Situation Analysis of Perceptions on Comprehensiveness of Rape Prevention Interventions by Implementing Agencies in Addis Ababa

by

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DECLARATION

I declare that **SITUATION ANALYSIS OF PERCEPTIONS ON COMPREHENSIVENESS OF RAPE PREVENTION INTERVENTIONS BY IMPLEMENTING AGENCIES IN ADDIS ABABA** is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any other degree at any other institution.

26th February 2019

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Difabachew Setegn Hailegeorgis **Date**

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Dedication

This dissertation is dedicated to my mother Wro. Yehualashet WoldeMichael for her unwavering love and commitment that kept inspiring our family even after two decades she passed away!

ABSTRACT

The victimization of women and children represents one of the public health problems deserving urgent attention in Ethiopia, making the prevention of rape in all its forms a matter of vital importance.

The purpose of the study was mainly to describe the extent of rape prevention interventions in Addis Ababa and examine efforts to assist rape survivors based on the perceptions of professionals working for organizations operating in this context. The study had a further purpose of identifying difficulties faced by government institutions and making suitable recommendations for the improvement of rape prevention interventions and programs in the future.

A qualitative descriptive research approach was adopted mainly involving in-depth interviews for primary data collection. The study involved 14 research participants purposively selected from five government institutions.

The study findings indicated Gandhi Memorial Hospital to be the only institution in Ethiopia implementing an integrated rape prevention intervention. Efforts were directed largely at secondary prevention, with little attention being paid to primary prevention. Recommendations included tackling the multiple factors influencing rape at different levels of the social-ecological model simultaneously through the implementation, strengthening, and intensification of well-designed, comprehensive rape prevention interventions and programs.

KEYWORDS:

Rape; prevention interventions; comprehensiveness of rape prevention; social-ecological model; multiple factors influencing rape; primary prevention

TRANSLATION (IsiXhosa)

ISISHWANKATHELO

Ukuxhatshazwa kwabafazi nabantwana e-Ethiopia kufana nenye yeengxaki zempilo kwaye kudinga ukuthathelwa ingqalelo ngokungxamisekileyo. Oku kwenza ukuba ukuthintela ukudlwengulwa ngazo zonke iindlela kube ngumbandela obaluleke kakhulu.

Injongo yesi sifundo ibikukucacisa iindlela zokuthintela ukudlwengulwa eAddis Ababa, nokuvavanya imizamo yokunceda abo bakhe badlwengulwa, ngokokubona kwabo basebenzela amaqumrhu aququzelela lo msebenzi. Enye injongo yesi sifundo ibikukuchonga ubunzima obufunyanwa ngamaziko aseburhulumenteni ajongene neli candelo ukuze kunikwe iingcebiso zokuphucula amacebo neenkqubo zokuthintela ukudlwengulwa.

Kuqhutywe uhlobo lophando lomgangatho nolucacisayo, apho kuqokelelwe iinkcukacha zolwazi ngokwenza udliwano ndlebe olunzulu. Kusetyenzwe nabathathi nxaxheba abali-14 abakhethwe ngobuchule kumaziko aseburhulumenteni ama-5.

Okufunyaniswe sesi sifundo kubonakalise ukuba isibhedlele esiyiGandhi Memorial siso sodwa esinenkqubo elungelelaniswe kakuhle yokuthintela ukudlwengulwa. Imigudu yokhukhusela ijoliswe ekuncedeni kwiziqhamo zodlwengulo nasekufundiseni ngodlwengulo (*secondary prevention*) hayi kudlwengulo ngqo (*primary prevention*). Amacebiso esifundo aquka ukulwa neemeko eziphembelela udlwengulo olwenzeka kumazinga ahlukeneyo oluntu, ngaxeshanye nokuqinisa ukusetyenziswa kweenkqubo eziqulunqwe kakuhle zokuthintela udlwengulo.

AMAGAMA APHAMBILI:
Udlwengulo; amacebo okuthintela; ubunzulu nobubanzi bothintelo lodlwengulo; inkqubo yokujonga kunikezelwano lwefuthe kumazinga ahlukeneyo oluntu; iimeko ezininzi eziphembelela udlwengulo; uthintelo ngqo

TRANSLATION (Afrikaans)

OPSOMMING

Die viktimisering van vroue en kinders is een van talle kwessies in die openbare gesondheid van Ethiopië wat dringend aandag vereis, aangesien die voorkoming van verkragting in enige vorm van die allergrootste belang is.

Die doel van hierdie studie was om die omvang te bepaal van intervensies om verkragting in Addis Abeba te voorkom, en om die hulp wat aan verkragtingslagoffers verleen word, te ondersoek op grond van die belewenisse van beroepslui wat in hierdie verband vir organisasies werk. Hierdie studie het dit verder ten doel gehad om die probleme aan te toon waarmee staatsinstellings in hierdie opsig te kampe het, en om beter intervensies en programme vir die voorkoming van verkragting aan te beveel.

'n Kwalitatiewe en deskriptiewe navorsingsbenadering is gevolg. Dit het omvattende onderhoude behels waartydens primêre data versamel is. Altesame 14 deelnemers by vyf staatsinstellings is vir hierdie doel gekies.

Volgens die bevindings is die Gandhi Gedenkhospitaal die enigste instelling in Ethiopië wat 'n geïntegreerde program vir die voorkoming van verkragting ingestel het. Sekondêre voorkoming geniet voorrang, terwyl primêre voorkoming min aandag geniet. Daar word aanbeveel dat tegelykertyd werk gemaak word van die veelvuldige faktore wat verkragting op verskillende vlakke van die sosiaal-ekologiese model beïnvloed. Dit moet gedoen word deur deeglik ontwerpte, omvattende intervensies en programme om verkragting te voorkom in werking te stel, uit te bou en te verskerp.

SLEUTELWOORDE:
Verkragting; voorkomingsintervensies; omvattendheid van verkragtingsvoorkoming; sosiaal-ekologiese model; veelvuldige faktore wat verkragting beïnvloed; primêre voorkoming

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
BoFED:	Bureau of Finance and Economic Development
CDC:	Centers for Disease Control and Prevention
CSA:	Central Statistical Agency
DNA:	Deoxyribonucleic Acid
EDHS:	Ethiopia Demographic and Health Survey
FMoH:	Federal Ministry of Health
GBV:	Gender-Based Violence
HIV:	Human Immunodeficiency Virus
ICL:	International Clinical Laboratories
IPPF:	International Planned Parenthood Federation
MoWCYA:	Ministry of Women, Children & Youth Affairs
NORAD:	Norwegian Agency for Development Cooperation
RHRC:	Reproductive Health Response in Conflict Consortium
SACT:	Sexual Assault Crisis Team
STI:	Sexually Transmitted Illnesses
UNFPA:	United Nations Population Fund
UNISA:	University of South Africa
USA:	United States of America
VDRL:	Venereal Disease Research Laboratory
WHO:	World Health Organization

CHAPTER 1: INTRODUCTION AND BACKGROUND INFORMATION

1.1. Introduction

This study described the existing situation on the nature of rape prevention interventions and programs implemented by the government agencies in Addis Ababa. In conducting the study, the researcher hoped to gain insights into the possible gaps and challenges as to the rape prevention interventions and programs encountered by the implementing institutions. Hence, the study intended to come up with workable recommendations to enhance the rape prevention interventions implemented so far by the government agencies. To this effect, the researcher employed a qualitative descriptive research design; and thereupon, collected qualitative data through conducting in-depth interviews with research participants. The study mainly included experienced professionals and purposively selected them from the major government institutions implementing rape prevention interventions and programs in Addis Ababa.

The prevailing attitude and interpretation towards rape can influence the nature of rape prevention interventions including services provided to rape survivors. Thus, according to WHO (2003:10-11), having proper understanding on rape is a prerequisite to address the problem. As a result, the laws of several countries have been increasingly adopting an all-inclusive understanding of rape (WHO 2015b:3, 36). However, the challenge of rape is severe in Ethiopia due to the erroneous socio-cultural views and the inadequate legal understanding towards rape to mention among others (Gessessew & Mesfin 2004:140). The high incidence of rape in Ethiopia can be associated, for example, with the widespread traditional practice of child marriage, which often involves forceful sex (MoWCYA 2013:24). The non-consideration of spousal rape by the Criminal Code (414 of 2004) on the other hand implies the challenge in the legal aspect.

The design of prevention intervention approaches of rape and other forms of sexual violence considers target groups. The universal intervention or primary prevention

approach is targeting the entire public irrespective of the risk of rape or perpetration. However, the selected and indicated interventions focus on those identified as highly vulnerable and already victimized target groups, respectively (Centers for Disease Control and Prevention-CDC 2004:7; CDC 2014:2-4). A comprehensive and effective rape prevention program is inherent to the implementation of a holistic approach with simultaneous, combined and mutually reinforcing interventions. Such rape prevention program addresses influencing factors behind the risk of rape and perpetration. Intervention activities correspond to the influencing behavioral and related other factors at the levels of individuals, groups, institutions and broader societal or policy environments (Basile *et al* 2016:11; DeGue 2014:1, 4).

Despite the lack of research on rape prevention programs implemented so far in Ethiopia, few studies witness that institutions implementing rape prevention interventions have limited practices of evidence-based programming (Gebre *et al* 2009:24). Even though various reports confirm high incidence of rape and other forms of sexual violence, the issue of rape remained among the least researched in Ethiopia (Gessessew & Mesfin 2004:140; Ethiopian Demographic and Health Survey-EDHS 2016: 65, 263, 303; Getinet 2009:174). Therefore, the researcher believed that the study would contribute to filling the gap of knowledge on rape prevention interventions and programs in Ethiopia. Besides, the study will inform and provide helpful inputs to practitioners and stakeholders interested in addressing the challenge of rape and other forms of sexual violence.

1.2. Background of the study

Females are at higher risk of rape globally, while males are the majority of the assailants (World Health Organization-WHO 2015:35), and the same scenario exists in Ethiopia (Wolde 2014:1-2). However, according to Haile, Kebeta, and Kassie (2013:1), the increasing number of young boys have also become survivors of rape in Addis Ababa. Although no one has specified incidences of rape so far, the problem is widespread in Ethiopia (NORAD 2009:11).

Ethiopia has several age-old practices of Gender-Based Violence (GBV) maintained by harmful cultural and traditional values as well as religious beliefs. These involve patriarchal norms and erroneous socialization of boys to be dominant and violent. These in turn subjugate women to different gender-based violations such as abduction, sexual exploitation, and limited control over resources to be mentioned (United Nations Economic Commission for Africa 2010:65-66; Ministry of Women, Children & Youth Affairs-MoWCYA 2014:15-16). For example, forcefully arranged marriage and child marriage practices are still among the common challenges in rural Ethiopia (Federal Ministry of Health-FMoH 2016:12). Despite regional discrepancies, the same report shows 19% of girls forced to marry before their 15 years of age in Ethiopia. Child marriage practice is common in the Amhara region, where 50% of girls marry at the age of 15 years (Annabel & Muthengi 2009:6).

There is extensive evidence implying high incidents of rape in Ethiopia. According to a school-based study, with a broader area of research coverage in central Ethiopia, 74% of female high school students reported sexual harassment (Yemane 2004:131). The same study shows that five percent of female high school students reported completed rape, where 10% encountered attempted rape. Analysis of statistical records of the Prosecution Office in Addis Ababa denotes that rape is a serious problem. The analysis of those records shows that rape consists of 58% of all the cases of violence against women reported between July 2006 and June 2008 (Ministry of Justice 2008:9).

Socio-cultural barriers like stigmatization, shame, societal norms of rejection, fear of offenders and lack of awareness among parents often hinder the timely reporting of rape cases to concerned institutions. Gessessew and Mesfin (2004:140) show that of all the rape survivors, only 16% informed the police, and 17% provided with medical care in Addis Ababa. Hence, there is a significant delay in reporting. In most cases, rape incidents remain not reported, and if reported, prosecutors give less attention to the cases (Lakew 2001:80; United States Department of State 2013:25-26).

Delayed reporting of rape eventually reduces possible medical and psychological care and other prevention interventions including legal measures. The earlier the report, the more appropriate it would be for the provision of necessary psychosocial care and

collection of evidence to legally-redress rape survivors. Consequently, timely reporting the rape incidence would be helpful for prevention interventions in general and reduction of harmful health consequences in particular (Lakew 2001:80).

According to the World Health Organization–WHO (2014a:20, 39, 46, 50), several developing countries have limited knowledge about the magnitude of rape and how to comprehensively address the problem. These countries also have limitations in the enforcement of existing laws on the prevention of rape and weaknesses in the coordination of stakeholders. In this regard, as the same WHO global status report mentions, Yemane (2004:132) describes that the situation in Ethiopia is similar to the problem in most developing countries.

1.3. The rationale of the study

1.3.1. Problem statement

Existing evidence on rape and other forms of sexual violence show that females and children represent among the disproportionately affected groups in Ethiopia, including Addis Ababa (Gessessew & Mesfin 2004:140; Federal Ministry of Justice 2008:12). There is influx of rural girls to Addis Ababa due to various pushing and pulling factors (Addis Ababa BOFED 2013:43). Most of those rural girls smuggled into the city mainly suffer from the horrors of human trafficking, sexual exploitation, and rape (Government of Ethiopia 2007:58; Gebre *et al* 2009: 13, 33). The major challenges of young females in Addis Ababa include high unemployment (up to 35%), low-income, and risky jobs like nighttime petty-trades (Gibson & Gurmu 2012:1-2; Gebre *et al* 2009:8-12, 47). Having those challenges and engaging in such risky jobs exacerbate vulnerability of young girls to rape. Male rape is also a growing concern in the city, particularly committed against street boys (Habtamu & Adamu 2013:1; Getinet 2009:176).

The need for rape prevention interventions and programs is highly attributed to the damaging consequences of rape inflicted upon the survivors. Campbell, Dworkin, and Cabral (2009:3) depict the magnitude of the pain and horror of rape from the

survivors' point of view. They portray rape as "one of the most severe of all traumas, causing multiple, long-term negative outcomes." Hence, addressing difficulties of rape survivors demands specially designed interventions and effective programs on medical care, psychosocial care, and legal support services (WHO 2008:37). Quadara and Wall (2012:1-2) also broadly indicate that effective primary prevention involves implementing comprehensive, participatory, and contextualized programs.

Exposure to service statistics on the number of clients provided with services related to rape survivors inspired the researcher to think of designing effective rape prevention project The researcher had the opportunity of implementing sexual and reproductive health programs at the Family Guidance Association of Ethiopia. As a result, the researcher has been accessing data on medico-legal services to rape survivors in Addis Ababa since 2008. Since then the researcher tried to search for publications related to the problem. However, as Emebet (2016:43) witnesses, relevant study documents are not available at the government institutions working on the area of violence prevention including rape.

Studies show the lack of research describing details on what kinds of rape prevention interventions or programs implemented in Ethiopia (Gebre *et al* 2009:24). The desk review of 61 studies and programmatic documents of various institutions in Ethiopia regarding violence against children and youth asserts more focus given to young females (Emebet 2016:53). Despite the increasing victimization of male to sexual violence in Ethiopia, studies often focused on sexual violence of young females. More specifically, none of those 61 studies paid attention to examine rape prevention interventions and programs. Getinet (2009:174) further observes the limited knowledge regarding the problem of male rape, where the rape of street children remained among the topics not adequately researched in Ethiopia. Gebre *et al* (2009:24) also reveal that implementing institutions have limited evidence-based programs on rape prevention, where existing interventions hardly informed by scientific knowledge such as on the magnitude of the rape problem.

The researcher, therefore, learned gaps of scientific research that particularly inform questions related to what extent the existing rape prevention interventions in Addis Ababa are comprehensive. Gaps on scientific research also represent inquiries

whether scientific approach informed the existing interventions in design, implementation and other processes. Finally, but not least, the researcher also had the drive to inspire further studies by identifying relevant issues of research inquiry, which can eventually enhance rape prevention interventions in the future. As research-oriented evidences are instrumental to create positive changes, this study would provide such inputs and inform concerned stakeholders to design and implement effective rape prevention interventions and programs. Hence, the researcher wanted to contribute filling those knowledge gaps through addressing the purpose of the study and the research questions indicated in the sections below.

1.3.2. Purpose of the study

The purpose of the study was mainly to describe the situation on the comprehensiveness of rape prevention interventions in Addis Ababa and examine efforts to address the problems of rape survivors based on the perceptions of research participants. The study also had the drive to identify possible challenges faced by government institutions implementing rape prevention interventions, and simultaneously make recommendations to enhance rape prevention interventions and programs in the future.

1.4. Objectives of the study

In line with addressing the research purpose, the specific objectives of the study refer to the following:

- To understand the nature of rape prevention interventions and programs by government institutions in Addis Ababa;
- To describe how the implementing institutions respond in addressing problems of rape survivors;
- To describe the perception of professionals on the comprehensiveness of rape prevention interventions in Addis Ababa;
- To identify possible challenges faced by the government institutions in implementing the rape prevention interventions and;

- To indicate priority areas for consideration of implementing institutions to enhance rape prevention interventions and programs in the future.

1.5. Research questions

The key research questions inquired in this study represented the following:

- What is the nature of existing interventions and programs on the prevention of rape by government institutions in Addis Ababa?
- How the implementing institutions of rape prevention interventions respond in addressing problems of rape survivors in Addis Ababa?
- What is the perception of professionals on the comprehensiveness of rape prevention interventions implemented by the government agencies in Addis Ababa?
- What are the major challenges that the government institutions encountered in implementing the rape prevention interventions;
- What should be the priority areas for consideration of implementing institutions to enhance rape prevention interventions and programs in the future?

1.6. The operational definition of key terms and concepts

The researcher operationally defined key terms and concepts, particularly on the frequently appeared terms and concepts in line with the scope of the study. The intention here is to maintain consistency and avoid ambiguity in usage. Thus, the keywords and concepts include rape, sexual violence, prevention interventions, comprehensiveness of rape prevention interventions, and perceptions of professionals on the comprehensiveness of those interventions.

1.6.1. Sexual violence

This study understood sexual violence as a broader concept comprising a wide range of offensive sexual acts and behavioral practices. Sexual violence manifested in

offensive sexual behavior of the individual ranging from acts of sexual harassment up to that of inflicting grave health damages by committing rape. Sexual harassment in this regard is committed through touch or verbal abuse (WHO 2012:1-2, 4; WHO 2015:84). Sexual violence also attributed to GBV in cases of harmful customary and traditional practices that subdue and expose women and girls to suffer from various kinds of sexual harm. These kinds of sexual violence, for example, include female genital mutilation, child marriage, forced widow inheritance, and marriage through abduction to be mentioned among others.

1.6.2. Rape

This study employed a broader understanding of rape that appears beyond the Ethiopian legal conceptual interpretation. The Ethiopian Criminal Code (414 of 2004) describes rape (Article 620) as an act of forcefully committed sexual intercourse out of marriage through inflicting serious threat or making the women unconscious so that she is unable to defend herself using whatever means. Being limited to forceful sexual act of a man against a woman and committed out of wedlock, the Ethiopian law only recognizes specific form of rape. Hence, the researcher preferred to consider a more inclusive understanding on rape that encompasses other forms of rape. Therefore, in addition to the Ethiopian legal definition on rape, this study considered spousal rape, statutory rape, and rape of men.

