉም ትብብሯ አመስግኝት

ይህ መጠይቅ የሴቶችን አስገድዶ መደፈርን እና ሊያስከትሉ የሚችሉትን መንስኤዎች
በተለይ በጎዳና ተዳደሪዎች ላይ ለማጥናት በ አ.አ. ዩኒቨርስቲ መጋቢት 1992 ተዘጋጀ

ቀ. ዘ		ሰአት [ ] ደቂቃ [ ]
ክፍል አንድ አጠቃላይ መግለጫ		
ጥያቄ		ምላሽ	ኮድ
	የሚስጥር ቁጥር	[ ]	
ሪ	እድሜሽ ስንት ነው?	[ ]	
	የምትከተይው ሃይማኖት ምንድን ነው?	1. አርቶዶክስ 2. ሌላ ክርስቲያን 3. እስልምና 4. ሃይማኖት የለኝም 5. ሌላ ካለ ይገለፅ [ ]	
	ትዳር ይዘሽ ታውቂያለሽ ?	1.አግብቼ አላውቅም 2.በትዳር ላይ ነኝ 3. ተፋትቻለሁ 4. ባለቤቴ ሞቶብኛል 5. ሌላ ካለ ይገለፅ [ ]	
	የትምህርት ደረጃሽ ምን ይመስላል?	1. አልተማርኩም 2. ማንበብና መፃፍ 3. አንደኛ ደረጃ 1-6 (ክፍል) 4. ሁለተኛ ደረጃ 7-12 (ክፍል) 5. ከሁለተኛ ደረጃ በላይ 6. ሌላ ካለ ይገለፅ [ ]	
	በአሁኑ ወቅት ትማሪያለሽ?	1. እማራለሁ 2. አቋርጫለሁ	
	በቋሚነት የምትኖሪበት ቦታ የት ነበር?	1. አዲስ አበባ ከተማ ውስጥ (ወደ 10 ኛ ጥያቄ ሂጂ) 2. አዲስ አበባ ከከተማ ውጪ 3. ከአዲስ አበባ ውጪ ከተማ ውስጥ 4. ከአዲስ አበባ ውጪ ገጠር	
	ወደ አዲስ አበባ መቼ መጣሽ?	[ ]	
	ወደ አዲስ አበባ ለምን መጣሽ ?	1. ስራ ፍለጋ 2. በጓደኛ ተገፋፍቼ 3. የማላውቀውን ሰው ተከትዬ 4. በከተማ ኑሮ ተማርኬ 5. ከተማ የገባ ቤተሰብ ፍለጋ 6. ስላረገዝኩኝ 7. ከፈተና ስለወደቅሁ 8. በቅርብ ቤተሰብ በመደፈሬ 9. ከልጅነት ባሌ ኮብልየ 10.ከልጅነት ባሌ ተጣልቸ 11. ሌላ ምክንያት ካለ ይገለፅ [ ]	
0	በአንድ ቤተሰበብ ስር የሚተዳደሩ ከአንች ሌላ ስንት የቤተሰብ አባላት አሉ? አባት ወይም እናት ካለት X ምልክት አድርጊበት እህት፤ ወንድም ወይም ሌላ የሚለው ላይ ቁጥር ሙይበት	1. አባት [ ] 2. እናት [ ] 3. እህት [ ] 4. ወንድም [ ] 5. ሌላ ካለ ይገለፅ [ ]	
1	የእናትሽ የትምህርት ደረጃ?	1. አልተማረችም 2. ማንበብና መፃፍ 3. አንደኛ ደረጃ 1-6 (ክፍል) 4. ሁለተኛ ደረጃ 7-12(ክፍል) 5. ከሁለተኛ ደረጃ በላይ	