The conceptual understanding of rape in this study closely related to the view of some scholars in Ethiopia. Habtamu and Adamu (2013:5) consider rape as "any non-consensual penile penetration of the vagina or anal by physical violence or by threat of harm, or when the survivor is incapable of giving consent due to drug or intoxication of alcohol." However, as the issue of consent to sexual act appears central to the authors in defining rape, it is also essential to include relevant factors beyond intoxication. Consideration of factors beyond consent particularly refers to cases of minors due to age or other reasons of incapacity like physical and mental disability. Therefore, the word rape in this study signifies any forceful sexual penetration of a person (male or female) without consent, including similar acts against children and other minors who cannot give their consent.

1.6.3. Prevention interventions

The design of relevant approaches to prevent rape and other forms of sexual violence mainly considers the target group that the intervention intends to address. The word intervention frequently appeared in this study with the phrase rape prevention, where this represents similar usage by the CDC. Thus, the word intervention in such a usage linked to rape prevention refers to “any prevention or service-related activity" (CDC 2004:3). Therefore, the phrase Prevention Interventions in this study refers to the implementation of project activities or programs on rape by concerned institutions. Prevention interventions also refer to both scenarios of efforts undertaken with the intention of avoiding rape before it occurred and that of responding properly after the rape incidence.

1.6.4. The comprehensiveness of rape prevention interventions

Comprehensiveness is a prominent prerequisite for effective rape prevention intervention, where a comprehensive program entails “addressing the multiple levels of influence for sexual violence victimization and perpetration” (DeGue 2014:1, 4). Comprehensiveness of rape prevention interventions is inherent to the holistic approach of the socio-ecological model. It represents simultaneous, combined, and mutually reinforcing interventions or programs to address influencing behavior for risk of rape or perpetration (Basile *et al* 2016:11).

The usage of the phrase ‘comprehensiveness of rape prevention interventions’ in this study, therefore, represents prevention approach with packages of evidence-based educational, promotional, health care, and legal support activities. In other words, considering both primary and secondary/tertiary prevention interventions characterize comprehensiveness of prevention interventions. Such packages also constitute empowerment on risk-reduction and creating an enabling environment for target groups. It also embraces emotional support to rape survivors. Besides, comprehensiveness of the intervention entails multi-sectoral engagement through partnership and networking among stakeholders (Basile *et al.* 2016:13).

1.6.5. The perception of professionals on the comprehensiveness of rape prevention interventions

The perception of research participants on the comprehensiveness of rape prevention interventions at their respective government institutions remained a central issue of inquiry in the study. Moreover, gathering of primary data on how existing interventions respond in addressing problems of rape survivors relied on the perception of professionals working on rape prevention.

According to the Longman Advanced American Dictionary (2006, sv 'perception'), the word perception refers to "the way you understand or think of something and your beliefs about what it is like". From this dictionary definition, the word perception signifies how an individual comprehends and views towards a particular fact or situation. Therefore, usage of the word perception in this study represents personal understanding or view of research participants regarding comprehensiveness of existing rape prevention interventions. Besides, the word perception denotes views of the participants on relevant issues of the research inquiry based on their experience as professionals working in this area.

1.7. Limitation of the study

The study considered aspects of inquiry from the professionals' points of view regarding rape prevention interventions and programs by government institutions. In order to understand and describe the rape prevention interventions and programs in Addis Ababa, the study preferred to adopt the qualitative research approach. Hence, the researcher decided to rely on the experience and expertise of the study participants working in the area of rape prevention interventions and programs. Therefore, with such a limited scope of the study, the researcher only selected participants from professionals working on rape prevention at the government institutions in Addis Ababa. As a result, the study did not include rape survivors, the family of the *survivor*s, and convicted perpetrators to be mentioned among other relevant primary data sources due to the shortage of time and financial constraints.

1.8. Structure of the study

This study has a structural arrangement divided into five Chapters. Chapter-One introduced the research topic and dealt with introductory sections of the study, mainly on justifying the rationale to conduct the study by discussing the problem statement and defining the purpose. Similarly, the researcher set the study objectives and drawn the corresponding research questions in Chapter-One. Besides, the first Chapter operationally defined the key terms and concepts to the study. The first Chapter also encompasses the section on the limitation of the study.

The study reviewed relevant literature addressed under Chapter-Two and given emphasis to the consultation of relevant scholarly works and studies on the pertinent views linked to this study. The review of literature started with the basic concepts and facts about rape, mainly on the various interpretations of rape, the causes, and effects as well as the incidence. Substantial literature reviewed on the nature of rape prevention interventions and programs globally, and few of the available works referring to the context of Ethiopia. The review of literature considered crucial intellectual debates focusing on rape prevention interventions and programs. The Chapter also covered the essential elements of effective rape prevention interventions and programs, as well as the challenges and lessons learned referring to the global literature. Besides, this Chapter dealt with the social-ecological model as a framework that informed the study.

Chapter-Three discussed the methodology of the study, which indicated the research approach and thereby informed the research design. The section under study design explained why the researcher preferred to use a qualitative approach and adopted the descriptive nature of research design. The third Chapter also briefly reflected on the research process. Further sections on the methodology addressed under Chapter-Three accommodated explanations on the units of analysis, and the sampling techniques employed for the selection of research participants. The third Chapter also dealt with methods of data collection with the corresponding instruments, as well as illustrations on data analysis and interpretation. Furthermore, this third Chapter showed how the researcher ensured the validity of data sources and the study findings. The Chapter

also elaborated Ethical Considerations of the study, particularly on how the researcher maintained ethical standards evidenced in ensuring confidentiality, voluntary participation and the informed consent of the research participants.

The fourth Chapter presented and discussed the research findings sequentially in line with the research questions. Thus, Chapter-four reported the outcome of the analyzed data through narrative statements. At the end of the study report, Chapter-Five presented conclusions drawn from the research findings. Moreover, the fifth Chapter considered recommendations to address the corresponding gaps and challenges identified in the study, and thereby to enhance existing rape prevention interventions in Ethiopia.

Having this structure of the study in mind as indicated above, the next section covered the review of literature constituting Chapter-Two. The following Chapter deliberated on scholarly discussions pursuant to the major topics associated with problem statements, the study purpose, the objectives, and the pertinent inquiries underlining the research questions.

CHAPTER 2: REVIEW OF RELATED LITERATURE

2.1. Introduction

In this Chapter, the study presented the review of relevant literature or what other scholars have undertaken in their studies, particularly in line with the major topics related to the research questions (Creswell 2014:29). The researcher reviewed various studies to get helpful insights throughout the study process. This mainly assisted in deciding the study design and methodology, in determining the scope of the research questions, and to learn more about related scientific works (Neuman 2007:69).

The fundamental purpose of the study inquiry has to do with describing the situation on rape prevention interventions and programs in Addis Ababa, and investigate how the implementing institutions respond to address problems of rape survivors. In line with these inquiries, the study asked complementary questions on the comprehensiveness of rape prevention interventions or programs implemented in Addis Ababa with the intention of identifying possible challenges encountered. Then, the study attempted to come up with workable recommendations on what shall those institutions do to address challenges and thereby enhance the implementation of rape prevention interventions.

The study reviewed electronic resources from online library of the University of South Africa (UNISA) as well as available books and government reports in hardcopies. The researcher primarily searched for recent resource materials as available. Hence, about 92% of the reviewed literature published within the last 17 years, i.e. as of 2000. However, few of the citations referred to earlier literature, specifically in cases of proclamations and in search of the original works. Therefore, review of the literature under this Chapter started by showing the various interpretations of rape. The views towards rape discussed referring to the different forms of rape, the socio-cultural oriented understandings on rape, the distinct legal definitions, as well as the clinical interpretations. Then, this section discussed topics on the causes of rape, effects on rape survivors, as well as the incidence of rape globally, nationally, and at the level of Addis Ababa.

The other significant topics of interest to the study considered in the literature review referred to the nature of rape prevention interventions and the characterizing elements of effective prevention interventions. The reviewed literature then addressed the dominant intellectual debates pertinent to enhancing interventions and programs on rape prevention. The literature review section also summarized the appropriate research works on the challenges and lessons learned so far regarding rape prevention interventions and programs. Finally, but not least, this Chapter on literature review identified an approach and set the benchmark that served as a conceptual framework to guide the research inquiry. Therefore, this section briefly explained the social-ecological model based on the scientific works about its formulation and summarized the fundamental theories that built up the model.

2.2. Conceptual and theoretical frameworks

2.2.1. Conceptual understanding of the various interpretations on rape

The WHO guideline on medico-legal care for survivors of sexual violence (2003:6-7) indicates that the word rape is often regarded to have similar connotation, and alternately applied with other phrases. Those phrases include sexual assault, sexual abuse, sexual harassment, sexual outrage, and sexual violence to be mentioned among others. Even though those phrases alternately applied with rape as if they were synonyms, they have different meanings in varying contexts. For example, sexual harassment, according to WHO (2012:2, 4), can refer to forms of sexual violence such as abusive verbal sexual comments and unwanted sexual touch.

Even though the term sexual violence appears inclusive, there is still disagreement in defining sexual violence as an overarching phrase and in understanding specific elements (Basile *et al* 2014:1-2). The phrase sexual violence has multidimensional interpretations. The act of sexual violence involves several forms, ranging from a forced act of sexual penetration up to the traditional practice of female genital mutilation or forced exposure to pornography. Thus, such a broader category of sexual violence constitutes rape (WHO 2004:7). Similarly, the report of WHO (2015:84) identifies rape under sexual violence, where rape is specifically associated with forceful penetration.

Sexual violence is generally defined as “a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse” (Basile *et al* 2014:12). The same authors further show that infringement of consent in rape constitutes "forced or alcohol/ drug-facilitated penetration of a victim". The survivor can also be compelled on the other hand to commit sexual intercourse with the assailant or another person, including through drug or alcohol intoxication. For these authors, sexual violence also involves both purposeful body contacts of a sexual kind and actions without involving physically- i.e. "non-contact acts of a sexual nature".

The interpretations given to rape are limited in scope when compared to that of sexual violence, where the latter encompasses broader connotation. Unlike the definition of sexual violence above (Basile *et al* 2014:12), interpretations of rape often do not refer to issues like “intentional sexual touching” and “non-contact acts of a sexual nature”. The usage of the word rape usually denotes an aggravated and worst form of sexual violence, and thus, the word rape cannot necessarily represent all forms of sexual violence. As indicated in the “Background Paper for Medicolegal Toolkit”, WHO (2015a:3) includes rape as an element of sexual violence by stating, “Sexual violence includes rape”. The same paper defines rape as “physically forced or otherwise coerced penetration even if slight of the vulva or anus, using a penis, other body parts, or an object.”

In defining rape, issues of consent and penetration appear among the contentious points and factors to alter varying interpretations of rape. The notion of consent invokes an endless dispute when it comes to the question of verifying whether there was consent or not. Even though consent appears simple and refers to “the response by an individual to sexual interactions”, the problem lies in evaluating consent from an external and independent point of view (Eriksson 2010:110). The concept of consent by itself has an indefinite nature due to socio-cultural or customary practices. Thus, the challenge in defining consent involves that “its interpretation varies greatly between its factual and everyday use and its various legal definitions” (Eriksson 2010:110). For example, such difficulty appears where a minor can factually agree to sexual intercourse, but determining consent in such cases is inherent to the legal age limit.

Associating rape with the issue of sexual penetration also contributes to the differences in interpretations. Sexual penetration refers to “physical insertion, however slight, of the penis into the vulva; contact between the mouth and the penis, vulva, or anus” (Basile *et al* 2014:11). Same authors also consider “physical insertion of a hand, finger, or another object into the anal or genital opening of another person” as sexual penetration. However, as discussed in the legal interpretation section below, there are cases where rape does not necessarily involve sexual penetration. For example, Karina (2011:2) mentions two broader scenarios when countries define rape. Accordingly, when some countries consider every forceful act of sex as rape, other countries require sexual intercourse involving male and female genitals as fundamental requirement.

There are erroneous views of rape based on myth. Such views prevail when societies overlook or misconceive the act of rape, or blame the rape survivor instead of the assailant. Moreover, the prevailing view among implementing institutions towards rape and the survivors can influence the nature of rape prevention interventions, including service provision. Hence, distinguishing between misconceptions of rape based on myth and the proper understanding is essential to address the problem of rape survivors (WHO 2003:10-11).

The term rape can also signify varying legal interpretations in different countries. One can get various meanings of rape within the laws of a single country, like the variation in the United States of America (USA) from state to state (Herman 2008). As the Ethiopian Criminal Code (414 of 2004) states under Article 620, rape appears as if exclusively associated with offense against female. The Criminal Code does not directly mention the term rape when it comes to the male survivors of sexual violence. The Criminal Code (414 of 2004) indirectly mentions the possibility of sexual violence against boys. This particularly refers to the section on "sexual deviations” and the sub-section on “Homosexual and Other Indecent Acts Performed on Minors” (Article 631). As indicated under the same article, this indirect reflection of the Criminal Code about the rape of boys attributed to the statement “Whoever performs a homosexual act on a minor”.

The illustrations above confirm that there exist various usages and expressions on rape. Such variations generally attributed to the distinct legal definitions in different countries, medical interpretations, societal value-oriented meanings and the feminist scholarly views among others. The sections below address major interpretations of rape with further elaboration.

2.2.1.1. Conceptual interpretations referring to the different forms of rape

There are interpretations of rape associated with the different forms of rape. The common forms of rape include forcible rape, date rape, acquaintance rape, spousal rape or marital rape, and statutory rape or rape of a minor. There are also other forms of rape known as male rape, rape while falling asleep and being intoxicated with alcohol or drug. Furthermore, forms of rape can refer to sexual coercion in return to certain benefit, prison rape, gang rape, as well as mass rape or systematic rape (Basile & Smith 2011:407-408; WHO 2003:6-7; WHO 2015a:3; Reproductive Health Response in Conflict Consortium–RHRC 2004:13).

To further elaborate on the forms of rape, date rape also known as relationship rape, signifies sexual offense by a partner who has some sort of close relationship with the survivor (Russo 2000:1, 3). Date rape is usually happening at occasions of romantic meeting arrangements. Acquaintance rape refers to forced sex where the assailant is someone that the survivor knows (Eriksson 2010:202). Marital rape, also termed as spousal rape and often mentioned under domestic violence, occurs among couples in wedlock or between husband and wife (Eriksson 2010:227; RHRC 2004:13). Marital rape involves one of the spouses or couples as an assailant (Basile & Smith 2011:208). Statutory rape, also known as the rape of a minor, occurs when the sexual offense is committed to a child below 18 years of age (Karina 2011:1). According to the international standard, a minor below 18 years of age considered incapable of giving consent (RHRC 2004:13). Besides, when sexual violence involves two or more perpetrators, it is termed as gang rape (WHO 2015a:3; RHRC 2004:13).

The more severe and complicated forms of sexual violence to be highlighted here are crimes of rape committed to people in custody and during conflicts of war. Prison rape entails compelling prisoners to commit forceful sexual intercourse to female prisoners or could generally involve “sexual abuse in detention” Eriksson (2010:201).

When such abuse is committed against male prisoners, it often intends to emotionally damage the inmate or humiliate sexual identity such as damaging “sense of masculinity or manhood” (Eriksson 2010:202). WHO (2015b:37) depicts the severity of prison rape stating, "Rape in custodial situations has been regarded as a form of torture and cruel, inhuman and degrading treatment". In cases where the assailant is a government authority, prison rape considered as a "grave and abhorrent form of ill-treatment".

Interpretation of rape appears by far complicated when it comes to the crime of mass rape, also regarded as systematic rape. It is mainly associated with the application of massive sexual violence against a particular group in times of armed conflict (Basile & Smith 2011:207). Mass rape could have an intention of either deliberately impregnate women of the group under attack to change the identity of the next generation (Eriksson 2010: 13, 70, 163). The same author also shows that mass rape is committed to show superiority by vanquishing the enemy group. This view of rape resulted in consideration of the use of rape as a weapon of war intending to suppress the victimized group. Consequently, systematic rape, when committed in a conflict of war, interpreted as a "crime against humanity and an integral component of genocide" (Karina 2011:2). Interpreting rape with the notion of violence also urges to get rid of the biased view of rape confined to sexuality and gender issues, as well as consideration of male victimization of rape (Eriksson 2010:70). However, as indicated below in the legal interpretation of rape, the Ethiopian Criminal Code directly addressed few of the forms of rape. Having such a narrow scope of legal interpretation would have negative implication on prevention of rape with particular reference to the contribution of law enforcement agencies.

2.2.1.2. Socio-cultural value-oriented conceptual interpretations of rape

Social and cultural factors are among the driving agents inherent to the widespread gender-based abuses and discrimination. The International Planned Parenthood Federation–IPPF (2007:35) describes the major contributing factors to GBV including rape. They include "socialization and cultural definitions of appropriate sex roles, belief in the inherent superiority of males, and values that give men proprietary rights over women and girls".

The statement of WHO (2008:30), substantiating the above argument of IPPF, asserts that there is a higher incidence of rape in a society that upholds male domination. Among the long practiced traditions of gender-based violence, a forced arrangement of marriage, particularly in cases of child marriage, widow inheritance, and abduction practices highly involve rape (WHO 2015b:38). In other words, rape committed in circumstances of customary practices often socially tolerated and condoned in several countries. Thus, in such traditions, the social interpretations of rape would have a different picture rather than inferring it as a crime (Watts & Zimmerman 2002:1234).

Despite encouraging changes in countries like Ethiopia modifying discriminatory laws, there are countries still having oppressive laws as opposed to the internationally ratified human rights (WHO 2015b:39-40). Among the promising changes, some countries modified laws that used to grant immunity to the assailant with the pretext of agreement to marry the rape survivor. However, legal reform by itself does not necessarily mean that the societal understanding of rape has changed. The national survey results in Ethiopia evidenced the above statement. For example, 35% of women and 13% of men age 15-49 years agreed that a husband is justified in beating his wife if she "refuses sexual intercourse" (EDHS 2016:263). There is also substantial incidence of child marriage in Ethiopia as opposed to the criminalization of marriage below the age of 18 years (648 of 2004). Rape of boys has been increasing despite the prohibition of sexual outrage on minors (626 of 2004) by the Criminal Code. This paradox is due to the prevailing customary practice of child marriage. About 58% of women age 25-49 years married before their 18th birthday in Ethiopia (EDHS 2016:67). The same EDHS (2016:72) shows that among adolescent girls from 15-19 years of age, 5.7% married at the age of 15. There would be a high possibility of rape as the age of marriage declines.

A government study shows 50% of girls married under the age of 10 years encountered rape at first sex (MoWCYA 2013:24). The same study also witness 30% of those married from 10-14 years of age similarly suffered from rape at the beginning. In other words, cultural practices in Ethiopia mainly child marriage contributed to the society to be tolerant of the crime of rape despite the criminalization of early marriage and sexual outrage with a minor.

The issue of consent to have sex, particularly in a marriage situation, appear among the controversial views in Ethiopia due to the interrelated socio-cultural factors with legal provisions. The society highly associates marriage with a view of the unquestionable right to sexual intercourse. Hence, only 45% of married women in Ethiopia reported, "they can say no to their husbands if they do not want to have sexual intercourse" (EDHS 2016:286). In other words, the majority of Ethiopian women in wedlock are less likely to consider consent to have sex with their husbands. Similarly, according to the Revised Family Code (213 of 2000), Article 53 granted the spouses to have sexual relations except it immensely influences their health.

2.2.1.3. Conceptualizing rape based on legal interpretations

Legal interpretations of rape evolved and changed a lot through time. Historically, changes in the legal interpretations of rape trace back to the Roman law (Karina 2011:1). The Romans used to associate sexual violation with either the husband or father of the survivor. The Romans also considered rape as humiliating offense to the women with the alleged assumption that the women have lost their virginity. As far as the contemporary legal understanding of rape is concerned, international criminal law has undergone changes from limited scope to a wide-ranging definition. In the past, rape referred to as illegal sexual intercourse out of wedlock and committed by a man without the consent of the woman. This view of rape in the past also implicates “vaginal penetration by a penis” (WHO 2015b:36).

Countries could have varying legal interpretations of marital rape, such as the difference between Australia and Ethiopia. Australia criminalized marital rape since the 1970s (Russo 2000:1), whereas the Ethiopian law does not refer to such context at all (Wolde 2014:40). In Ethiopia, as indicated in the Criminal Code (620 of 2004), rape is a crime committed to a woman in the context of being compelled to sexual intercourse out of wedlock. To make it clear, the Ethiopian legal interpretation of rape does not entertain marital rape. It instead appears to have disregarded spousal rape (MoWCYA 2014:71). In consideration of marriage to inherently entail sexual intercourse, consent to having sex is a taken for granted onus among the couples. However, critiques highly challenged such views in these days as a scapegoat to avoid spousal rape (Karina 2011:3). Hence, while several countries have legally

acknowledged marital rape, some countries like Pakistan appeared to have preferred the traditional interpretation of rape similar to Ethiopia.

The narrowed notion of rape has changed over the years, where radical changes occurred in 2010 as the international criminal law has expanded the legal interpretation of rape (WHO 2015b:3, 36). Hence, a more comprehensive understanding of rape, ranging from gender-neutral sexual offense up to forced spousal sex, has been increasingly adopted by the laws of several countries (WHO 2015b:3, 36-37). Recent legal interpretations of rape emphasize the act of sex where there is no free will, i.e. the rape survivor coerced to have sex. The typical example associated with such a broader interpretation of rape applies to the experience in Norway. A woman assailant in Norway sentenced to rape in 2005 as she orally committed a sexual act without the consent of the man (Karina 2011:4).

The controversial interpretations of rape mainly refer to explanations focusing on penetration, the application of force, and the question of whether there is consent or not. For instance, Karina (2011:2) states that there are some legal definitions of rape considering “penile penetration of the vagina” as a prerequisite. The same author also notes that other laws entertain all forms of sex committed without the agreement of the involved individual as rape. In the case of the legal definition of rape relying on consent, the law can consider some sexual activities as rape irrespective of the issue of penile penetration. The same author also points out the issue of gender as a basis for defining rape in some countries like Brazil. However, the law in such countries does not consider cases of forced sex involving male rape survivors and same sex acts as an act of rape. Similarly, the Ethiopian Criminal Code (620 of 2004) directly referred to rape in line with gender and thus considered the woman as the survivor of rape. Moreover, the Ethiopian Criminal Code has not directly mentioned male rape.

The age of sexual consent also leads to differences in legal interpretation because the minimum age to give consent could vary in line with the legal provisions of different countries (Basile *et al* 2014:55). In Pakistan, for instance, “sexual intercourse with a girl under the age of 16 is always construed as rape, whether or not she is a consenting partner" (Karina 2011:3). However, the Ethiopian Criminal Code (626 of 2004)

criminalizes sexual intercourse with a minor-i.e. below the age of 18 years, where it considered this crime under acts of “sexual outrages” rather than rape.

2.2.1.4. Conceptualizing rape based on medical or clinical interpretations

This study viewed medical interpretation of rape based on clinical and pathological explanations. According to the WHO (2003:44) guidelines for medico-legal care for rape survivors, health facilities provide clinical and pathological descriptions about the damage of rape to criminal investigators and courts. These descriptions usually consist of duration of the damage, how the damage inflicted harm, and ill after-effects of the injury. The same WHO guideline underlines the importance of using internationally set standards. It also categorizes injuries due to rape mainly comprising of: "abrasions, bruises, lacerations, incisions, stab wounds" as well as "Genito-anal injuries related to penetration” (WHO 2003:45-46, 48). Thus, medical or clinical interpretation of rape in this regard refers to the description by clinicians and pathologists about the injuries mentioned above often in replies of the demands of law enforcement agencies.

Studies on rape trauma symptoms have set benchmarks for the diagnosis of Post-Traumatic Stress Disorder (PTSD) long ago referring to the physical, sexual, emotional, and mental aspects of the damage due to rape. The long list of PTSD caused due to rape includes depravity, fatigue, embarrassment, resentment, and loneliness, guilty consciousness, desperate, and behavioral tendency to commit suicide, vengeance, sleeplessness, and lose of sexual feeling. Furthermore, the PTSD mentions stammering, reduced self-esteem, being reserved, a propensity to substance abuse and alcohol intoxication. Moreover, emotional disarrays, a recollection of bad memories, short-tempered, dreadful, horrified, distrustful, and excessive reaction refer to the PTSD among others to mention here (Winkler & Wininger 1997:248).

To summarize the discussion on the various interpretations of rape in line with the context of the study, the reviewed literature shows multiple views towards rape. The views mainly represent variations based on the forms of rape, socio-cultural values, legal ground, as well as clinical descriptions on damage due to rape. The above illustrations not only aim to enrich the understanding on rape, but also intend to inform the design and implementation of effective prevention programs.

2.2.2. Theoretical framework on rape prevention interventions and programs

2.2.2.1. The essential elements of effective rape prevention interventions and programs

There are essential elements that theoretically characterize the implementation of effective rape prevention interventions and programs. For instance, the social-ecological model referred to as comprehensive because of its effectiveness in addressing multidimensional factors influencing rape victimization and perpetration (DeGue 2014:1-3). The widely accepted view on effective prevention of rape is to protect the incidence not to occur from the outset or interventions of primary prevention. Effective primary prevention intervention entails addressing the influencing factors inherent to "relationships, communities, and society that make sexual assault possible" (Quadara & Wall 2012:2).

The major elements in implementing effective primary prevention interventions on rape include "comprehensiveness, community engagement, theory-driven programming, contextualized programming and evaluation" (Casey & Lindhorst 2009:92, 97; Quadara & Wall 2012:1, 9-10). According to Carmody *et al* (2009:23), the Australian national standards for effective sexual assault prevention education stipulate six factors. These factors consist of employing a logical framework informing the methodology of program development and evidenced with a designed theory of change to achieve the results. The third standard refers to implementing a holistic and locally appropriate intervention, followed by the fourth standard of developing and implementing an all-inclusive program. The rest Australian standards consist of the use of workable methods to evaluate programs as well as human resource capacity building to support educational programs.

2.2.2.2. The social-ecological model for rape prevention interventions

Addressing the challenges of rape demands to design and implement comprehensive prevention interventions and programs. Having an effective prevention intervention and program, in turn, needs an in-depth understanding of the problem of rape including the causes, risk factors and the corresponding methods of protection. In this regard, various theoretical approaches contributed to the understanding of the problem of rape. Those theoretical approaches also informed the design of prevention

interventions and programs that can ultimately "sustain protective factors and reduce modifiable risk factors" (CDC 2004:4). Hence, the CDC adopted the social-ecological model since 2004 as an inclusive framework that allows and accommodates consideration of influencing factors in rape occurrence. The influencing factors are manifested either in exacerbating the risk of rape or in averting the threat of rape at multiple levels or domains of influence.

Studies show that adopting multilevel social-ecological model for rape prevention is helpful as evidenced in relevant other public health programs (Quadara & Wall 2012:9, 11-12; Casey & Lindhorst 2009:96, 99). Such programs refer to interventions focusing on changing risky sexual behaviors exposing to HIV infection. Programs on addressing challenges among young people such as drug addiction, alcohol intoxication, teenage pregnancy, and youth violence mentioned among others. Various publications also attempted to develop a guide on rape prevention (Lonsway *et al* 2009:1). However, Townsend and Campbell ([sa]:1) argue that lack of experimental studies on successful approaches urged CDC to develop the social-ecological[1] model for rape prevention. This model is rooted in the various fields of studies such as psychology, sociology, public health, and medicine. Campbell *et al* (2009:4) witness the usefulness of the social-ecological model in considering various approaches. Accommodating broader approaches, in turn, allows program implementation with multiple stages of analysis helpful in rape prevention and addressing consequences of rape. Quadara and Wall (2012:4-5) also discuss that social-ecological model "describes the interrelatedness of different spheres of social life and the interactions between individuals and their environments".

The ecological model has attracted the attention of CDC and WHO, where both considered the model as applicable to designing broader prevention interventions on rape (Campbell *et al.* 2009:5). The broader nature of ecological model is attributed to its consideration of the "psychological, social, and organizational levels of influence" (Sallis, Owen & Fisher 2008: 466). Besides, ecological model intended to establish "comprehensive framework for integrating multiple theories, along with consideration of environments and policy in the broader community" (Sallis *et al* 2008: 467).

[1] The word ecology, according to Sallis *et al* (2008:467), is "derived from biological science and refers to the interrelations between organisms and their environments" 2008:467).

As indicated in the 2002 World Report on Violence and Health, the ecological model first appeared at the end of the 1970s. In this report, WHO (2002:12) employs the ecological model to comprehend the complex issues involved in sexual violence conceptually. The model views that rape involves multifaceted factors attributed to the individual, interpersonal linkages or relationships and further elements influencing at socio-cultural and policy levels or legal environments. Hence, for rape prevention interventions and programs, the WHO (2002: 159) report considers the essentials of understanding the various factors influencing the occurrence of rape. The same WHO report witnesses that "There is no single factor to explain why one person and not another behaves violently (WHO 2002:9).

The CDC (2014:2) submits an evidence-based document to the White House Task Force on the prevention of students from sexual violence. This CDC document considered "the four-level social-ecological model" as helpful instrument to learn about the problem and the expected results through potential program interventions. Using this model allows addressing influencing factors at the levels of individuals, their interaction with friends or family members, the community and the broader socio-cultural environment where individuals dwell (CDC 2014:3). Basile (2015:2351) also illustrates that the social–ecologic model refers to "a useful framework for understanding and preventing violence". According to this author, the social-ecological model advises, "contributing factors for violence exist not only at the individual level but also within the context of relationships, communities, and the larger society. To prevent sexual violence, we must develop strategies at all of these ecologic levels."

The social-ecological model boldly considers various factors leading to rape. Thus, prevention programs should pay attention to addressing those multi-level factors and thereby bring about the corresponding changes required to happen (Quadara & Wall 2012:6, CDC 2014:3). Besides, changes of the influencing factors at different levels would eventually result in societal level changes, such as through supporting the development of commendable social norms (Quadara & Wall 2012:8). Employing the social-ecological model also helps to examine the design of an effective prevention program to achieve the desired changes at various levels (Cook-Craig *et al* 2014:1166).

Reviewing the existing theoretical approaches, empirical studies, and the various social and health problems, the CDC (2004:2-5) develops comprehensive model helpful to understand and address the complex problem of rape. Thus, the researcher preferred and adopted the social-ecological model of the CDC to inform this study. For instance, the research questions entail an understanding of rape prevention interventions and programs in line with addressing the multi-dimensional causes of rape. Besides, the damaging consequences of rape on the survivors simiarly need appropriate attention and interventions accordingly. Therefore, the resercher attempted to understand whether the concerned institutions implemented comprehensive rape prevention interventions mainly based on primary data representing research participants' point of view.

To tie the threads together, the researcher mainly adopted the view of the social-ecological model in the effort of achieving the research purpose, and particularly in addressing the research questions. In other words, the research questions asked about the rape prevention interventions and programs implemented by the selected government institutions in Addis Ababa, where the social-ecological model served the researcher as a vital benchmark.

2.2.3. Major debates on rape prevention interventions and programs

There are diverse and contentious views on what factors to consider as causes of rape, and which approaches or strategies to recommend for rape prevention. The diversities of views and intellectual debates mainly refer to the global experiences from rape prevention programs implemented so far. For instance, tackling risk factors to sexual violence and working upon protective factors influencing at the institutional level or the community as a whole have been widely recommended. To this effect, the design and implementation of the research-based holistic program on rape prevention highly recommended in achieving the required change at public level. Nevertheless, the argument here is that there is still insufficient knowledge regarding risk factors influencing the community or institutional levels. Besides, the quest for a practical approach to the prevention of sexual violence is still undergoing (CDC 2014:9).

There is no exact and specific approach to rape prevention despite the continuously growing research engagement. Those research inquiries dwelling on the questions of

“who is at risk for sexual violence perpetration and who is vulnerable to sexual violence victimization” (CDC 2004:11). In this regard, the “Rape Prevention and Education (RPE) Programme” of the CDC suggests consideration of the relevance of strategies based on target groups’ vulnerability. According to the view of Rape Prevention and Education Program, the appropriateness of an approach for the prevention of rape depends on vulnerability of target group. Similar challenges reflected in school-based sexual violence prevention program initiatives globally. Reviews of studies in this regard conclude that there is lack of evidence on how to effectively-address the problem (Parkes *et al* 2017:5).

The public health approach of prevention has been commendable for considering broader inputs from various fields of studies to develop a holistic prevention program. The approach has been praised as suitable to address complex factors and effects associated with rape or sexual violence. However, the public health approach adapted to rape prevention is still questionable. Despite the results achieved so far through the public health approach, Basile and Smith (2011:412) remind that scholars still have questions. Intellectuals argued that they still “need ‘new eyes’ to fully capitalize on what a public health approach can offer" to address the challenges of sexual violence. This argument entails the need for further studies to justify the public health approach to the prevention of rape.

Scholars argue that the public health approach should have utilized clinical or medical intervention to decide occurrence of rape exactly adopting similar procedures as in the case of other diseases. As a result, such scholars claim that there is a “missed opportunity” (Basile & Smith 2011:412). This debate involves the contentious argument whether to consider “universal screening for sexual violence victimization” as it serves in determining other diseases of public health concern. As opposed to the demand of several intellectuals for consideration of universal screening for sexual violence, the issue remains subject to further study.

The other intellectual debate referred to ideological arguments inherently drawn from the clear understanding of rape or sexual violence. For instance, such intellectual debate with direct contradiction is evident among the supporters of conservative ideology on the one hand and the advocates of the feminist theory of rape on the other

hand. The conservative ideology claims that the behavior of women is a driving factor for rape, where the failure of adherence to the established societal norms leads to rape (Valentich & Gripton 1984:452).

In contrary with the conservative ideology, the feminist theory of rape proclaims that the deep-rooted causes of rape attributed to the socialization or socio-cultural orientation of the perpetrator (Boakye 2009:1636). This situation is inherent to the patriarchal dominance (Watts & Zimmerman 2002:1232). In other words, the followers of conservative ideology prefer to prevention interventions targeting behavioral factors of the rape survivors themselves. On the other hand, advocates of feminist theory focus on factors influencing the perpetrator engrained to repressive societal values.

The researcher did not come across a typical scholarly debate in the available studies conducted so far in Ethiopia. However, some scholarly works indirectly reflected on controversial issues where solving such stalemates could make a difference in enhancing rape prevention interventions. For example, Tegbar *et al* (2010:43) point out lawyers challenging the views on spousal rape by referring to the Ethiopian Family Code (213 of 2000). The lawyers' claims here cited Article 53 where spouses have legal obligation to provide sex to each other, and "Any agreement to the contrary shall be of no effect."

According to the above argument of the lawyers, mentioning the issue of spousal rape or sexual violence in a marriage appears baseless or inappropriate from the Ethiopian context. In line with this argument, the Ethiopian Criminal Code (414 of 2004) rules out spousal rape particularly in the statement that defines rape (Article 620). On the other hand, as noted in Yemane (2004:131), the Ethiopian Constitution grants women equal rights with men in marriage. Besides, the constitution recognizes the international conventions on human rights and the abolition of oppressive practices and laws on women. To cite the Ethiopian Constitution (1 of 1995), Article 35 declares, "The State shall enforce the right of women to eliminate the influences of harmful customs." This article proclaims, "Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited." More importantly, Article 1

of the Constitution asserts, "Any law, customary practice or a decision of an organ of state or a public official which contravenes this Constitution shall be of no effect."

The argument of whether to criminalize forceful sex in wedlock or not appears beyond academic debate in the context of Ethiopia, where the issue is a matter of ensuring constitutional declaration. Ethiopia enacted both Family Code (213 of 2000) and the Criminal Code (414 of 2004) after the Constitution (1 of 1995). However, both proclamations fail to ensure constitutional provision by criminalizing spousal rape, which appears inherent to the age-old traditional practice. The researcher, therefore, realized that if there were evidence-based interventions and programs on rape prevention in Ethiopia, it could have facilitated fertile ground for scholarly observations and advocacy. In other words, implementing research-based programs can set a room for scholarly debates on which approach of rape prevention intervention or program is more effective and why. Besides, research oriented interventions help to address scholarly inquiries on what lessons learned and limitations encountered from the implementation of a particular program to mention among others.

2.3. Prevalence and incidence of rape

2.3.1. Prevalence and incidence[2] of rape globally

As the existing reports on rape to law enforcement, health care, and relevant other agencies represent the limited proportion of the actual cases, getting the actual incidence of rape is difficult. Nevertheless, the existing reports collected on rape under several challenges still show a widespread magnitude of the problem globally. The WHO (2015b:35) report reveals that the global incidence of sexual violence among women throughout their life accounts for 35%. However, the same report points out the influence of under-reporting in determining the incidence. Hence, the report states, "Very few cases of rape reported to the police, making it almost impossible to estimate the actual extent of rape worldwide" (WHO 2015b:36). Nevertheless, the same global report witnesses the occurrence of rape everywhere,

[2] Incidence of rape: refers to the prevalence of forced sex measuring to what extent that rape is committed against a particular group such as among women, children or boys within a specific period (MoWCYA 2013:19).

and happening to women in wedlock, out of marriage, and those having intimate relationship.

The WHO (2005:8-9) study among women of 16 years and above, conducted in 20 selected cities of various countries, also reiterate the above challenges of rape. This WHO study considered six countries in Africa, six in Latin America, four in Asia, and four in Eastern Europe. Hence, the study report came up with varying figures on rape incidence. Eriksson (2010:182) also shows study finding on "sexual violence by non-partners" in 10 different countries with incidence of 10-12% in Peru, Samoa, and Tanzania. However, similar report points out lower incidence in Bangladesh that only accounts one percent. Nevertheless, according to the United Nations, more than 250,000 rape cases annually reported at the global level (Karina 2011:1).

Rape represents a global phenomenon, where females and children constitute most of the vulnerable or affected groups, while males are the majority of perpetrators (US Department of Justice 2008:2; WHO 2015:35). Gessessew and Mesfin (2004:140), reviewing cases of rape in the USA, Czech Republic, and South Africa, affirm that there is varying and a higher incidence of rape worldwide. Basile and Smith (2011:408) also indicate high prevalence of rape in the USA among girls and females. As such, these authors report rape incidence of 10.6% and 2.1% among women and male survivors in the USA, respectively. Referring to the 2011 survey on sexual violence in the USA, Basile (2015:2350) reaffirms considerable victimization of children. According to the same survey, from the total women with experience of rape during their lifetime, 40% had forced sex during childhood. Reporting high prevalence of rape in the USA, Basile *et al* (2016:7) show 19.3% of women and 6.7% of men faced rape throughout their life. The United States Department of Justice (2008:2) report on rape identifies females as disproportionately (89%) affected, where young rape survivors (12 to 17 years) constitute 81%. Regarding the perpetrators, the same report asserts that male assailants committed the majority (95%) of the offence (2008:2).