12	የአባትሽ የትምህርት ደረጃ?	1. አልተማረም 2. ማንበብና መፃፍ 3. አንደኛ ደረጃ 1-6 (ክፍል) 4. ሁለተኛ ደረጃ 7-12(ክፍል) 5. ከሁለተኛ ደረጃ በላይ	
13	ወላጆችሽ በህይወት አሉ?	1. ሁለቱም በህይወት የሉም 2. እናቴ ብቻ በህይወት አለች 3. አባቴ ብቻ በህይወት አለ 4. አዎን ሁለቱም አሉ	
14	በአሁኑ ወቅት የምትኖሪው ከማን ጋር ነው?	1. በትዳር 2. ከእናትና ከአባቴ 3. ከአባቴ ጋር 4. ከእናቴ ጋር 5. ከእንጀራ እናት / አባት ጋር 6. ከአጎቴ / ከአክስቴ ጋር 7.ከአያቶቼ ጋር 8. ከሌሎች ዘመዶቼ ጋር 9. ድርጅት ውስጥ 10. ለብቻየ 11. ሌላ ካለ ይገለፅ [ ]	
15.	ከወላጅ/ ከአሳዳጊ /ከድርጅት ምን ድጋፍ ታገኛለሽ? (ከአንድ በላይ መልስ መስጠት ትችያለሽ) 1. ምንም 2. ምግብ 3. ልብስ 4. መጠለያ 5. የትምህርት ቤት ክፍያ 6. ሌላ ካለ ይከለፅ (መልስሽ 2, 3, 4, 5, 6, ከሆነ ወደ ጥያቄ 19 ሂጂ)	አላገኝም / አገኛለሁ 1 2 1 2 1 2 1 2 1 2 1 2	
16	በስንት አመትሽ ከቤት ወጣሽ?	[ ]	
17	ለብቻሽ የምኖሪበት ምክንያቱ ምንድን ነው?	1. ቤተሰብ ከቤት ስላስወጣኝ 2. በጓደኛ ተገፋፍቼ 3. ከቤተሰብ ቁጥጥር ውጪ ለመሆን 4. በቤተሰቦቼ ድብደባና እንግልት ስለደረሰብኝ 5. በቅርብ ቤተሰብ ያለፍላጎቴ ስለተደፈርኩ 6. በወንድ ጓደኛዬ / ፍቅረኛዬ ተገፋፍቼ 7. በትልቅ ሰው ተታልዬ 8. እራሴን ለመቻል ስለደረስኩ 9. በትዳር 10. ስላረገዝኩኝ 11 ከፈተና ስለወደቅኩኝ 12. ሌላ ካለ ይገለፅ [ ]	
18	ሌሊቱን የት ታሳልፊያለሽ?	1. በጎዳና ላይ 2. በአነስተኛ አልቤርጎ 3. ባለላስቲክ ቤት 4. የዘመድ ቤት 5. ሌላ ካለ ይገለፅ [ ]	
19	ዋና የገቢ ምንጭሽ ምንድን ነው?	1. የገቢ ምንጭ የለኝም (ወደ ክፍል ሀለት ጥያቄ ቁጥር 1 ሂጂ) 2. አነስተኛ ንግድ 3. ሴት አዳሪነት 4. ልመና 5. ሌላ ካለ ይገለፅ [ ]	
20	በአማካኝ የቀን ገቢሽ ምን ያህል ይሆናል ?	1.ከአምስት ብር በታች 2. ከ 5-10 ብር 3. ከ10-15 ብር 4. ከ 15 ብር በላይ	