2.3.2. Prevalence and incidence of rape in Ethiopia

There is ample evidence on the high occurrence of rape in Ethiopia (Gessessew & Mesfin 2004:140). The general picture regarding the incidence of rape in Ethiopia is

similar to the global situation, where rape often occurs against females and committed by male perpetrators (Ministry of Labor & Social Affairs-MoLSA 2005:13; Yemane 2004:131-132; Fikir & Assaye 2005:223-226). Despite a higher estimation of rape incidence in Ethiopia, mainly because of the widespread practices of forced marriage such as abduction and child marriage, getting an accurate figure on rape incidence is difficult.

The widespread problem of rape and other forms of sexual violence uncovered through studies undertaken at national level and in various parts of Ethiopia. The EDHS (2016:65) report on median age at marriage among women is 17.1 years. According to another government report on child marriage in Ethiopia, among ever-married women, 7% married before their age of 10, and 33% married before their age of 15 years (MoWCYA 2013:25-26). The critical issue about child marriage refers to high possibility of forceful sexual intercourse at the beginning of the marriage and the continued practice despite its criminalization. The underreporting of rape, therefore, is a common challenge in Ethiopia where the legal, socio-cultural, and religious influences exacerbated the problem (Wolde 2014: 21, 23, 30; Gessessew & Mesfin 2004:140-143; NORAD 2009:11).

Studies conducted on sexual violence against young women in Ethiopia also show prevailing incidence of rape crime. For instance, a study on female high school students in North-Western Ethiopia indicates that 33% started sexual intercourse with rape (Yohannis *et al* 2005:217). A study on female high school students also reported 5% of completed rape and 10% of attempted rape, whereas 85% of the rape survivors were minors (Yemane 2004:131). Higher rape victimization of children also reported by Fikir and Assaye (2005:223-226), where from 214 allegedly abused children below 15 years of age, the rape cases consist of 96%. The male survivors on the other hand account 10%. According to a study on street children in two towns of Ethiopia, namely Shashemene and Dilla, 20% of street girls and 10% of street boys found rape survivors (Government of Ethiopia 2007:55-56). A relatively recent study conducted among adolescent female students in the southern part of Ethiopia came up with an 11% incidence of rape (Mekuria et al 2015:1). According to another study on “Sexual Violence against Female Students in Wolaita-Sodo University, Southern Ethiopia”,

completed rape accounts 8.7%, whereas attempted rape constitutes 23.4% (MoWCYA 2013:40).

The studies mentioned above conducted at different parts of Ethiopia from 2004 to 2015 show various figures on rape incidence among female students, which range between 11 to 33 %. On the other hand, the United Nations Population Fund (UNFPA) and Population Council had an effort in 2008 to determine the incidence of rape at a broader scale in Ethiopia. Thus, among the sexually active respondent women, 25% found to have started sexual intercourse in a coercive manner. The incidence of rape in rural Ethiopia is also severe, where 33% of rural women start marital life with forced sex (MoWCYA 2013:24). However, the government not formally considered the aforementioned 25% report on rape incidence. The government rather taken only 17% as rape because of the argument from the legal side not to consider cases of forceful sex committed under wedlock. The same government report also shows that only a few of the survivors went for health care (below three percent) and reported to law enforcement agencies (1.9%). This report not only acknowledges high incidence of child marriage, but also recognizes rape as the highly prevalent crime among the other forms of sexual abuse against children (MoWCYA 2013:23).

Even though the Ethiopian Criminal Code (Article 620) does not recognize marital rape, studies witness extensive prevalence of domestic violence by intimate partners coupled with socio-cultural values and religious beliefs. For instance, a qualitative study in northwest Ethiopia shows the tradition where the man is supposed to initiate sex and religious views urging the woman to obey the husband (Tegbar, *et al* 2010:42-43). The EDHS (2016:263) report came up with more compelling evidence on the prevalence of high domestic violence (63%) in Ethiopia.

Regarding spousal rape, 35% of women and 13% of men within the age of 15-49 years believe that wife beating is justifiable. They think that it is acceptable for the husband to beat his wife if she is not willing to have sex with him. The same EDHS (2016:44) report further shows the prevalence of spousal violence among young married women age 15-19 years constitute 10%. There were also government reports showing a high incidence of violence against women, but study findings mixed up

sexual violence with other types of violence. For instance, a study on Intimate Partner Violence in Western Ethiopia against women reveals prevalence of 57%, which refers to a combination of "sexual, physical and psychological violence" (MoWCYA 2013:22). This report further depicts a severe prevalence (65%) of the same combination of violence against women by husbands in Southwest Ethiopia. According to this government report, the proportion of sexual violence is outweighing the physical offence.

On the other hand, the lifetime sexual violence against women by their husbands in Ethiopia varies by rural versus urban residence and the regions. This variation on incidence of lifetime spousal sexual violence ranges from 19% to 59%, of which spousal rape specifically constitutes 20% (Semahegn & Mengistie 2015:4-5).

2.3.3. The prevalence and incidence of rape in Addis Ababa

Addis Ababa is not only the biggest metropolis in Ethiopia, but it is also the socio-economic and political nerve center of the country, literally since its foundation around 1887 by emperor Menelik II. Currently, Addis Ababa is the capital of the Federal Democratic Republic of Ethiopia. It also serves as a seat of several international and continental organizations, including the United Nations Economic Commission for Africa and the African Union. The city has ten sub-cities with a total area of about 540 Sq. Km^2, which is geographically located at the center of the country (Addis Ababa BOFED 2013:13, 15). Addis Ababa has an estimated “metro population of more than 4.6 million” (http://worldpopulationreview.com/world-cities/addis-ababa-population/).

Rural girls are smuggled by drivers, brokers, sex workers and relatives living in the capital, where most of the smugglers themselves migrated earlier to Addis Ababa from rural areas, (Gebre *et al* 2009:33-34). These migrant girls to Addis Ababa constitute among the highly exposed to rape and sexual exploitation. Most young girls have also fled from the countryside to avoid child marriage. Unfortunately, these young rural girls often indulged in a transactional sexual relationship. They finally end up with risky life on the street as night street girls and transactional sex occupants (Wolde 2014:5-6; Gebre *et al* 2009:34).

There is limited data on the incidence of rape in Addis Ababa. However, analysis of raw data based on the rape cases reported to the Federal Prosecution, currently named Federal Attorney General, shows that females and children are among the severely affected group. The existing reports confirm that women constitute the majority of rape survivors in Addis Ababa. The crime of rape is highly prevalent among minors (below 18 years), women collecting fuel-wood on Entoto Mountain-i.e. at the outskirts of the city, adolescent girls within and out of school settings, and among housemaids or female servants (Tsegahun 2008:37). The Federal Supreme Court of Ethiopia and Save the Children Sweden (2006: 6-8) joint report also depicts 1,572 cases of six types of correlated sexual offences. The Federal Prosecution registered these cases from July 2005 to June 2006, which consist: rape, attempted rape, homosexuality, abduction, attempted abduction and crime against morality. The report indicates that females constitute 96.4% of the survivors, where 91% are below 18 years of age. In the following two years (from July 2006 to June 2008), about 1,708 charges and claims represent abuses against women and children recorded in Addis Ababa. In the latter report, female survivors count 78%, whereas 42% registered below 13 years of age (Federal Ministry of Justice 2008:12).

There are also male survivors of rape, where a significant incidence reported among street boys in the city. Getinet (2009:174) reveals 28.6% of rape among street boys in Merkato[3] area. The author describes rape incidence among boys mounting horribly at an alarming rate (2009:176). Lifetime prevalence of rape among male students in Addis Ababa also estimated at 4.3% (Haile *et al* (2013:1, 4). However, male survivors of rape are less likely to report the incidence as compared to girls, and thus most of such cases hardly appear before the court of law (Assefa 2011:13).

2.3.4. Under-reporting as a challenge on prevalence and incidence of rape

Although rape is committed all over the world, the only limited proportion of the actual incidence of rape reported to the law enforcement agencies. The WHO (2015b:36) report on sexual health, human rights, and the law show that rape cases usually fail to be reported and recorded. The same WHO report shows reasons for insufficient documentation on rape. They include massive emotional damage upon the

[3] Merkato is a very big open market place in Addis Ababa

survivor, guilty consciousness, embarrassment, frustrating reactions from family and neighborhood, mistreatment by health care and legal support agencies. The reactions towards rape survivors usually lack empathetic and unbiased care.

Moreover, individuals dwelling on transactional sex are among the highly exposed groups to the victimization of rape, but they constitute among the less likely to reported. This usually involves bar owners, pimps, customers, sex partner as well as police and related security officers. As the WHO (2015b:42) report shows, commercial sex workers often face sexual violence by law enforcement personnel as an exchange to avoid penalties. In such instances, and the sex workers are less likely to report rape cases as they have the minimal confidence to get legal protection. Karina (2011:1) shows that rape survivors fear further victimization and humiliation by law enforcement agencies themselves. Such concerns contribute to the underreporting of rape and thereby hindering efforts to capture data on the incidence adequately. The same author also reveals an increasing trend of drug use is inhibiting proper consent or to duly notice the very fact of forced sex to report the incidence.

There are also legal and related factors deterring rape survivors from reporting the rape incidence. This challenge of under reporting refers to the situation caused by repressive laws and traditions in some countries. The practice in the Sudan is more relevant in this regard. If a rape survivor reports to the police or seeks for health-care, the Sudanese could consider herself as an offender and liable to adultery (Karina 2011:3). Hence, in such instances, limited rape survivors dare to report the crime to the law enforcement agencies. As a result, repressive legal and traditional practices eventually contribute to the difficulty of knowing the actual incidence of rape (WHO 2015b:36).

A study conducted in two towns of Ethiopia shows similar picture to the global scenario revealing that 44% of reported cases of rape ended up as lost cases. In other words, substantial proportions of alleged assailants remain not prosecuted and thus acquitted from the offense (Government of Ethiopia 2007:58). Even though rape is globally known as “a seriously under-reported crime” (Schreiner 2004:3), this challenge is more critical in countries like Ethiopia. Such challenge is attributed to the varying interpretation and understanding towards the crime of rape. Referring to the Ethiopian context, the primary factors influencing under-reporting of rape include

lack of consistent definition towards rape, and the socio-cultural elements. The long established traditional practices in Ethiopia upholding forceful sex, disclosing rape is associated to humiliation, where covert nature of the crime exacerbates under-reporting (Mekuria *et al* 2015: 2).

Underreporting of rape cases could be more common when the crime is committed against children due to fear of stigma among the family and lack of information among the survivors (Government of Ethiopia 2007:58). Rape of boys is a rarely reported crime to the police because of socio-cultural sensitivity towards such cases. As a result, Getinet (2009:176) argues the possibility of a higher incidence of rape among street boys in Addis Ababa. The same author anticipates that the reported cases of rape among the street boys are by far lower than what is happening on the ground. Similarly, sexually abused boys usually decline from reporting for fear of stigma (Haile *et al* 2013:1).

2.4. Causes and effects of rape

2.4.1. Causes of rape

Rape assailants can coerce an individual to involve in the sexual act using several means. Coercion ranges from directly exerting physical force to subjugating the survivor for sexual intercourse and incapacitating the survivor with substance abuse or intoxication of alcohol. Unlawful enrichment using one's authority for sexual exploitation, exchange of sex for livelihoods and cheating the survivor with deceitful promises can be instruments of rape. Besides, continuous intimidations against the survivor to give in for sex and verbal extortions to cease the partnership or defame the survivor with rumor can serve as means of rape (Basile *et al* 2014:13).

Review of research literature for practitioners with the support of the CDC asserts that being intoxicated with alcohol or drug has a significant role in causing rape (Lonsway *et al* 2009:2, 8). For instance, the national survey in USA shows that 20% of female and 40% of male survivors raped while drunk or under drug influence. The same survey indicates nearly 50% of the assailants committed rape "under the influence of alcohol at the time of the assault" (Lonsway *et al* 2009:12).

Existing evidence shows that female children are substantially (twice or more) exposed to sexual abuse worldwide as compared to male children. Highly contributing causes of vulnerability refer to the "absence of one or both parents or being raised by a stepfather, parental conflicts, family adversity, and social isolation" (Mekuria, Nigussie & Abera 2015:2). The authors also mentioned being from low-income families or among disadvantaged groups in the list of vulnerability factors to rape. The same authors identified further factors of victimization of rape among female high school students in the southern region of Ethiopia. Hence, more vulnerability detected among students residing alone and among those living with friends, as compared to the students who were in custody of their parents (Mekuria *et al (2015:1).*

There is a linkage between victimization to rape and other forms of abuse. According to the CDC technical package on sexual violence, "girls who have been sexually abused are more likely to suffer from … sexual violence re-victimization" in their future life (Basile *et al* 2016:8). Moreover, those who had the experience of "bullying in early middle school" will have more tendencies to committing rape later on. Furthermore, sexual debut at a younger age and facing challenges like the inability to perform sexual intercourse are associated with the likelihood of perpetration among males (Basile & Smith 2011:413).

The IPPF Office in South Asia region (2007:35) identifies causes of GBV in line with addressing the needs and rights of the survivors. The causes of GBV for IPPF mainly attributed to cultural, economic, legal, and political factors. The cultural causes of sexual violence include gender-oriented socialization determining sexual entitlements, deep-rooted beliefs of male domination. These causes also refer to the traditions subjugating the female as if she were property of the man. The economic factors also affect the woman being heavily dependent on the man where she usually has a narrow opportunity for employment and thereby self-sufficiency. The legal factors that IPPF mentioned as causes of GBV emanate from the wrong definition of rape and other forms of sexual violence. Legal factors also encompass lower awareness of women on the existing laws and reluctance of law enforcement agencies in redressing justice for

rape survivors. As indicated in the above section on the legal interpretation of rape, this attribute also represents the situation in Ethiopia (Wolde 2014:40).

Women are less represented at political positions in general, where issues like domestic abuses including marital rape often overlooked and not given attention (IPPF 2007:35). The challenge of domestic violence has remained a widely prevalent problem in Ethiopia (EDHS 2016:303-309). Besides, the situation would be more severe in the context of Ethiopia where "Abduction, spouse alcohol consumption, hostility, and previous witnessing of parental violence" could contribute to rape, including spousal rape (MoWCYA 2013:22). In line with cultural factors, Mekuria *et al (*2015:1) show higher incidence of rape among students who do not transparently discuss sexuality issues with parents.

The Ethiopian government report similarly identifies "poverty, economic inequalities, dysfunctional families, rural-urban migration" among responsible factors to the vulnerability of children (MoWCYA 2013:23). The same report further recognized "gender discrimination, irresponsible adults' sexual behavior, and harmful traditional practices" among the root causes of sexual abuse and exploitation of children. The other government report reveals a category of fundamental and immediate factors as causes of violence against women in Ethiopia (MoWCYA 2014:20). According to this report, the fundamental factor refers to the "systemic gender-based discrimination against women". The immediate causes, however, constitute triggering factors like economic constraints and incapacities of survivors.

The section discussed above on various and multiple causes of rape referring to relevant literature shows that addressing multidimensional influencing factors implies developing comprehensive rape prevention program. It further infers the need to work on relevant strategies to address the causes at different levels. Considering the context of Ethiopia, for instance, entails developing a holistic program accommodating various factors influencing the occurrence of rape at different levels as indicated above. Those factors are ranging from the individual socialization up to the socio-cultural values, and institutional challenges linked to the law enforcement, economic and political empowerment.

2.4.2. Effects of rape

2.4.2.1. Reflection on the effects of rape in general

Rape can cause emotional and physical health damages in addition to societal threats against the survivor. According to WHO (2015a:3), the physical health-related damages of rape usually appear as an immediate consequence such as unwanted pregnancy, infectious diseases through sexual intercourse including HIV and AIDS. Furthermore, physical dames include gynecological problems like inability to fertility, damages to genital organs, fistula, and ureteral infections among others. There could also be other sexual health problems on abortion implications as well as gynecological and obstetric complications (WHO 2015b:36).

The mental health and related societal impacts of rape, as shown in WHO (2015a:3), often sustain long-term damages on the survivor. Those damages are causing emotional instability or trauma, sleeplessness, being fearful, exposure to addiction, hopelessness, and suicidal tendencies. Dills, Fowler, and Payne (2016:8) indicate that teenagers who encountered rape could have more inclinations to commit suicide when compared to those who never had such experience. The WHO (2015a:3) medico-legal toolkit also mentions the social harms of rape, where rape survivors could be socially disgraced and ostracized, including by their family members.

The act of rape, when committed against children, could cause substantial damages to the emotional or the psychological wellbeing of the survivors. Basile and Smith (2011:411) attest effects of rape on a child in catalyzing tendencies of vulnerability to precarious behavioral practices. The major predispositions on such children to risky behavior include unsafe sex, transactional sexual relationship, addiction, and substance abuse, unwanted and early pregnancy. Those tendencies could fuel susceptibility to indulge in illegal activities like drug trafficking, car accident due to alcohol intoxication, and related other acts of violence.

Survivor of rape as a child could face substantial health disorders to the individual future life. Facing rape as a child, for instance, could lead the person to end up with chronic illnesses and death. This could be associated with unhealthy diet, addictions to drugs, alcohol and sexually transmitted diseases including HIV and AIDS without

mentioning the psychosocial and economic impact among others (Basile & Smith 2011:411-412). Hence, rape is considered as a violation of fundamental human rights, where human beings have the inalienable right of protection from any harm (WHO 2015:36; Eriksson 2010:14). As indicated earlier, rape causes both immediate and long-term damages to survivors including physical and sexual health impacts with severe emotional and mental disorders. Luster and Small (1997:131) show vital damages of rape on the survivors including "posttraumatic stress disorder, sexualized behavior, depression, anxiety, high levels of anger and aggression, and low self-esteem". The same authors depict that rape survivors could suffer from withdrawal, drug abuse, self-inflicting acts including suicide.

Ferraro (1996: 669) exposes the grave impact of rape and depicts the maximum level fright of women attributed to the shock and fury associated with rape. Hence, the same author depicts rape as "the ever present terror" among most women. Basile and Smith (2011:410) also show rape highly associated with life-long depression and suicidal attempts. Rape survivors often feel profoundly humiliated and ashamed of themselves, where they could face stigmatization by their family members (WHO 2015a:3). Acts of sexual violence, particularly rape, can enormously influence the survivor's attitude about life (Basile & Smith 2011:410).

2.4.2.2. Effects of rape from the context of Ethiopia in particular

The view on rape in Ethiopia often associated with sexual violence committed against women, and thus studies and government reports mainly refer to the effects on the women and female children. Within this context, the government report identifies consequences of rape comprising 1) damages on health, 2) infringements of human rights and 3) restraining individual entitlements or the person's choice (MoWCYA 2014:20). The abuses of rights and curtailing choices of a woman are widely prevailing in Ethiopian communities with harmful traditional practices. The infringement of rights and choices entails subjugating a minor or the under aged girl for marriage, including forced marriage and abduction. In such cases, the effects of rape are exceeding the health impacts, because there are instances where rape survivors could be unable to develop their talents and exploit opportunities. The rape survivors often remain trapped for their lifetime, and eventually unable to get rid of their vicious circle of misfortunes of life (MoWCYA 2014:21).

The impact of rape appears severe by far among communities in Ethiopia where virginity is at most valued. A study on the status of GBV at selected areas in Ethiopia shows damages beyond the emotional and physical injuries, where rape survivors often forced to marry assailants (Tsegahun 2008:39-40). In such instances, community members will no longer consider the rape survivor as a virgin. As a result, she will have rare chances to marry in the future. The family will further despise the survivor as a disgrace. In other words, the rape survivor will take the blame for the erroneous belief that she brought shame to the family.

A study conducted in the southern part of Ethiopia on childhood sexual abuse experience shows consequences of child sexual abuse. For instance, unwanted pregnancy often followed by unsafe termination appears among the critical ill-after effects of rape against the health of adolescents (Mekuria *et al.* 2015:1). The same study further mentions child rape survivors suffering from despair, reduced self-esteem, alienation, violence, inflicting harm on oneself and loss of sexual desire in the future. The researchers also reveal several indications of behavioral attributes at the margin of personality disorder among the diagnosed high school students (Mekuria *et al* 2015:2). Assefa (2011:15-16) similarly shows possibilities of various consequences of rape, where the survivors suffer from medical, psychological and social sufferings that could be lifelong aftereffects. Girls in Ethiopia reflected the effects of rape as "traumatic and can lead to devastating consequences such as depression, isolation, and low self-esteem" (Marielle 2016:12). Psychological trauma, social isolation and the horror occurring due to rape can even push a rape survivor in Ethiopia to commit suicide (Yemane 2004:131).

2.5. Comprehensive rape prevention interventions and programs with the challenges in implementation

This section focused on the reviewed literature regarding the nature of rape prevention interventions and programs in general. Rape prevention interventions focus on educational programs, health care and emotional support services to rape survivors, law enforcement aspects on prosecution and conviction of perpetrators. Advocacy engagements at a higher level also appear focus areas for changes in policies, laws,

and enhancing related other commitments. These focus areas entail different approaches to rape prevention attributed to the nature of intervention or program discussed below. However, due to the lack of research regarding the existing situation of rape prevention interventions in Ethiopia (Gebre *et al* 2009:24), the study mainly considered relevant research works out of Ethiopia. The issue of rape, in general, has remained among the least researched areas in Ethiopia (Getinet 2009:174). Nevertheless, having minimal research undertakings on the current nature of rape prevention interventions by the government institutions, the study relied on reviewing related scientific publications to inform the study. Hence, the discussion below reviewed literature on the sections attributed to the CDC illustration including program categories by target group for intervention.

2.5.1. The comprehensiveness of rape prevention interventions and programs

The comprehensiveness of a program in rape prevention intervention allows the simultaneous tackling of influencing factors at the individual, peer group, and societal levels. For example, improvements attained at the societal level can reinforce desired changes achieved at the individual level. According to Mekuria *et al* (2015:1), rape prevention interventions at different levels are reinforcing one another. To put it as the authors stated, "Comprehensive school-based reproductive health education, community-based awareness creation, open discussions about sexuality and reproductive health matters with students at family level".

According to the review of Lonsway *et al* (2009:6), educational programs on the prevention of sexual violence show an amalgamation of intervention elements. Educational program elements focus on improving the understanding on rape, and evidence based awareness creation on the magnitude of the problem and the need for empathy. Educational interventions also consist of social behavior change and communication activities on tackling misconceptions about gender roles and GBV. Further educational elements encompass teaching on the impacts of rape on survivors, factors causing rape at all levels. Those factors also include behaviors characterizing potential perpetrators. The other program elements are educating on identifying vulnerability, consent and life skills on interpersonal relationships to have safe dating. Educational programs also constitute disseminating information on existing supports and available opportunities to help rape survivors (Lonsway *et al* 2009:7).

In cases where primary prevention interventions could not avert rape occurrence, availing health care, legal support, and related interventions based on the needs of rape survivors is crucial (Basile & Smith 2011:414). The intervention with prosecution and conviction of rape perpetrators has a substantial role in deterring further offence and potential offenders. Legally redressing rape survivors also supports efforts on a tertiary dimension of prevention. The notion of legal punishment and deterrence asserts that "the perceived costs of crime" determine the drive of perpetration (Bachman, Paternoster and Ward 1992: 345-346). This notion is mainly associated with the inevitability of legally enforced strict and severe punishment.

On the other hand, there is an issue of "time dimension" of rape prevention intervention constitutes among the basic considerations to determine comprehensiveness. The time dimension involves primary, secondary, and tertiary dimensions of prevention (Quadara & Wall 2012:3-4). Consequently, the implementation of rape prevention programs needs to be designed in-line with those dimensions of timing. For example, primary prevention involves activities implemented irrespective of the occurrence of rape with the intention of avoiding perpetration or risk of rape at all (Carmody *et al* 2009:16). As discussed in the earlier sections, secondary and tertiary dimensions refer to prevention interventions after the occurrence of rape (CDC 2004:3). The purpose of secondary and tertiary dimensions represents preventing immediate and long-term damages on the survivor (Dills *et al* 2016:6; Quadara & Wall 2012:3).

2.5.1.1. Interventions with elements of community participation, inclusive approach, and local contextualization

The element of community engagement in effective rape prevention intervention refers to a viable and achievable program through meaningful involvement of the targeted community. Full ownership and commitment of the community members including parents represent among the attributes of effective rape prevention programs (Basile *et al 2016:*23, 25; Quadara & Wall 2012:10, 12). In line with the element of community engagement, contextualized programming is also helpful to intervene by the specific and corresponding influencing factor. Contextualization of programming helps to tackle community-level challenges like rape prevailing within a particular

societal context and embedded as an established value practice of members of a locality (Quadara & Wall 2012:12).

Furthermore, developing a socio-culturally relevant program is one of the characteristics of effective prevention programs (Nation *et al* 2003:449). According to Nation *et al* (2003:452), socially and culturally relevant prevention programs involve interventions customized or tailored to the culture of the targeted community. Thus, community participation is pivotal in the program design and execution processes. In other words, an effective rape prevention program should duly consider the local context such as socio-cultural practices and religious beliefs among others (Casey & Lindhorst 2009:98-100).

2.5.1.2. A program informed by a theory of change

With the attribute of "theory-driven programming", an effective rape prevention program should have a scientific theoretical explanation, which shows the theory of change to achieve program objectives (Nation *et al* 2003:452). It demands a scientific explanation of the problem, mainly on the causes and the corresponding instruments or better approaches to bring the desired change (Casey & Lindhorst 2009:101; Carmody *et al.* 2009:30). In other words, prevention programs should be "based on a sound theory of change" (CDC 2014:4).

Scholars, for instance, advise implementing interventions up to the "sufficient dosage" for effective rape prevention programs. The sufficient dosage entails the requirement of working upon the target groups with the adequate intervention that leads to achieving results (Nation *et al* 2003:452). Citing these authors, CDC (2014:34) underlines the need for repeated implementation of interventions on rape prevention. The CDC also reminds that addressing behavioral influencing factors would be hardly possible through a single intervention.

2.5.1.3. A program having the elements of monitoring, evaluation, research, and learning

The importance of progress monitoring and outcome evaluation of a program noted since the early 2000s to guide decision-making, i.e. whether the program is effective or not, which also represents among the elements of effective rape prevention

programs. In this regard, Nation *et al* (2003:454) underscore the crucial role of conducting program evaluation research reiterating that it informs implementers to determine program effectiveness objectively. As evidence-based strategies inform comprehensive prevention interventions and programs on rape, evaluation research findings serve as essential inputs for decision-making. Research-based programming, as a result, ensures a proper and in-depth understanding of the influencing factors to sexual violence and in making an informed decision (CDC 2014:4, 16). Quadara and Wall (2012:12) restate on the significance of "comprehensive evaluation" as a crucial element of effective prevention. Comprehensive evaluation not only showing the framework for intervention but also in measuring the program goal as well as sharing or disseminating the lessons learned.

2.5.2.The major categories of rape prevention interventions and programs

According to the CDC (2004:3-7), there are five major categories of sexual violence prevention, which in turn are also grouped into two. The first group comprises of three questions that prevention programs should address, namely: "WHEN do we intervene…WHAT is the focus…WHO is it for". The second group is representing two components of prevention programs derived from integrating the above three questions, i.e. through "Integrating the WHEN and the WHAT" as well as "Integrating the WHAT and the WHO".

2.5.2.1. When do we intervene?

The first category of prevention- i.e. "WHEN do we intervene" is about the timing of intervention with particular reference to an occurrence of violence or rape. This first category represents a further classification into three types of prevention, known as primary, secondary and tertiary. This classification into the three levels of prevention relies on the "public health model" of violence prevention (Dahlberg & Krug 2002:15). CDC (2014:2-3) underlines the need to focus on primary prevention as a priority area of intervention targeting the public. Primary prevention would be helpful when implemented with programs that emphasize "risk reduction, criminal justice, recidivism prevention, and victim services."

Primary prevention entails avoiding the very incidence of rape and other forms of sexual violations from happening (Dills *et al* 2016:6). Thus, primary prevention

demands broader interventions and not limited to addressing individual rape survivors. It entails prevention interventions that can achieve the maximum level goal at the larger public. Primary prevention, therefore, refers to interventions irrespective of the occurrence of rape aimed at avoiding any possibilities to commit rape or being vulnerable to rape (CDC 2004:3). Secondary prevention intervention, on the other hand, intends to meet the sudden and urgent demands of the rape survivor as immediately as possible following the incidence and thereby prevent health related complications (Dills *et al* 2016:6). It refers to the immediate intervention after the incidence of rape focusing on addressing the damages caused by the rape (CDC 2004:3). The same CDC documents point out that tertiary prevention is intervention after the occurrence of rape intending to manage harms on rape survivors that could last for an extended period through follow up and related assistance. It also encompasses interventions addressing the assailants.

Similar to the category of the CDC (2004:3-7), i.e. in the first group, Quadara and Wall (2012:3) also show categories of sexual assault prevention interventions by referring to three inter-related dimensions. These include "when interventions occur (the time dimension); who they are targeted at (the population dimension); and their location within the social-ecological model…of influences and risk factors for violence (the ecological dimension)".

2.5.2.2. What is the focus of intervention?

The second category of the CDC (2004:4) on prevention, i.e. WHAT is the focus, urges the need to have proper knowledge of the contributing factors behind sexual violence or rape. To this effect, the CDC underlines the importance of considering the various theoretical models to understand the inherent causal factors of rape and other forms of sexual violence, and thereby determine proper focus area for prevention. Thus, in the drive of addressing the question of what should be the focus of prevention, the CDC adopted the four-level social-ecological model (Dahlberg & Krug 2002:12). According to the CDC (2004:4), the social-ecological model is inclusive and helpful in determining the focus of prevention interventions to addresses "risk and protective factors from multiple domains".

Determining priority areas for rape prevention intervention involves identifying the pertinent factors at the individual, relationship, community, and societal levels influencing the occurrence of sexual violence (Dahlberg & Krug 2002:12-13). Hence, the social-ecological model informs to design focus areas of prevention intervention in line with the four-level influencing factors for vulnerability to rape and the risk to commit rape (CDC 2004:4). According to the social-ecological model, prevention program designed to address influencing factors at individual-level could focus on substance abuse, alcohol, and drug addiction (CDC 2004:5). To tackle further influencing factors leading a perpetrator to commit rape, prevention program pays attention to rebellious inclinations towards women. Such behavioral manifestations represent individuals socialized as a child to sexual violence practices in a family, and norms promoting patriarchal domination and sexual subjugation of women. The model also informs to consider interpersonal relationship of individuals as relevant factor in leading assailants to commit rape. The relationship in this regard refers to the interaction with friends and other family members who are fundamental to the behavioral formulation.

Furthermore, community-level factors influencing vulnerability to rape or perpetration represent a situation where individuals exposed to a community including institutions that overlook and tolerate practices of sexual violence. Thus, the social-ecological model suggests targeting such community-level experiences including unsafe conditions in different institutions like educational or workplaces. Finally, prevention of influencing factors at the societal level represents intervention that identifies and tackles causes of rape rooted in the socio-cultural values, religious beliefs, legal and policy frameworks (CDC 2004:5).

2.5.2.3. Who is it for or the target of prevention intervention?

The third category of rape prevention is designed in line with a specified target group for an intervention, and thus, “who is it for” represents the critical question here. Prevention interventions in this regard are aiming at addressing target groups, and thus divided into three, namely universal, selected, and indicated interventions. According to the CDC (2004:7), target groups for “universal interventions” determined irrespective of their vulnerability or tendency to commit rape. On the other hand, “selected interventions” focus on vulnerable groups with the risk of rape

or those with more behavioral tendency to commit rape. On the contrary, the category of "indicated intervention" targets groups already known to have had experience of rape either as survivors or as perpetrators. To summarize as stated in Lonsway *et al* (2009:1), the universal strategy considers the general population as a target irrespective of vulnerability or risk to sexual violence. The selective and indicated strategies prioritize groups with high vulnerability and those targets already identified as survivors of rape or assailants, respectively.

2.5.2.4. Integration of interventions referring to when to intervene and what is the focus

The fourth category of rape prevention refers to the integration of interventions under the first and second categories mentioned above. In other words, the fourth category of rape prevention incorporates elements drawn from a combination of interventions designed to address questions of when to intervene and what is the focus of prevention intervention. This fourth category entails rape prevention interventions that could be in advance irrespective of either crime incidence or following the occurrence of rape. The focus of intervention in this category considers the entire influencing factors at the four levels as per the social-ecological model (CDC 2004:5-6). Hence, the fourth category of rape prevention implies the need to design relevant interventions to address questions on the timing of intervention. It also demands designing interventions in line with identified factors influencing at an individual, relationship, community, and societal levels.

To illustrate the fourth category of rape prevention with practical activity intervention, for instance, prevention-oriented dialogues can be facilitated among male to address influencing factors at the individual level. The dialogue facilitation in this case does not consider any incidence of rape. The dialogue topics can be whether a belief in manhood really exists, and if it has a contribution to the rape of a woman. Besides, participants discuss on what can the target groups do as a person to avoid rape before it happens (CDC 2004:6). A panel discussion can also be possible in a classroom setting among teenage students. They would discuss on how the students can make a difference in the effort of ensuring a safe environment for girls and preventing sexual harassment practices.

On the other hand, interventions after the occurrence of rape targeting the individual level factors imply health care and trauma management services for the survivor. Such interventions following the aftermath of rape can also target perpetrators, which include correctional and rehabilitation services for the assailant (CDC 2004:6).

2.5.2.5. Integration of interventions focusing on influencing factors and the target groups

The fifth category on rape prevention according to the CDC (2004:7-10) represents integrating the second and the third categories of prevention indicated above. In other words, it is about "Integrating the WHAT and the WHO" intervention components. This fifth category of prevention comprises of interventions designed to address influencing factors of rape across the four levels of the social-ecological model integrated with interventions designed by target population. The target-oriented interventions represent the universal, selected, and indicated interventions. Some examples below illustrate the integration of target-oriented interventions with programs designed to address influencing factors at the four levels of the social-ecological model.

A rape prevention program with “selected interventions”, for example, is intending to address individual-level factors influencing high school students in drug abuse and alcohol intoxication (CDC 2004:9). This program can consider implementing selected interventions with specific activities on rehabilitation of the students from drug addiction and alcohol. Besides, selected interventions in such cases may include training of the students on informed consent in sexual relationship.

According to the CDC (2004:9), in order to address influencing factors at the level of interpersonal relationships, for example, among risk-prone high school students, engaging parents is advisable. Such a program is designed to improve communication skills with children and change violent behaviors. Similar intervention can include supporting students to develop responsible behavioral practices and become change agents themselves on rape prevention.

For the tackling of influencing factors at the community level, selected intervention consider targeting, for example, localities promoting alcohol and treating women as

sexual objects. Such prevention programs, for instance, could have interventions against practices of advertisements. Hence, such interventions can serve as a tool to inform and challenge the social environment. Consequently, the society would oppose erroneous views on women and thus will not tolerate practices that promote sexually violent behavior (CDC 2004:9). This type of intervention also involves changes in how organizations operate, which can in turn bring a change of practices and norms in a particular community (Davis, Parks & Cohen 2006:12). To add further example on addressing societal level influencing factors, there could be a situation where a program intervention requires the buy-in of decision makers. In such cases, it might be advisable to work on advocacy for the support of policymakers. Advocacy related interventions in rape prevention programs might call upon policy changes so that it might be possible to reduce the risk of identified groups from sexual violence (CDC 2004:9).

Regarding the examples of indicated interventions, to address individual-level factors, programs should prevent secondary victimization to rape (CDC 2004:10). The typical example to support rape survivors is to undertake a proper assessment of risky behaviors during medical examination and arrangement of mechanisms to protect any victimization in the future (Basile & Smith 2011:413). On factors influencing sexual violence behavior at the relationship level, designing treatment programs is helpful "for at-risk children and families to prevent problem behavior" including sexually offensive behavior (Basile *et al* 2016:11).

In the case of community-level influencing factors, for instance, a school may consider developing an appropriate guideline or code of conduct to identify and address possibilities of sexual violence (Basile *et al* 2016:27). As a result, a school can create a safe environment and deter further victimization. The same authors also suggest practical interventions to address influencing factors at a societal level. Such interventions represent economic empowerment of women through creating access to loans together with educational messages promoting equitable gender norms. Societal level interventions can make a difference in reducing the risk of partner sexual violence against women (Basile *et al* 2016:25).

2.5.3. The nature of rape prevention interventions categorized by gender oriented programming

Lonsway *et al* (2009:6) review and identify about 11 rape prevention programs and intervention strategies. However, existing programs on sexual violence prevention also viewed and discussed into three broader categories. They include "i) prevention programmes for men, ii) risk reduction programmes for women, and iii) prevention programmes for mixed-gender audiences." Gender-based classification of sexual violence prevention programs underlines on changing the problem behavior of men as a likely assailant target group. On the other hand, the priority for women in such programs would be on enabling interventions to avoid or minimize the risk of rape. The gender-based classification of the prevention program, however, does not mean that women are the only victims of sexual violence, and men are the only perpetrators. There are cases of male rape survivors where the assailants can be either female (though limited proportion) or male (Lonsway *et al* 2009:2, 12). The discussion below refers to the three categories of rape prevention in line with gender-oriented programming.

2.5.3.1. Rape prevention programs for men

The category of rape prevention programs for men usually emphasizes on men, where the core element of this intervention conveys that men are in charge of controlling sexually inappropriate and abusive behavioral practices. In addition to the obligation of governing their behavior, such programs involve teaching men as change agents on techniques to challenge other men exhibiting sexually abusive and aggressive behavior (Lonsway *et al* 2009:2).

There are also social marketing programs like the use of a media campaign to address misconceptions about the behavior of men on sexuality issues. This program relies on the "social norms approach", which considers men misperceive behavioral practices of other men, and they can profoundly influence each other (Lonsway *et al* 2009:11). Thus, such programs promote norms depicting men as responsible citizens who condemn gender stereotypes and chauvinistic attitudes. A similar approach can also serve programs targeting young boys to challenge and tackle erroneous views. The focus here is to enable young boys to influence their peer groups positively, mainly on challenging violent sexual behaviors (Lonsway *et al* 2009:11).