	ክፍል ሁለት አደንዛዥ ዕጽንና የአልኮል መጠጥን አወሳሰድ በተመለከተ		
	በአሁኑ ጊዜ ታጨሻለሽ? ካጨሽ ባለፈው ወር በቀን ስንት ሲጋራ አጨስሽ?	1. አላጨስም 2. ከ 10 በታች 3. ከ 10 እስከ 20 ያላነሰ 4. ከ20 በላይ	
	አልኮል መጠጥ የምትጠጪ ከሆነ አጠጣጥሽ እንዴት ነው ?	1. አልጠጣም (ወደ ተራ ቁጥር 5 ሂጂ.) 2. በየቀኑ 3. በየሁለት ቀኑ 4. በሳምንት ከ 3-4 ቀን 5. በየሳምንቱ 6. በየወሩ 7. በባአላትና ከሰዎች ጋር ስገናኝ	
	በአማካኝ በጠጣሽባቸው ቀናት ስንት ጠጥቻለሁ ትያለሽ?	1. የተለመደ የመጠጥ ቁጥር [ ] መለኪያ ፤ ብርጭቆ ፤ ብርሌ	
	የምትጠጭበት ዋና ምክንያት ምንድን ነው?	1. ጓደኞቼ ስለሚጠጡ 2. ለመደሰት 3. መረቀት ስለሚሰጠኝ 4. ችግሬን ለመርሳት ስለሚጠቅመኝ 5. ሌላ ካለ ይገለፅ [ ]	
	ጫት ትቅሚያለሽ? ከቃምሽ በምን ያህል ጊዜ ትቅሚያለሽ?	1. በፍፁም አልቅምም (ወደ ተራ ቁጥር 7 ሂጂ.) 2. በየቀኑ 3. 3-4 ቀን በሳምንት 4. በየሳምንቱ 5.በየወሩ 6.አንዳንድ ጊዜ	
	የምትቅሚበት ዋና ምክንያት ምንድን ነው?	1. ጓደኞቼ ስለሚቅሙ 2. ለመደሰት 3. መረቀት ስለሚሰጠኝ 4. ችግሬን ለመርሳት ስለሚጠቅመኝ 5. ሌላ ካለ ይገለፅ [ ]	
	እንደሃሺሽ ያሉ እፆች ወስደሽ ታውቂለሽ? የምትወስጂ ከሆነ አጠቃቀምሽ እንዴት ነው?	1. አልወስድም (ወደ ተራ ቁጥር 9 ሂጂ) 2. በየቀኑ 3. በየሁለት ቀኑ 4. በሳምንት ከ 3-4 ቀን 5. በየሳምንቱ 6. በየወሩ 7. አልፎ አልፎ 8. ሌላ ካለ ይገለፅ [ ]	
	እፅ ለምን ትወስጂያለሽ?	[ ] 1. ጓደኞቼ ስለሚወስዱ [ ] 2. ለመደሰት [ ] 3. መረቀት ስለሚሰጠኝ [ ] 4. ችግሬን ለመርሳት ስለሚጠቅመኝ 5. ሌላ ካለ ይገለፅ [ ]	
	ቤንዚን ትስቢያለሽ? የምትስቢ ከሆነ አወሳሰድሽ እንዴት ነው ?	1. አልስብም (ወደክፍል ሶስት ሂጂ.) 2. በየቀኑ 3. በየሁለት ቀኑ 4. በሳምንት ከ 3-4 ቀን 5. በየሳምንቱ 6. በየወሩ 7. አልፎ አልፎ 8. ሌላ ካለ ይገለፅ [ ]	
0	ቤንዚን ለምን ትስቢያለሽ ?	1. ሌሎች ስለሚስቡ 2. ስለሚያስደስተኝ 3 . መረቀት ስለሚሰጠኝ 4. ችግሬን ስለሚያስረሳኝ 5. ሌላ ካለ ይገለፅ [ ]	

	ክፍል ሶስት ስለ አስገድዶ መደፈር		
1/	የግብረስጋ ግንኙነት አድርገሽ ታውቂያለሽ?	1. አድርጌ አላውቅም (ወደ ተራ ቁጥር 9 ሂጂ) 2. አዎን	
2/	የመጀመሪያ ግንኙነትሽ በስንት አመትሽ ነበር?	በ[ ] አመቴ	
3/	በመጀመሪያ ግብረስጋ ግንኙነት እንድታደርጊ የገፋፋሽ ምክንያት ምንድን ነው? (መልስሽ ከተራ ቁጥር 6 ውጭ ከሆነ ወደ ቁጥር 7 ሂጂ)	1. በትዳር 2.በፍቅር 3. በጓደኞቼ ተገፋፍቼ 4. በቃላት ተደልዬ 5.ገንዘብ ለማግኘት 6.ተገድጄ 7. ሌላ ካለ ይገለፅ [ ]	
4/	ተገደሽ ከሆነ አስገዳጁ ማነው	1.የቅርብ ቤተሰብ /ዘመድ 2. የቤተሰብ ጓደኛ 3.ጎረቤት 4. የማላውቀው ሰው 5. በቡድን 6. ሌላ ካለ ይገለፅ [ ]	
5/	የደፈረሽ ሰው እድሜ በግምት ስንት ይሆናል ?	1. የእድሜ እኩያሽ ይሆናል 2. ከአንቺ ትንሽ ከፍ ይላል 3. ከአንቺ በጣም ይበልጣል 4. ሌላ ካለ ይገለፅ [ ]	
6/	የደፈረሽ ሰው ለማስገደድ በምን ተጠቀመ ?	1.በኃይል በመደብደብ 2.በስለት በማስፈራራት 3.በመሳሪያ በማስፈራራት 4. በቃላት በማስፈራራት 5.በመጠጥ በማስከር 6.በእፅ በማደንዘዝ 7. ሌላ ካለ ይገለፅ [ ]	
7	ባለፉት ሶስት ወራት ከፍላጎትሽ ውጭ የግብረስጋ ግንኙነት አድርገሽ ነበር ?	1. አላደረኩም (ወደ ተራ ቁጥር 9 ሂጂ) 2. አድርጌአለሁ	
8	ስንት ጊዜ ተገደድሽ ?	1. አንድ ጊዜ 2. ከ 2-4 ጊዜ 3. ከ 5 ጊዜ በላይ	
9	ባለፉት ሶስት ወራት ከፍላጎትሽ ውጪ በተቃራኒ ፆታ ተስመሽ ታውቂያለሽ?	[ ] 1. አልተሳምኩም (ለተራ ቁጥር 7 እና 9 መልሱ አይደለም [ ] 2. ተስሚአለሁ ከሆነ ወደ ተራ ቁጥር 23 ሂጂ)	
10	ስንት ጊዜ ተገደድሽ ?	1. አንድ ጊዜ (ወደ ተራ ቁጥር 14 ሂጂ) 2. ከ 2-4 ጊዜ 3. ከ 5 ጊዜ በላይ	
11	ተደጋጋሚ ከነበር የተደፈርሽው በአንድ ሰው ነበር ?	1. አይደለም 2. ነው	
12	በተደጋጋሚ የተደፈርሽው በአንድ ሰው ከሆነ ይህ ሰው ምንሽ ነበር?	1 የፍቅር ጓደኛሽ 2. ለጊዜው አብሮሽ የሚኖር 3. የማታውቂው ሰው 4. ጎረቤት 5. ሌላ ካለ ይገለፅ [ ]	
13	አስገድዶ መድፈሩ ተደጋጋሚ የሆነበት ምክንያት ምን ይመስልሻል?	ይገለፅ _____	
14	ከእንግዲህ ወዲያ ሌላ ሰው ሊደፍርሽ ቢሞክር መከላከል ትችያለሽ ?	1 . አልችልም (ወደ ተራ ቁጥር 16 ሂጂ) 2. እችላለሁ	
15	መልስሽ አዎ ከሆነ እንዴት ትከላከያለሽ?	_____	