2.5.3.2. Risk reduction interventions and programs for women

There are risk reduction education programs that only target women. These programs include educating women on how to reduce risk of rape, and techniques of avoiding rape under the influence of alcohol or substance abuse. Risk reduction education also covers topics on ill after effects of rape, and the available services for rape survivors. The other strong prevention program targeting women refer to self-defense training on the use of force and other physical fighting skills. Evidences show that such vigorous confrontation methods can make a difference in deterring attempts and avoiding rape (Lonsway *et al* 2009:4).

2.5.3.3. Prevention programs for mixed-gender target groups

Prevention programs for mixed-gender audiences on sexual violence developed represent broader interventions. According to Morrison, and his friends, (cited in Lonsway *et al* 2009:6), such prevention programs addressing both male and female target groups in a mixed setting account of about 64%. Educational interventions of mixed category involve both male and female as targets, concerned about the in-depth understanding of sexual violence, the magnitude of the problem, and consequences on rape survivors. This program also teaches where to find possible support for rape survivors, as well as the contribution of misconceptions about issues of sexuality and gender inequalities. Furthermore, educational programs for mixed-gender target groups comprise topics focusing on the different factors leading to rape, and on how to identify victimization or perpetration. Programs for mixed-gender also deal with value clarification exercises on what does consent for sexual intercourse means, and life skills development to negotiate safe practices. These educational interventions teach on distinguishing rights and responsibilities from offensive and stereotyped attitudes and behavioral acts among others (Lonsway *et al* 2009:6).

The “Bystander Education Programme” on rape prevention also involves men and women, where both serve as change agents by challenging inappropriate views and attitudes (Lonsway *et al* 2009:8). In this regard, the change agents are challenging instances where peer groups try to excuse or ignore rape and other forms of sexual violence. Moreover, Davis, Parks, and Cohen (2006:16) suggest interventions in line with Bystander Education Program to enhance capacity so that bystanders assertively challenge potential risky behavioral reflections. The deployment of bystanders as

change agents as per this prevention program considers the bystanders beyond the ordinary target audience. The central element in the Bystander Program refers to the empowerment of both men and women being in charge of taking proactive measures by intercepting acts of sexual violence (Lonsway *et al* 2009:8). Such programs teach bystanders on earlier detection of likelihoods or risk of rape. However, this approach also addresses bystanders on how they should react in cases where sexual violence is already committed, for example in showing family members of the survivor on the next appropriate steps and measures to take.

Furthermore, prevention programs for a mixed-gender audience encompass prevention education to younger students with the belief that rape prevention intervention would have useful results if started as early as possible. Specific to this program, Lonsway *et al* (2009:13) advises launching prevention education at an earlier age of students. Starting prevention education at junior school level found more effective to achieve results as compared to late interventions targeting senior level grades in high schools. However, integrating rape prevention programs into the curriculum of relevant fields of study at higher learning institutions considered a valuable approach (Basile & Smith 2011:413). Lonsway *et al* (2009:12-14) also discuss programs on rape prevention emphasizing on addressing male and female target groups jointly, namely "capacity building and creating community partnerships". Such programs require the engagement of stakeholders with interventions designed to address specifically targeted groups evidenced by risk behaviors such as addicted youth. For example, prevention programs through partnership can involve law enforcement agencies and educational institutions. However, rape prevention programs in this regard attributed to both primary prevention as well as secondary interventions in their nature.

2.5.4. Rape prevention interventions and programs in Ethiopia

To reflect on the nature of rape prevention interventions and programs from the context of Ethiopia, the researcher had to rely on very limited research publications that discuss the nature of rape prevention interventions in Ethiopia. Thus, this section briefly informs the situation in Ethiopia by referring to the studies that indirectly reported on rape prevention-related interventions. According to Yemane (2004:132),

there is a lack of intervention on the prevention of negative consequences or damages to the rape survivors. Regarding awareness creation engagements on rape prevention, Getinet (2009:181) observes that the mass media played a minimal role so far to address the challenge. Assefa (2011:28) also refers to the existing undertakings as inadequate and immaterial as opposed to the high magnitude of the problem of child victimization.

There is also a limited engagement of civil society in the prevention of rights violations. The involvement of non-governmental organizations jeopardized as the Ethiopian government took restrictive legal measures (Assefa 2011:28). This government restriction particularly refers to the Charities and Societies Proclamation (621 of 2009) as stated in Article two, sub articles two, three and four, in combination with Article 14 sub article five. This proclamation prohibited non-governmental organizations generating more than 10% foreign funding to implement programs on promoting human and child rights issues, gender equality, and enforcement of the laws among other areas of intervention. Law enforcement agencies are among institutions that need attention as the existing justice process in Ethiopia considered to have contributed to the victimization of children. To put it as stated in Assefa (2011:11), "Ethiopian justice process has permitted the subjection of child victims to cycles of traumatization". Assefa further points out the cycles of victimization represent processes of "investigation, prosecution, and trial phases of cases" in which child victims are involved. Ethiopia does not have laws that require the special treatment of children who are victims or witnesses of crime."

Sexual violence or rape against male survivors appears distinctive to that of the same crime committed to female when viewed in terms of the Ethiopian criminal law. The criminal law of Ethiopia is directly associating female with victimization to rape, while differently treating cases of male survivors of rape (Assefa 2011:14). The crime of rape against males, such as that of street boys, in Addis Ababa appears extremely hidden and hardly reported to concerned agencies (Getinet 2009:181). The same author mentions erroneous views for the under reporting of male rape, where same sex practice remained among the highly despised practice in Ethiopia. As a result, the level of sexual abuse of street boys remained unknown or undermined, and thus not given proper attention by the responsible institutions. Getinet also shows the absence

of specifically designed program based on the demand of target groups and addressing the challenges of the rape survivors.

Prosecutors often lose most of the rape cases reported in Addis Ababa. Review of the reported cases of rape to the law enforcement agencies in Addis Ababa shows only limited cases succeeded to appear before the court, and there is a low rate of conviction. The failure in prosecution evidenced among 677 cases of sexual violence investigated in Addis Ababa from September 2004 to June 2005. During this period, only 124 (18%) cases of sexual violence pleaded guilty and penalized (Federal Supreme Court & Save the Children Sweden 2006: 25). Furthermore, out of 1,671 cases of sexual violence against women and children reported to prosecutors from July 2006 up to June 2008, only 144 (8.6%) convicted guilty (Ministry of Justice 2008:5-7). Though rape cases appear before the court, most cases fail as prosecutors unable to produce sufficient evidence to render a verdict as per Article 42 of the Criminal Procedure Code (185 of 1961). In this regard, Yemane (2004:132) shows the severity of the problem saying “beyond imagination in the 21st century". The limited access of rape survivors to legal support services also exacerbated the challenge. These limitations imply enhancing interventions pertinent to the law enforcement agencies so that perpetrators effectively face justice and convicted for the crime of rape.

Furthermore, as the Ethiopian Criminal Code (414 of 2004) considers rape out of wedlock (Article 620), it demands strong advocacy interventions for the criminalization of marital rape. Similarly, Tegbar *et al* (2010:45) suggest for "continuous culturally sensitive information, education, and communication programs". This suggestion indirectly confirms the lack of such interventions to address misconceptions about different forms of spousal violence against women including rape. The same authors also note the gap in the school or education program. Hence, they called upon the need to teach equitable gender relations including in marriage, and challenge erroneous beliefs and practices against women.

2.5.5. Major challenges and lessons learned in the implementation of rape prevention interventions and programs

2.5.5.1. Globally noted challenges in the implementation of rape prevention interventions and programs

The pressing challenges in the field of rape prevention generally refer to lack of clear direction on how to evaluate achievements of rape prevention programs in a better way. The other challenge constitutes on what specific details to consider and avoid in the implementation of rape prevention interventions.

2.5.5.2. Evaluation-related challenges

Evaluation of rape prevention interventions and programs is more challenging when it comes to multi-level engagements and for programs that involve various approaches (Quadara & Wall 2012:2,12). Besides, there is a difficulty in setting a relevant indicator to evaluate prevention interventions or programs and the corresponding impact objectively. The problem here is, to put it in the words of Wall (2013:12), "the challenge of what to measure" (Wall 2013:12). This challenge mainly linked to the due course of time and complex dynamics involved in achieving societal level changes that naturally take time and happening step-by-step. On the other hand, evaluation of prevention programs implemented through mass media is also challenging, where Lonsway *et al* (2009:9) indicate the difficulty of employing complex evaluation techniques.

Wall (2013:2) observes further limitation on evaluation, where the practice of evaluating rape prevention programs remains on development. Thus, the evaluation of prevention programs appears not yet proficient to the level of measuring the program outcome. This challenge is happening because of the issue where averting rape is associated with the complexities of social change. Evaluation of programs focusing on sexually aggressive behavior among men is even more challenging. Lonsway *et al. (2009*:2) further witness shortcomings on evaluating prevention programs because of the limited studies so far on evaluating sexually aggressive behavior among men.

Quadara and Wall (2012:12) show the difficulty in the evaluation of rape prevention programs implemented by multiple agents. The challenge of evaluating such programs mainly associated with the difficulty to convince and bring multiple actors together to have a unifying evaluation platform. The challenge here is due to the competing interests and varying levels of commitment such as in resource allocation among the implementing institutions. The frail multi-sectoral coordination among concerned stakeholders in Ethiopia characterizes such challenge despite the government policy demanding for coordinated engagement on prevention of sexual violence (MoWCYA 2013:76; Government of Ethiopia 2007:59). Furthermore, evaluating programs that implement interventions focusing on primary prevention of rape still involves ambiguities because areas of engagement lack clear demarcation in such interventions (Quadara & Wall 2012:2). Besides, the same authors show limitations and difficulty of having a defined guideline to measure achievements associated explicitly to the program implementation.

2.5.5.3. Challenges related to lack of knowledge

Rape prevention programs also face the challenge of inadequate knowledge about the multi-dimensional causes of rape, mainly at community and societal levels (Wall 2013:2-3). This limitation of knowledge, in turn, hampers the sharing of evidence-based practices, such as on rape prevention interventions addressing community and societal level factors (DeGue *et al* 2012:2).

2.5.5.4. Challenges related to prevention interventions after the occurrence of rape

The challenges of rape prevention interventions after the incidence of rape mainly refer to the inadequacy of health care, emotional, and legal support services as well as attitudinal problems and community-based values and practices. Health care and legal support related to rape prevention interventions face challenges to meet minimum standards. According to Basile *et al* (2014:15), physical evidence collection requires “Collection of hairs, fibers or specimens of body fluids from a victim's body”. Those evidences gathered to verify the identity of the assailant. Physical evidence collection, however, is hardly possible having ill-equipped medical facilities. In this regard, WHO (2014b:2) asserts that health systems usually fail to "adequately addressing the

problem of violence and contributing to a comprehensive multisectoral response". These challenges of rape prevention are highly prevailing among several "low-income countries" in the world (WHO 2014a:40-41).

2.5.5.5. Challenges related to the implementation of rape prevention interventions in Ethiopia

The challenges mentioned above also attribute to the context of Ethiopia, where the report of the Ethiopian government also shows the same (MoWCYA 2013:73, 77). Those challenges applicable to law enforcement take account of weakness in the areas of Physical Evidence Collection and utilization for the prosecution of an assailant. The report also shows the challenges of the limited practice of reporting on rape cases because of several factors like fear of further attack and the desire to avoid stigma and the time taking judicial process. The same government report accounts the pressure from traditional community leaders on the family and the survivors in the guise of reconciliation. Lack of community awareness is also substantially obstructing the attempts to redress the rape survivors legally.

The findings of Marielle (2016:6), corresponding with the government report, states that the crime of rape less likely appears before justice because of stigma. Disclosing rape or sexual violence is highly suppressed due to the fear of humiliation and social discrimination. The same author mentions further factors associated to "weaknesses in the law enforcement system". The study supported by Care Ethiopia (Tsegahun 2008:49) witnesses similar challenge regarding the Judiciary System in Ethiopia on crimes of sexual violence. The same study reports on the reaction of law enforcement stating, "The legal process often offers little or no protection" for rape survivors. Furthermore, in cases where survivors reported the rape incidence and succeeded to appear before the court, they usually face challenges of shelter or safe homes.

In order to design and implement effective rape prevention programs, having adequate data is extremely important. Nevertheless, nationally representative studies in Ethiopia such as the EDHS address limited aspects of rape-related data. Such limitation of national studies has repercussions in "designing adequate response and prevention mechanisms, implementation of existing policy and legal frameworks" (MoWCYA 2013:77). It is also hampering "evidence-based policy and legal revision"

exercises nationally. In other words, lack of data to inform the design of rape prevention programs including policy advocacy remain among the pertinent challenges.

2.5.6. Major lessons learned in the implementation of rape prevention interventions and programs

2.5.6.1. Global lessons from the implementation of rape prevention interventions and programs

To start from the historical development of rape prevention interventions and programs, health service facilities had a decisive role in this regard. Health facilities noted as key players since several years back evidenced in the treatment of rape survivors and in serving as learning benchmarks for primary prevention interventions (Russo 2001:4). As shown in Basile and Smith (2011:413), health facility-based interventions on education, i.e. beyond medical treatment, contributed to the primary prevention of rape. Valentich and Gripton (1984:449) review the emergence of facility-based services to rape survivors in North America and witness interventions on psychotherapy, awareness creation, and activism for legal improvements.

The establishment of rape crisis centers in the USA dated back to the 1970s, where feminist scholars and the women's liberation movement during that period had contributions (Karina 2011:1-2). A Sexual Assault Nurse Examiner program launched in the 1970s emphasized gathering "forensic evidence and address the physical and psychological" damages of rape survivors (Basile & Smith 2011:414). Another vital lesson related to rape crisis centers linked to the intervention of “Comprehensive Rape Crisis Services” in the USA, also referred to as “Sexual Assault Crisis Team (SACT)”. According to Towers (2013:132), SACT represents “a rape crisis shelter intervention” whereby all types of rape survivors provided with services and supports in a certain facility or shelter house. The SACT intervention admits rape survivors irrespective of the duration of the rape occurrence. Innovative attributes of the SACT intervention on rape prevention mainly include the use of “expert knowledge”. The innovative attributes include involvement of skilled rape survivors in supporting others, service provision to both female and male survivors, and support on legal matters (Towers 2013:132, 135).

Partnership engagement among stakeholders from multi-disciplinary fields, as shown in Casey and Lindhorst (2009:109), plays a vital role in the effectiveness of interventions and programs on rape prevention. Even though various actors could have different views and capacities, lessons so far show that closer and holistic partnership engagements help to set up better approaches and tools, including for effective evaluation of rape prevention programs. However, such a holistic partnership and development of shared instruments for program evaluation requires a commitment of various actors for the joint intervention rather than fighting for unilateral competing interests (Quadara & Wall 2012:12).

According to Carmody *et al* (2009:20), the lesson from rape prevention interventions and programs in Australia provides useful prevention strategies, namely "promoting ethical sexualities" as well as working on "positive gender norms". This lesson entails a shift of approach, i.e. rather than focusing on the curse of influencing factors or potential risks, the priority would be on nurturing positive and acceptable sexual norms. In other words, because of the shift in approach, the rape prevention programs incline on promoting ethical sexuality in line with the socio-cultural contexts (Carmody *et al* 2009:40). The other lesson is learned from rape prevention program implemented in Australia, known as *"*Coordinated and integrated services: the integrated rape crisis service in Yarrow Place" (Franzway & Neill 2013:139). This program is identified as a best practice for consideration of "longer-term or life-span health effects". The same authors note "Yarrow Place Rape and Sexual Assault Service" brought about a change in the practices that used to focus on "acute or crisis care responses". The change in this regard is attributed to the notion of addressing the demands of rape survivors irrespective of the timing of the rape incidence.

The Australian program also actively involves local communities, namely the Aboriginal people, in prevention interventions and service provision. The program trained those who had the rape experience. Then, the trainees deployed to educate the community and provide emotional support or counselling to other rape survivors. Therefore, the program represents an innovative intervention mainly characterized by client-centered, service integration and cost-effectiveness (Franzway & Neill 2013:140).

Furthermore, there are effective lessons from "risk reduction programs" administered for women, specifically through training and skills development on how to defend themselves from harm or attempts of sexual violence. These lessons witness reduced probability of rape victimization and improved self-confidence (Lonsway *et al* 2009:4). Quadara and Wall (2012:9, 12) also advise to draw the lessons learnt from relevant public health programs, such as from the experiences of HIV prevention interventions and adopt for rape prevention.

2.5.6.2. Lessons learned nationally and in Addis Ababa in implementation of rape prevention interventions

Drawing lessons on rape prevention interventions and programs with particular reference to Ethiopia based on the few study reports with limited scope and coverage appeared problematic. However, the advice to draw lessons from health programs appears relevant and viable to the context of Ethiopia as the HIV prevention programs brought about substantial achievements in curbing the HIV epidemic nationally. For instance, a significant decline in HIV prevalence reported over the years in Ethiopia (FMoH 2016:8, 43). The lesson to draw here is adapting the intervention strategies employed in HIV prevention programs to serve the purpose of rape prevention in Ethiopia. Furthermore, the initiative of institutionalizing "child protection units in police stations" at bigger cities of Ethiopia, and the adoption of “community conversation approach” were taken as promising drive (Government of Ethiopia 2007:59). Civil societies also engaged in a partnership with government institutions (UNFPA 2016:24, 41).

The Ethiopian government has also taken encouraging steps by formulating special-units at the law enforcement institutions dedicated to working upon cases of sexual violence against women and children (MoWCYA 2013:72-73). The same government report on the “Assessment of conditions of violence against women in Ethiopia” shows institutional structures established to work on the protection of violence against women and children. These include child and women protection units in police stations, investigation, and prosecution team at the Federal Attorney General, and that of child and client-friendly benches at Federal Courts in Addis Ababa.

The government of Ethiopia has established the first "One-Stop-Center" in Addis Ababa considering the need for support systems to provide services for rape survivors (MoWCYA 2013:74). The One-Stop-Center (also referred to as the 'Center' in this study) started service as a pilot since April 2012 within Gandhi Memorial Hospital. The Center intends to avail all of the required services for the rape survivors under a single facility. The services include medico-legal care, emotional support and arrangement of safe-homes as deemed necessary. The same government report depicts the experience-sharing visit of the Ethiopian Delegate from different government institutions to the Republic of South Africa. The visit facilitated to adopt the lessons learnt on rape prevention programs, which eventually led to the establishment of the One-Stop Center in Addis Ababa.

2.6. Conclusion

This Chapter laid the basis for informing the study through consulting the relevant research works. Hence, the Chapter unpacked the problem of rape as a social phenomenon and thereby addressed various interpretations of rape, its causes, and effects referring to the global milieu and the context of Ethiopia. The review of scholarly works showed that understanding the divergent views towards rape is pivotal in informing the design of rape prevention interventions and programs.