16	መልስሽ አልችልም ከሆነ ለምን አትችይም ?	_____	
17	ከተደፈርሽ በኋላ ችግርሽን ለማን አካፈልሽ?	1. ለማንም 2. ለጓደኛ 3. ለእህት ወይም ለወንድም 4. ለጤና ባለሙያ 5. ለወላጆቼ 6. ሌላ ካለ ይገለፅ [ ]	
18	ችግሩን ለየትኛው ህጋዊ አካል አመለከትሽ?	1. አላመለከትኩም (ወደ ጥያቄ ቁጥር 20 ሂጂ) 2. ለቀበሌ 3. ለፖሊስ 4. ለአገር ሽማግሌ 5. ሌላ ካለ ይጠቀስ	
19	የደፈረሽ ሰው ምን ተቀጣ?	1. ምንም 2. እስራት 3. የገንዘብ ቅጣት 4. በሽማግሌ የገንዘብ ካሳ እንዲከፍል ተደረገ 5. እንዲጠቀልል ተደረገ 6. ሌላ ካለ ይገለው	
20	ለተራ ቁጥር 17 እና 18 መልሱ ለማንም አልተናገርኩም ከሆነ ለምን ዝም አልሽ? 1. ምን ማድረግ እንዳለብኝ አላወኩም 2. ቤተሰቦቼን በመፍራት 3. ነውር በመሆኑ ፈራሁኝ 4. ደፋሪው ስላስፈራራኝ 5. ፖሊስ አይቀበለኝም በማለት 6. ሌላ ካለ ይገለፅ [ ]	አይደለም ነው 1 2 1 2 1 2 1 2 1 2 1 2	
21	ካለፍቃድሽ በመደፈርሽ የተነሳ ከሚከተሉት ችግሮች የትኞቹ አጋጥመውሻል?	1.እርግዝና 2. ማስወረድ 3. የብልት መጎዳት 4. ከብልት ፈሳሽ መውጣት 5. ከብልት አካባቢ እባጭ መውጣት 6. ሌላ ካለ ይጠቀስ [ ]	
22	ባለፉት 3 ወራት ውስጥ በመደፈርሽ የተነሳ ከሚከተሉት የህመም ስሜቶች የትኛው አጋጥሞሻል? 1. ራስ ምታት 2. የምግብ ፍላጎት መቀነስ 3. የእንቅልፍ ማጣት 4. በቀላሉ መፍራት 5. እጅችሽ ይንቀጠቀጣሉ 6. ስለደረሰብሽ ሁኔታ ሌሎችን ትጠያለሽ 7. ራስሽን ትወቅሻለሽ 8. ደስታ የለሽም 9. ከበፊቱ የበለጠ ታለቅሻለሽ 10. የግብረስጋ ግንኙነት ፍላጎትሽ ቀንሷልን 11. የአልኮልና ጫት ሱሰኛሆነሻል 12. የየእለት ህይወትሽ ተበላሽቷል 13. ለማንኛውም ነገር ፍላጎት የለሽም 14. ዋጋ ያለኝ ሰው አይደለሁም የሚል ስሜት አለሽ 15. ሕይወትሽን ማጥፋት ትፈልጊያለሽ 16. ሕይወትሽን ለማጥፋት ሞክረሽ ታውቂያለሽ 17. አዘውትሮ ይደክምሻል	አልነበረኝም ነበረኝ 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 1 2 1 2 1 2 1 2 1 2	
23	ተደፍረሽ የማታውቂ ከሆነ የመደፈር ሙከራ ተደርጎብሽ ያውቃል? እንዴትስ አመለጥሽ ? 1. የመደፈር ሙከራ አጋጥሞኝ አያውቅም 2. ሌላ ቀጠሮ በመስጠት 3. በመታገል 4. በመጮህ	አይደለም ነው 1 2 1 2 1 2 1 2	

	5. በሌሎች ሰዎች እርዳታ 6. ሮጦ በማምለጥ 7 . በማስፈራራት 8. በቡድን በመተጋገዝ 9. ሌላ ካለ ይገለፅ [	1 2 1 2 1 2 1 2 1 2	
24	ባለፈው አመት ውርጃ የነበራት ጓደኛ ታውቂያለሽ?	1.አላውቅም 2.አውቃለሁ	
25	ከእርግዝና ጋር በተያያዘ የሞተች ጓደኛ ታውቂያለስ?	1.አላውቅም 2.አውቃለሁ	
26	ከእርግዝና ጋር በተያያዘ የአካልጉዳት የደረሰባት ጓደኛ ታውቂያለሽ?	1.አላውቅም 2.አውቃለሁ	
27	ባለፉት ሶስት ወራት ውስጥ ተገዳ የግብረስጋ ግንኙነት ያደረገች ጓደኛ ታውቂያለሽ?	1. አላውቅም 2. አውቃለሁ	
28	ባለፉት ሶስት ወራተ ውስጥ ተገዳ የተሳመች ጓደኛ ታውቂያለሽ ?	1. አላውቅም 2. አውቃለሁ	
29	ከተደፈረች በኋላ ደፋሪውን የከሰሰች ጓደኛ ታውቂያለሽ ? የምታውቂ ከሆነ ደፋሪው ምን ደረሰበት?	1. አላውቅም 2. በነፃ ተለቀቀ 3. ታሰረ 4 እንዲጠቀልል ተደረገ 5. ሌላ ካለ ይገለፅ	

ክፍል አራት

የቤተሰብ ምጣኔ፤ የአባለዘር በሽታ እና ኤች አይ ቪ - አድስን አስመልክቶ

1	አራስሽን ከእርግዝና እንዴት እንደምትከላከይ ታውቂያለሽ	1. አላውቅም (ወደ ተራ ቁጥር 7 ሂጂ) 2. አውቃለሁ	
2	የምታውቂ ከሆነ ግለጭው	1. የወሊድ መከላከያ በመጠቀም 2. በባህል መድሃኒት 3. በተፈጥሮ መንገድ 4. ሌላ ካለ ይገለፅ [ ]	
3	ይዜን የመከላከያ መንገድ ከየት አወቅሽ ? 1. ከጓደኞቹ 2. ከቤተሰብ 3. ከጤና ባለሙያዎች 4. የተለያዩ ፅሁፎችን በማንበብ 5. ከራዲዮ 6. ከቴሌቭዥን 7. ሌላ ካለ ይገለፅ	አይደለም ነው 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
4	ምን ምን አይነት የወሊድ መቆጣጠሪያዎች ታውቂያለሽ ? 1. ኮንዶም 2. ዲያፍራም 3. ፒልስ 4. የመከላከያ መርፌ 5. ክንድ ላይ የሚደረግ መከላከያ (ኖር ፕላንት) 6. በመሃፀን ውስጥ የሚቀመጥ (አይ.ዩ.ዲ) 7. በወር አበባ ኡደት 8. ሌላ ካለ ይገለፅ [ ]	አላውቅም አውቃለሁ 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
5	በመጨረሻ ግንኙነትሽ ምን አይነት መከላከያ ተጠቀምሽ ? (መልስሽ ከአንድ ሌላ ከሆነ ወደ ተራ ቁጥር 7 ሂጂ)	1.ምንም አልተጠቀምኩም 2. ኮንዶም 3. ዲያፍራም 4. ፒልስ 5. የመከላከያ መርፌ 6. ክንድ ላይ የሚደረግ መከላከያ (ኖር ፕላንት) 7. በመሃፀን ውስጥ የሚቀመጥ (አይ.ዩ.ዲ) 8. በወር አበባ ኡደት 9. ሌላ ካለ ይገለፅ [ ]	
6	ያልተጠቀምሽ ከሆነ ለምን ? 1. መሃን ስለሚያደርግ 2. ካንሰር ስለሚያመጣ	አይደለም ነው 1 2 1 2	