The literature review on rape prevention interventions and programs in Chapter-Two enabled the researcher to identify and discuss the relevant interventions and programs with evidence-based experiences from different parts of the world. The critical intellectual debates also identified in the Chapter with the intention of providing insights to enhance rape prevention and inspiring further evaluation research on rape prevention programs. This Chapter highlighted the critical challenges and lessons drawn from contemporary rape prevention interventions and programs. The Chapter also summarized the social-ecological model that informed the study on effective rape prevention interventions and programs. The discussion in this Chapter gave direction to the study towards addressing the research questions including determining the research methodology as illustrated by the following section in Chapter-Three

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CHAPTER 3: METHODOLOGY OF THE STUDY

3.1. Introduction

The third Chapter of the study focused on research methodology and thus discussed the research design, the units of analysis, the sampling techniques, data collection, and analysis. The study employed a qualitative research method to get an in-depth understanding and thereby describe the situation of rape prevention interventions by implementing agencies in Addis Ababa based on the perception of practitioners working in those institutions. The study preferred a qualitative research method to collect in-depth qualitative data on the perception of individual workers about the rape prevention interventions implemented by institutions in Addis Ababa. Moreover, the researcher chose qualitative descriptive research method as appropriate to describe the nature of rape prevention interventions from the study participants' point of view (Babbie 2007:89, 286-287, 294-295; Neuman 2007: 88, 143, 276).

Hence, this methodology section elaborated procedures and steps taken to collect data and the sampling techniques employed in the selection of participants. It addressed methods of data collection in line with the corresponding instruments. The Chapter also discussed data analysis and interpretation, including the approach adopted for the analysis. Besides, this Chapter illustrated how the study process went through ensuring the validity of data sources, the findings, and the details on the measures taken to ensure ethical considerations.

3.2. Research design

The researcher mainly designed the research method to collect, analyze and interpret qualitative data regarding the existing situation on the nature of rape prevention interventions in Addis Ababa. The researcher decided to use a qualitative research approach because it allows further understanding and description of the existing situation. As Goodwin and Horowitz (2002:44) witness, the qualitative research method appears relevant to guide this study due to its methodological strength. These

authors state that qualitative approach is helpful to "create a deeper and richer picture of what is going on in particular settings".

Creswell (2014:206) further indicates the focus on "participants' perceptions and experiences", and attempts to understand existing situations represent among the inherent attributes of qualitative research. Likewise, this study collected, analyzed, and described qualitative data to understand the nature of rape prevention interventions in Addis Ababa. To this effect, the researcher relied on primary data collected based on the perception of professionals working in institutions implementing rape prevention interventions. Hence, according to Neuman (2007:364), the research design employed in this study represents qualitative descriptive study design.

3.3. Units of analysis

The units of analysis in the study mainly represented professionals working at the government agencies implementing rape prevention interventions in Addis Ababa. However, as the study collected some of the available official documents and formal reports, those few secondary sources also served as complementary units of analysis in the study.

The research participants as primary data sources comprised of professionals working at the government health facilities and law enforcement agencies implementing rape prevention interventions. The researcher selected participants setting an inclusion or exclusion criteria and used a purposive sampling technique as indicated under the following section. Participants were selected from experienced health personnel, the lawyers and social workers serving in the government institutions directly engaging in psychosocial, healthcare, legal support and related rape prevention interventions.

Primary data sources consisted of 14 professionals, specifically from backgrounds of medical, legal, and social work fields of studies. The health professionals include one Gynecologist & Obstetrician, one Pediatrician, two Physicians/ General Practitioners, and two Nurses. The lawyers on the others hand comprised of one Health Facility

Legal Advisor, two Federal High Court Judges, and four Federal Attorneys or Prosecutors. The study also involved one Social Worker as primary data source. Professionals with more years of experience were priority in cases where more than five professionals working on rape prevention at a particular institution. However, there were also cases where few of the available professionals automatically considered as they were exclusively handling rape-related cases.

The researcher collected and reviewed recent and relevant secondary data. These sources include research materials and evaluation reports produced by concerned institutions focusing on rape prevention. Content analysis of secondary data, as a result, mainly focused on topics referring to primary prevention education on rape, psychosocial, health care and legal support for rape survivors. In this regard, more emphasis given to official government documents referring to the situation of rape and prevention related interventions in Addis Ababa.

3.4. Sampling techniques

The researcher selected participants voluntarily and identified them using a purposive sampling technique. The researcher formally approached and requested the cooperation of each public health care institution and the law enforcement agencies working on rape prevention interventions to select relevant study participants. As indicated in the above section, the researcher developed an inclusion or exclusion criteria for the selection of primary research participants (Neuman 2007:143; Babbie 2007:184). The inclusion or exclusion criteria mainly refer to selection of experienced professionals on rape prevention serving at government health facilities and law enforcement agencies in Addis Ababa. The criteria set in this regard considered those professionals and senior practitioners served for at least five years on rape prevention at the selected institutions. However, as shown above, for some institutions that assigned few professionals to work on rape-related cases, the researcher directly selected the existed professionals as participants.

The researcher initially identified four institutions as potentially appropriate for the study based on a brief review of documents and in consultation of concerned units at the Federal Attorney General working on rape prevention in Addis Ababa. Thus, the study gave priority for two government hospitals, namely Gandhi Memorial Hospital and Black Lion Specialized Hospital having established linkage and interventions on rape prevention. They also have a strong linkage with the Federal Attorney General regarding the rape prevention and services to the rape survivors in Addis Ababa. Furthermore, Prosecution Offices operating at the sub-cities level in Addis Ababa identified as they closely engaged with the Federal Attorney General and the One-Stop-Center in Gandhi Memorial Hospital. The Federal High Court Lideta Criminal Bench also found handling all the cases of appeal on rape. As a result, the study considered participants from these law enforcement institutions as indicated in the section above.

The consideration of selecting research participants from the Federal Attorney General had to do with inputs gathered from the key informant interviews with three purposively chosen officials. Hence, the researcher learned that the Federal Attorney General got a decisive engagement in rape prevention interventions in Addis Ababa from the beginning of the initiative. Involvement of the Federal Attorney General in rape prevention to the context of this study referred to the legal support unit at the One-Stop-Center in Gandhi Memorial Hospital. This Center has been known for long as the only comprehensive service providing facility for female rape survivors in Ethiopia.

Public prosecutors and police officers engaged in handling legal issues and facilitation of safe homes for rape survivors at the Center as deemed necessary. The legal team at the Center was responsible to the Federal Attorney General, particularly to the department known as "Women and Children Multi-Sectoral Coordination". This unit assigned prosecutors and social workers operating as a team with health professionals at the Center and actively engaged in other rape prevention-related interventions.

3.5. The research process

The researcher conducted the study in line with the approved research proposal by UNISA. The research proposal document served as an instrument in guiding the research processes, mainly during the data collection and analysis. UNISA assigned the research adviser who actively engaged in the review, guidance, and enrichment of the study during the entire process. The researcher limited the scope of the study in Addis Ababa as the government institutions implementing integrated interventions on rape prevention only found in the capital. Scope of the study limited based on the desk review conducted during the phase of research proposal development. Pre-testing of the draft in-depth interview guide prior to launching data collection also contributed to this effect. These preliminary exercises to the study helped to identify the key institutions implementing rape prevention interventions in Addis Ababa. The in-depth interview guide (see Appendix 4) consists of five sections. The first section of the interview guide focused on the demographic profile of the research participants. The rest four sections of the guide constituted thematic issues categorized into major, sub and specific topics of inquiry. Open ended questions of the in-depth interview guide developed in a sequential and probing nature in line with addressing the research questions.

The researcher formally approached the identified government institutions and requested their facilitation to conduct the study. Each of those institutions selected for the study provided with a copy of the UNISA Ethical Clearance (see Appendix 5). The researcher also submitted formal letters requesting the cooperation of each institution to conduct the study (see Appendix 3). The UNISA Regional Office in Addis Ababa wrote these letters (see Appendix 6). Issues of ethical considerations were also properly addressed while the development of formats on Research Participant Information Sheet (see Appendix 1). As a result, the study acquired the permission and support of the respective authorities at the identified institutions to collect the required data.

The process of approaching all the identified institutions and selecting the research participants, however, was not entirely smooth. In some cases, the researcher took time and negotiated with concerned authorities to select the appropriate participant

and for the arrangement of a convenient schedule to conduct the interview. Nevertheless, the researcher started the data collection process following the finalization of preparatory arrangements and fulfilling formal procedural requirements, including selection of research participants as per the Research Ethics Policy of the University of South Africa (2007:4-6). The duration of primary data collection was from December 29, 2016, to March 09, 2017, where half of the in-depth interviews (07) conducted in January 2017. On the other hand, the researcher encountered a challenge to get relevant secondary resources at the selected government institutions. However, the researcher managed to access some of the available documents such as periodic reports and promotional materials with educational messages on rape prevention.

3.6. Data collection methods

3.6.1. Key informant interview

Key informants in this study represent three government officials that the researcher initially interviewed. The researcher approached those officials to collect general information about the responsible government institutions operating on rape prevention in Addis Ababa. The researcher conducted preliminary data gathering from three key-informants before launching the primary data collection. The researcher approached the key informants and held an informal discussion while gathering information. The study adopted an "informal conversational interview" approach with the selected key informants at the initial phase; and thus, determined appropriate direction to materialize data collection as intended in the study design (Berry 1999:6). The researcher considered the importance of key informants to gather basic and preliminary information to the study and selected them based on their government position and experience (Creswell 2014:97).

Key informant interview focused on gathering preliminary information, which helped to gather valuable information about relevant and concerned authorities as well as in identifying senior professionals with expertise on rape prevention. As the researcher developed a draft in-depth interview guide with the research proposal, the key informant interview session with the three senior officials also utilized to conducted

the pre-testing of the draft guide before launching primary data collection. Hence, the researcher modified the in-depth interview guide based on the inputs from the pre-test and suggestion of the key informants about the context on the ground. As a result, some open-ended questions of the in-depth interview guide amended or merged to avoid confusion. The pre-testing also allowed addressing interrelated issues and probing questions sequentially, which in turn maintained coherence and facilitated the in-depth interview process as the research participants smoothly discussed and conveyed their views.

The key informants also supported the researcher in identifying the formal and specific contact addresses of government institutions included in the study. They also oriented the researcher on procedural requirements of the government to conduct such a study, where all the three officials considered rape as a sensitive issue. In this regard, the professional link of the researcher with relevant institutions, such as the FMoH, helped to access key-informants and the gathering of the aforementioned information.

3.6.2. In-depth interview

The researcher conducted in-depth interviews with the research participants as indicated in the above sections under the units of analysis and the sampling techniques. The researcher employed an in-depth interview guide revised and enriched by incorporating inputs from the pre-test of the draft guide as indicated in the section above. The use of a general guide for the in-depth interview in this study (see appendix 4) intended to ensure addressing all the essential issues (Babbie 2007:305; Neuman 2007:178; Berry 1999). The researcher purposively selected the study participants for the in-depth interview as shown in the above sections.

In ensuring voluntary selection of research participants, as discussed under the section on Ethical Considerations, the researcher maintained expected standards on voluntary participation. To this effect, the researcher considered informed consent of the research participants (Neuman 2007:196; Babbie 2007:64). In this regard, the researcher discussed with each prospective study participant on relevant issues and informed the details as depicted in the Research Participant Information Sheet (see Appendix 1). Hence, all of those professionals who have voluntarily agreed to

participate in the study retained a copy of the Research Participant Information Sheet and the signed consent form with themselves. Thus, all study participants had the detail information, including contact details of the research project supervisor, in case they had concerns about the research process.

The researcher arranged convenient time schedules and appropriate place for the in-depth interview by the preference of study participants. The researcher facilitated most of the in-depth interviews within the offices of the study participants. The researcher also consulted relevant administrative personnel and the study participants for the arrangement of a convenient room to conduct an in-depth interview without interruption. In this regard, the researcher smoothly conducted most of the in-depth interview sessions except few cases of interruptions encountered due to intruders and phone calls. The researcher managed such incidents by pausing the tape recorder and the interview for a while and resumed the process after a short break.

The researcher also considered the willingness of the study participants on the use of tape recording during the interview, where two participants preferred the in-depth interview without tape recording. However, the researcher duly informed those participants refused tape recording on the need to take notes and simultaneously conduct the interview. Most of the in-depth interviewees (87.5%) agreed and tape-recorded, where the researcher also took short notes as much as possible while conducting the interviews with all participants.

Data gathering through the in-depth interview undertaken up to the level of data saturation, or to the point at which redundant information collected. In other words, the researcher maintained asking and probing the study participants with open-ended questions until reaching point of exhaustion. In other words, the researcher kept on asking until the stage where the research participants finalized to reveal new information (National Institutes of Health 2001:6; Guest, Bunce & Johnson 2006:64-65).

The researcher conducted in-depth interviews in Amharic, which is the official and working language of Ethiopia and the capital city, Addis Ababa. The researcher also preferred to facilitate the in-depth interviews in Amharic for the sake of convenience

and thereby ensuring easier and better communication of study participants using the local language. The researcher transcribed the data collected through in-depth interviews, i.e. the tape records, and produced the final interview transcript in Amharic. The transcript also considered notes taken during the interview sessions as well as those interviews collected without the support of audio recording for the few interviewees.

The researcher immediately reviewed the primary data collected through careful listening of the audiotape records and reading of the notes taken following each of the in-depth interview sessions. Thus, immediate corrective actions taken on data that appeared inconsistent. The researcher verified data in cases of inconsistency and contradictions either by asking the subsequent interviewees or corroborating with records from secondary sources particularly by cross checking with report documents.

The researcher translated the Amharic transcript into English and validated the translation using an authentic and standardized translator. The researcher selected the relevant and authentic translator with qualified status and experience on authenticating translation. Accordingly, the authentic-translators reviewed the draft translated English transcript against the Amharic transcript of the in-depth interview. Then, the researcher considered the suggestions and feedback on the draft transcript and enriched the document. The researcher collected the finally authenticated version of the translated transcript in English both in softcopies and hardcopies finally utilized for the data analysis.

3.7. Data analysis and interpretation

3.7.1. Thematic analysis

This study adapted “thematic analysis” as a method to analyze qualitative data (Fereday & Muir-Cochrane 2006:80). Data sets of in-depth interviews organized through a careful and thorough review of transcripts and notes of the researcher. The researcher also realigned some of the interview replies under the corresponding questions of the in-depth interview guide. The Amharic transcripts of the in-depth interviews produced in soft copy, as indicated under the in-depth interview section

above, translated into English, where the authenticated version of the document in soft copy employed for the thematic analysis.

This study can be categorized as an "inductive approach of thematic analysis", whereby the entire process of thematic analysis derived from the data collected through the in-depth interviews (Fereday & Muir-Cochrane 2006:83). The researcher followed a bottom-up approach in coding or classifying pieces of collected data and in identifying themes or parent nodes and patterns relevant to the research questions. More specifically, the researcher employed the step-by-step or systematic guide with six phases as Braun and Clarke (2006:86-93) suggest for thematic analysis. The guide involves "familiarization with the data, generating initial codes, searching for themes, reviewing themes, refine or defining themes, and producing the report".

The researcher utilized the appropriate software application for the qualitative data analysis, namely NVivo10, which suits to qualitative research in general and allows considering research questions directly as a basis for analysis (QSR International 2014:5). The NVivo10 system allows importing documents in soft copies directly into the application. Once the document formatted by headings and sub-headings or *formatting styles*, a researcher can formulate the themes and sub-themes or parent nodes and child nodes using the NVivo10 software. This application allowed exporting or extracting data in line with the thematic issues formulated by parent nodes and child nodes as discussed in Chapter-Four.

The researcher analyzed the imported soft-copy of the interview transcript by coding contents into the corresponding nodes, sub-nodes, and child-nodes (see appendix 8 on the node structure exported from NVivo10). After finalization of the coding, the researcher reviewed and ensured proper alignment of coded data in line with the themes or the nodes and child nodes. Then, the researcher extracted the crude report by the node structures using the quick thematic coding instruction of NVivo10. Consequently, generated the coded-data as per the coding patterns and based on the formatted font styles.

3.7.2. Content analysis of secondary data

The content analysis in this study referred to the analysis of data collected from secondary sources. Secondary data in this regard represent official documents collected from the government agencies implementing rape prevention interventions. The content analysis of secondary data, therefore, relied on documents focusing on the nature of rape prevention interventions. The focus issues include psychosocial support, health care, and legal support services, educational materials and program or project documents on rape prevention. The secondary data also included periodic performance reports of the selected health facilities and the Federal Attorney General on rape prevention, as well as unpublished workshop documents.

The study considered content analysis of secondary data for triangulation and verification of primary data collected through in-depth interview, particularly on referral linkages and partnership engagements. Besides, client loads or service uptakes, the type of rape cases by age and gender were among the data verified using secondary sources. The study also employed the content analysis to verify some of the exceptional and inconsistent arguments emerged from the analysis of primary data. In other words, the researcher corroborated those findings appeared contrary to the commonly stated views through triangulating with evidences from secondary sources. The content analysis of secondary sources, therefore, helped to verify dubious or inconsistent data emerged from the analysis of primary data. Such data verification eventually contributed to validate the study findings as shown in Babbie (2007:330) and Neuman (2007: 142-143, 227).

3.8. The validity of data and the study findings

The researcher emphasized ensuring the authenticity of data sources throughout the data collection process, which in turn implied the validity of the findings. Maintaining the validity of data remained a fundamental principle to a gain genuine and in-depth understanding of a situation in a particular setting (Neuman 2007:15; Babbie 2007:313). To this effect, the researcher fully engaged and exerted to grasp the research problem on the nature of rape prevention interventions and programs by the implementing agencies in Addis Ababa. Hence, the entire data, both primary and

secondary, collected from the responsible government health facilities and law enforcement agencies in the study area. For instance, secondary data sources like periodic reports and relevant other documents only considered and relied on official sources.

As the researcher undertook the data collection process adhering to the formal procedures, there was no room to collect unauthorized or non-official data. The researcher selected the study participants from the public health facilities and law enforcement agencies adhering to the formal procedures. Besides, relevant and easily understood open-ended questions asked in Amharic based on the general in-depth interview-guide to ease communication and better understanding. More importantly, the researcher employed authenticated transcripts of the in-depth interviews translated from Amharic into English for the analysis of the collected primary data.

The researcher gave due attention to ensuring impartiality; and thus, cautiously kept track of his ideas during the data collection and analysis processes. In cases where appropriate, the researcher noted such instances as “own ideas”, where such statements depicted being properly acknowledged (Babbie 2007:505-506). The researcher also exhausted opportunities among colleagues by arranging peer reviews of the draft findings against the in-depth interview transcript and accommodated remarks thereof.

More importantly, direct engagement of the researcher in the entire process, or “being there” by himself during the in-depth interview facilitated to sense and grasp emotional reflections of study participants (Babbie 2007:313). The researcher planned to organize deliberation workshops depending on the availability of a resource or utilizing relevant other platforms to disseminate the study findings among stakeholders. Research participants will access a copy of the study report through their corresponding institution.

3.9. Ethical considerations

3.9.1. Confidentiality

Study participants have their own opinions and feelings uncovered to the researcher during the in-depth interview. Hence, the researcher maintained integrity of the study process, evidenced through effecting professional obligation of safeguarding study participants not mentioned by name or kept anonymous in the study report. In this regard, the researcher formally confirmed to the study participants and the corresponding institutions in writing (see appendix 1 & 3) whereby confidentiality maintained at all levels (Babbie 2007:64-68). The researcher informed the study participants that the research would maintain their confidentiality and explained how the study would ensure their anonymity in the report. Thus, before they consented to participate in the research, all study participants knew that no name of a study subject registered during data collection and in the reporting of the research findings.