	3. ብዙ ልጆች እንዲኖሩኝ ስለምፈልግ 4. ደህና ምግብ ስለማላገኝ ይጎዳኛል ብዬ 5. ከየት እንደሚገኝ ስለማላውቅ 6. ይከላከልልኛል ብዬ ስለማላምን 7. ስለማላውቀው 8. ሌላ ካለ ይጠቀስ [ ]	1 2 1 2 1 2 1 2 1 2	
7.	ስለኤድስ ሰምተሽ ታውቂያለሽ?	1. አላውቅም (አላውቅም ከሆነ ወደ ተራ ቁጥር 11 ሂጂ) 2.አውቃለሁ	
8	የኤች. አይ. ቪ. መተላለፊያ መንገዶች የትኞቹ ናቸው? 1. ዘማዊነት 2. ያልተመረመረ ደም መውሰድ 3. መርፌ በጋራ መጠቀም 4.በሽታው ከያዘው ሰው ጋር ግብረስጋ ግንኙነት ማድረግ 5. ከእናት ወደ ፅንስ 6.በሽተኛውን በነደፉ ትንኞች 7. መፀዳጃ በጋራ በመጠቀም 8. በመጨባበጥ 9. የሰላምታ መሳሳም 10.በእርግማን 11. ሌላ ይገለፅ [ ]	አይደለም ነው 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
9	ኤድስ ይይዘኛል ብለሽ ታስቢያለሽ ? ለምን ?	1. አላስብም 2. አስባለሁ ይገለፅ _____	
10	የኤች አይ ቪ መከላከያ መንገዶችን ታውቂያለሽ ? 1. ግንኙነት ከማድረግ መታቀብ 2. ኮንደም መጠቀም 3. አንድ ታማኝ ጓደኛ መያዝ 4. ያልተቀቀለ መርፌ አለመጠቀም 5.ትንኞችን መከላከል 7. ጥሩ ምግብ መመገብ 8. ሽንትቤትን በጋራ አለመጠቀም 9. የተመረመረ ደም መውሰድ 10. ከጋብቻ በፊት ግንኙነት አለማድረግ 11.ሌላ ካለ ይገለፅ [ ]	አላውቅም አውቃለሁ 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	
11	የትኞቹን የአባለዘር በሽታዎች ታውቂያለሽ ? 1. ጨብጥ 2. ቂጢኝ 3. ከርክር 4. ባምቡሌ 5. ሌላ ካለ ይገለፅ [ ]	አላውቅም አውቃለሁ 1 2 1 2 1 2 1 2 1 2	
12	የአባለዘር በሽታ መተላለፊያ መንገዶችን ግለጭልኝ ? 1.በዘማዊነት 2 የጤና ማነስ / መቃወስ 3.በበሽታው ከተያዘ ሰው ጋር የግብረስጋ ግንኙነት ማድረግ 4.ከእናት ወደ ፅንስ 5.በጋራ መፀዳጃ በመጠቀም 6.ሌላ ካለ ይገለፅ [ ]	አይደለም ነው 1 2 1 2 1 2 1 2 1 2 1 2	

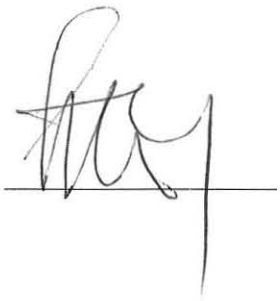
የመጠይቁ ልዩ መታወቂያ	
ዞን _____	[ ]
ወረዳ_____	[ ]
ቀበሌ_____	[ ]
የጎዳና ስም _____	[ ]
የመንደሩ ስም_____	[ ]

የመጠይቁ አሞላል ሂደት		
መጠይቁን የሞላችው ወጣት ስም	የመስክ ተቆጣጣሪው ስም	መጠይቁን ያረመው ባለሙያ ስም
[ ]	[ ]	[ ]
ቀን [ ] ወር [ ] ዓ/ም [ ]	ቀን [ ] ወር [ ] ዓ/ም [ ]	ቀን [ ] ወር [ ] ዓ/ም [ ]

Declaration

I, the undersigned, declare that this is my work and that all sources of materials used for this thesis have duly acknowledged.

Name Mitike Molla, BA

Signature 

Place Addis Ababa, Ethiopia

Date of submission _____

This thesis has been submitted for examination with my approval as University advisor.

Name Dr. SHABBIA ISMAIL

Signature