The researcher conducted interviews in a convenient setting based on the preference of study participants so that other people could not hear the conversation or identify participants while conveying their views. On the other hand, the researcher also came across institution-specific issues during the review of secondary data sources and the analysis of content such as reports and other official records. As some of those institution-specific records could appear case sensitive, the researcher remained vigilant not to disclose or report such cases in the name of a particular institution. Consequently, the study duly paid attention to issues of concern for confidentiality and thus maintained confidentially at all levels.

3.9.2. Voluntary participation of research participants

The researcher boldly mentioned to the study participants and their respective institutions that participate in the research entirely depends on voluntary and full consent of the study participants. To elaborate more on the steps taken in this regard, the researcher began in briefly informing the prospective study participant on the research purpose, the selection process of potential participants and possible contributions of the study findings. Then, the researcher proceeded with informing the prospective participants on the fact that there is no coercion to participate in the research.

Furthermore, the researcher pointed out that a study participant may withdraw at any time without consequences of any kind. The researcher also guaranteed that a participant could have refused to answer any question he or she found inconvenient to respond and remained in the study. In other words, study participants have had their informed choice, decided freely, and thus participated voluntarily in the study. The research further ensured voluntary participation in the study with a signed informed consent.

3.9.3. Informed consent

The researcher took every formal step and officially communicated with the selected institutions. Thus, each institution provided with a letter requesting for cooperation and permission to conduct the research. In this regard, the UNISA Regional Learning Center in Addis Ababa supported the researcher by writing letters in the name of each institution formally requesting for cooperation. The approval letter on the Ethical Clearance by the Research Ethics Committee was also enclosed.

More specifically, the researcher informed study participants individually on why and how he or she was included to take part in the study. The researcher then duly requested study participants for their informed consent before conducting the in-depth interview. To this effect, the Research Participant Information Sheet (signed by the researcher) and a written Consent Form[4] (see Appendix 2) utilized. These forms mainly state the research purpose, the importance of participation, and the full consent of the involvement in the study among other issues. Therefore, informed consent of the research participants ensured through both oral briefings and written consents undertaken during data collection (Babbie 2007:64, 68; Neuman 2007:196).

3.9.4. Debriefing during and after the data collection

Data collection in this study involved debriefing about the research and related issues as appropriate and demanded by the officials of the selected institutions and the study participants. The researcher started with a debriefing of concerned authorities in those institutions chosen for the research by focusing on the nature of the study and the reason for selecting that particular institution among others. The researcher took more

[4] The Informed Consent Form utilized during data collection process enclosed herewith this document.

time and provided sufficient information to the participants in cases where they have any query and whatever additional explanation requested during the data collection process.

The researcher mainly had debriefing sessions with each of the study participants before launching the in-depth interview and at the end. The researcher invited study participants to express their feelings and thoughts towards the in-depth interview session and the research itself at the end of each in-depth interview. Participants were also having an opportunity if they had something different to share the researcher off the record. The researcher reassured participants on their protection from any harm due to their participation in the study or if they had a concern about the consequences of information that they provided. To this effect, the researcher orally informed participants that names and other qualifiers on the individual identity would never be mentioned in the study report. Besides, the researcher reiterated on the purpose of maintaining the signed copy of the informed consent with each study participant, i.e. in safeguarding confidentiality (Babbie 2007:64-68, 72).

3.10. Conclusion

Chapter-Three discussed the research methodology, where the study employed a qualitative research approach and adopted a descriptive qualitative study design. This Chapter elaborated the procedures and sampling techniques in the selection of research participants. The Chapter explained the tools employed in the qualitative data collection. Besides, this Chapter elucidated how the study ensured the validity of data sources and the findings. Moreover, Chapter-three clarified ethical considerations, mainly on ensuring confidentiality and voluntary involvement of the research participants. The Chapter also outlined the approach that informed data analysis, including how NVivo10 software application used in the coding and extraction of data. Hence, the third-Chapter depicted methodological elements of the research that eventually led to the presentation and discussion of the findings presented as follows in Chapter-Four.

CHAPTER 4: PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1. Introduction

In line with the purpose of the study and addressing the research questions, this fourth Chapter presented and discussed the research findings drawn from the analysis of the collected data. The Chapter is structured with major and sub-thematic sections, where the research findings described in line with the parent nodes, sub-nodes and child nodes emerged in the process of data analysis. The parent nodes represented the main topics of the research findings, where each referred to the corresponding research questions. The sub-nodes and the child nodes discussed in this Chapter denote sub-thematic issues of the research inquiry coded from the primary data transcribed in-depth interviews.

This Chapter outlined the research findings into four major sections. The first section depicts the profile of research participants followed by presentation on the research findings. It described the perception of individual professionals on the existing nature or situation of rape prevention interventions in Addis Ababa. The chapter also discussed further research findings regarding the challenges encountered on existing rape prevention interventions with the corresponding priority areas for intervention to enhance rape prevention.

4.2. Brief profile of the research participants

The researcher conducted in-depth interviews with 14 research participants (see Appendix 7 on their profile[5]). As indicated in Chapter-three, ten of the participants (71%) constituted female professionals while the rest four (29%) were male. The age of research participants ranges from 27 to 45 years, where the mean age found 34.

[5]Appendix 7: refers to the table depicting the profile of each research participant by age, gender, experience (specific to rape prevention) and occupation annexed herewith this study report.

Regarding the composition of research participants by institutions, five (36%) selected from Gandhi Memorial Hospital and three (21%) from the Federal Attorney General. The rest six (43%) participants were from Black Lion Specialized Hospital, Lideta Sub-City Prosecution Office and the Federal High Court, where each institution represented by two (14%) research participants. Most of the research participants selected from Gandhi Memorial Hospital and the Federal Attorney General because of the active engagement of these institutions on the rape prevention interventions.

The study included research participants with relevant work experience, specifically on rape prevention. The mean service years or work experience on rape prevention interventions found six years, where the minimum to maximum experience ranged from two to 15 years of service. Regarding professional background, half of the research participants (seven) were lawyers, whereas health professionals accounted for 43% (six). Besides, the study involved one social worker. Even though the research participants represented the two major categories of professional backgrounds as health service providers and lawyers, each of these groups had differences in roles and specialization. For instance, health professionals constituted two nurses, two general practitioners, and two specialized physicians (a Gynecologist and Pediatrician). On the other hand, research participants from the lawyers' category were holding various responsibilities as five of them were public prosecutors while the rest two were judges.

4.3. Major findings of the research

4.3.1. The existing nature or situation of rape prevention interventions and programs in Addis Ababa

4.3.1.1. Interventions of the One-Stop-Center at Gandhi Memorial Hospital on rape prevention

One-Stop-Center was setup in Gandhi Memorial Hospital in 2012 with the involvement of various government institutions and other stakeholders with the major

objective of providing integrated services for rape survivors. One of the research participants mentioned April 06, 2012 as the date of formal inauguration of the One-Stop-Center and launching of the service. Senior health professionals at Gandhi Memorial Hospital and Federal Attorney General mentioned contribution of the experience-sharing visit to the Republic of South Africa for the establishment of the One-Stop-Center. The team mainly composed of the Medical Director of Gandhi Memorial Hospital and representatives from FMoH, Federal Attorney General, and the Federal Police Commission participated in the visit. Some research participants witnessed that the visit was a turning point to scale up the lesson on rape prevention into Ethiopia.

After the preparatory arrangements and finalization of setting up the One-Stop-Center, the government organized training of health professionals, mainly for nurses. The government conducted the training before launching of the Center and starting the service provision to rape survivors. One of the research participants in Gandhi Memorial Hospital, for example, narrated the initial phases of the Center as follows.

> *Following the inauguration of the One-Stop-Center at the Gandhi Memorial Hospital and dissemination of the news through the media and other channels,* survivor*s of rape who used to get the treatment elsewhere have begun to come here. Before the establishment of the One-Stop-Center, a team composing of the Medical Director of Gandhi and representatives from the Ministry of Health, Federal Attorney General, and Federal Police Commission visited and brought the experience of South Africa. After the finalization of preparatory arrangements, training provided to Nurses.*

The collaborative study between the Ethiopian Government, the United Nations Children's Fund (UNICEF), and the UCL (University College London) Institute of Education provides a concise illustration confirming the above discussion on the establishment of the Center except the slight variance on the date of establishment. To put it as stated in the document:

> "The first One Stop Center was opened in May 2012 in Gandhi hospital in Addis Ababa, and adapted from a model in South Africa. It provides a comprehensive service including medical and psychological

> treatment, legal service (by police and prosecutor) and shelter" (Parkes *et al* 2017:29).

Among the notable progresses achieved over the years, research participants mentioned engagement of five specialized physicians, two general practitioners, eight nurses, one laboratory technician, and a pharmacist at the Center. They also indicated that the Center provides full-time integrated services for rape survivors and related prevention interventions. One of the research participants particularly emphasized the vital role of the Center and witnessed the intervention on rape prevention as follows:

> *As there is no such a Center in all regional towns with complete service elements including legal support, psychiatry, laboratory, pharmacy, inpatient physical examination operational for 24 hours a day and seven days a week,* survivor*s are coming here from very far locations.*

On the other hand, some health professionals uncovered that Gandhi Memorial Hospital used to serve rape survivors long before the establishment of the Center. One of the research participants witnessed explicitly in this regard saying, "Previously, we were addressing cases of violence as an emergency basis and as an outpatient. However, it was not that much organized when compared to the existing services." Regarding the service situation before launching of the Center, a health professional stated:

> *Once rape survivors got medical treatment, they leave the hospital. Currently, however, following the medical treatment, health service providers would link rape survivors to the police and prosecutors within the same Center to take care of crime investigation and legal supports.*

According to the description of research participants, the service pattern of the Center in Gandhi Memorial Hospital represented that once the rape survivor came to the Center, they gave priority to medical treatment. Health service providers, particularly nurses, appeared at the forefront in taking care of the rape survivors. The nurse engaged starting from the support in processing client cards and providing preliminary medical services until linking the client with a physician. Following the

medical diagnosis and treatment, nurses would introduce rape survivors with the social worker and law enforcement personnel. Health care providers also direct rape survivors to work with the Police Officers and Public Prosecutors deployed within the same facility for crime investigation and prosecution. Police officers and prosecutors would then work upon collecting evidence from rape survivors. Research participants also indicated that there could be cases where rape survivors were required to revisit a doctor for further medication.

Research participants identified government institutions actively operating with the Center on rape prevention mainly referring to the health sector and the Justice System. They specifically mentioned Black Lion Specialized Hospital and the Addis Ababa Health Bureau in closely working with the Center through referral, networking, and technical support. On the other hand, the law enforcement institutions engaging in rape prevention interventions in collaboration with the Center include the Addis Ababa Police, Prosecution Offices at the sub-cities' level and the Federal Attorney General. Despite the active role and support of the Federal Attorney General on rape prevention interventions, health professionals, in particular, considered Gandhi Memorial Hospital as a responsible agent in the administration of the Center.

- **Available services for rape survivors in the One-Stop-Center**

Research participants with health background advised that rape survivors should come to the Center within 72 hours of the rape incidence. The rationale behind this argument of timely reporting on rape associated with the influence on the effectiveness of health service provision, including for the tests linked to medical investigations required for legal evidence.

Health professionals at Gandhi Memorial Hospital discussed that if the rape survivor timely came to the Center, it would be possible for the survivor to get the essential services as deemed necessary. Timely reporting of rape incidence appears crucial, for example, in prevention of HIV transmission through post-exposure prophylaxis, and availing safe termination of pregnancy services mentioned among essential services. However, in cases where the rape survivors found at their full-term pregnancy, health providers discussed that the hospital supports safe delivery. Other services were also

available at the Center. It conducted different laboratory tests such as HIV, hepatitis, pregnancy, Venereal Disease (VDRL), and Sexually Transmitted Illnesses (STI) diagnostics. To put it as stated by one of the health professionals:

> *If a woman is raped, she is expected to arrive within 72 hours for health services. If she is not let, it is possible to get services on the prevention of HIV and pregnancy. The Center has several tests here, including testing for HIV and hepatitis, pregnancy testing, VDRL, and STI diagnostics.*

In line with the treatment services, the Center also provides counselling to rape survivors by assigning a professional counsellor. Furthermore, health workers pointed out the availability of a pharmacy within the same facility, and thus the rape survivors could get most of the drugs at the Center. In addition to generating medical evidence, the police officers and prosecutors conduct a further investigation at the Center on the crime of rape considering the words of the survivor and through gathering other circumstantial evidence.

Research participants also appreciated that the government considered concerns of rape survivors on further victimization, and thus established the Center to maintain the safety of the survivors. Such matters mainly referred to as the situation where perpetrators are family members. The rape survivors in such cases are often afraid of their family members. Besides, rape survivors might not be willing to be exposed to someone they knew. Hence, the Center organized restrooms with two beds that serve rape survivors for 72 hours, which also got dining and shower facilities. According to health professionals, the purpose in this regard is to avoid further victimization by the same or potential perpetrator in a case where the rape survivor has no family. Thus, the Center did not send such survivors of rape; instead, they stay at restrooms or go to alternative safe homes facilitated at other places.

- **Brief description of clients served in the Center**

Both secondary and primary sources confirmed that majorities of rape survivors represent children and female clients less than 18 years of age. One of the senior health professionals at Gandhi Memorial Hospital described the situation saying that

most of the rape survivors (more than 90%) constituted female clients. On the other hand, male survivors of rape, though served in Black Lion Specialized Hospital, estimated to account from one to ten percent of rape survivors in Addis Ababa.

Research participants at the Center also indicated that they were addressing from 150 to 160 rape survivors per month. Unpublished records at Gandhi Memorial Hospital also show more than 1000 cases of child sexual abuse reported in the year 2016. Regarding the rape of boys, one of the study participants revealed that 327 cases of w diagnosed and treated in Black Lion Specialized Hospital from 2011 to 2015. The age of boys served at the hospital reported to range from 01 to 15 years.

Even though the Center was providing services to rape survivors from the entire country, health professionals underlined that most of the child rape survivors came to the Center from Oromia region. Participants, for instance, mentioned rape survivors who came from Jimma and Gondar areas that are 346 and 663 kilometers away from Addis Ababa, respectively. The health professionals also indicated that police officers accompanied clients coming to the Center from remote places. They explained referral of rape survivors from remote areas involves the belief that the Center is in a better position to provide helpful medical evidence to the court. However, health professionals pointed out rape survivors having no such awareness were also coming to the Center on their initiative. A health service provider indicated in this regard:

> Survivors, *for instance, come from Jimma, Gondar, Ambo, and from different other places accompanied by the police with a belief that this Center is in a better position to provide helpful evidence in court. However, those with no such awareness are also coming on their own initiative.*

- **Referral linkage and partnership of the Center**

The Center at Gandhi Memorial Hospital closely works in collaboration with specialized hospitals and law enforcement institutions in Addis Ababa. In this regard, a research participant at the Center confirmed the linkage and partnership saying, “We are working in collaboration and integration with the hospitals, the Police and Justice Departments.” Health workers at the Center indicated that Gandhi Memorial Hospital

established liaison offices at the hospitals operating in partnership to facilitate referrals for rape survivors. Those health facilities include Black Lion Specialized Hospital, St. Paul Hospital, Menelik II Memorial Hospital, and Hamlin Fistula Hospital.

Facilitation of referrals represents rape survivors suffering from cases of severe trauma beyond the capacity of social workers and psychologists at the Center and the sub-city level police departments. Thus, clients with such difficulties referred to St. Emanuel Mental Hospital for specialized services. Furthermore, as the Center in Gandhi Memorial Hospital established to serve female rape survivors, health workers confirmed that male survivors of rape not addressed in the same facility. The Center instead referred male rape survivors to Black Lion Specialized Hospital. According to the study participants and key informants, the arrangement at the national level for the cases of male rape survivors was through referral to Black Lion Specialized Hospital. As a result, a specific unit established at Black Lion and dedicated to providing specialized health services to the male rape survivors. Moreover, referral to Black Lion included female survivors of sexual violence in cases required surgical interventions. In this regard, health professionals working on cases of rape survivors at the Center and in Black Lion confirmed the existence of an established system on referral and follow-up of rape cases. They also mentioned a standby ambulance service assigned to the transportation of rape survivors within the two health facilities.

Some respondents further reflected on the existence of a referral mechanism in the regions, where police officers were handling referral of rape-related cases to Gandhi Memorial Hospital. One of the health service providers in Gandhi Memorial Hospital discussed this as follows.

> *As there is an integrated system in the regions, there are police officers to handle rape related cases and referring them to Gandhi Memorial Hospital. The police do accompany the* survivor *along her way to the hospital. A letter with information on the rape case sent to the hospital. They are mainly sending the* survivor *for medical treatment and the evidence but handling court cases at their own localities. After the medical treatment and tests, Gandhi Memorial Hospital provides test results with a signed letter to the police.*

Even though the Police Officers did sometimes accompany rape survivors to the hospital, they often preferred to share information formally on specific rape cases to the hospital. In such cases, the police Officers handle legal issues at districts. Besides, research participants indicated that the government (the FMoH or Regional Health Bureaus) organized command posts at the local level, where this body determined the place of referral. A health service provider at the Center witnessed that "rape survivors are using ambulance service these days even though they used to come to health facilities by themselves in the past."

Following the medical treatment and tests at the Center, Gandhi Memorial Hospital formally submits medical evidence with a signed and sealed letter to the public prosecutor or a court of law as appropriate. A prosecutor working at the sub-city level explained the process as follows:

> *As we send* survivor*s to Gandhi Hospital, they indicate physical damages found on the body in writing the medical report. The written medical evidence, for example, can include the existence of new deflowerment, as well as a sign of scratches on her face and neck.*

Public prosecutors mentioned that the Federal Attorney General leads the National Coordinating Committee on the prevention of violence against women and children (including rape). The intervention in this regard involves the mass media. Both research participants, those engaging in health care and law enforcement activities at the Center, underlined that mass-media agencies did come and conduct interviews on selected issues such as the health services provided to rape survivors. Health professionals at the Center also mentioned their effort to work in partnership with the Federal Attorney General and the Federal Court on rape prevention.

Moreover, some of the research participants at the Center positively reacted when asked whether they have gone to the mass media by developing rape prevention programs with a specifically designed approach. One of the health professionals at the Center stated that they were working with mass media in the past and said, "A medical doctor and a nurse were assigned and worked with media for a certain period. Awareness raising program as broadcasted for some months." The focus area of messages conveyed through the media includes issues on vulnerability of children,

and risk avoidance to rape. The media also gave coverage on the immediate need to visit a health facility and the benefits of timely reporting rape cases to law enforcement agencies.

The Addis Ababa Health Bureau was also working with the Center by encouraging the mass-media agencies, and thus they conducted a series of interviews with health professionals including the Medical Director. This partnership between the Health Bureau and the Center enabled the dissemination of messages on rape prevention over the mass media. The message dissemination program was on the air for about six months and that in turn increased client flow and demand for the service at the Center.

Health professionals serving in the Center pointed out the mechanism established on a proper referral system. The Center, for instance, encourages rape survivors to bring a letter from the local police. Clients have adopted such practice of linkage with law enforcement agencies or the police as a trend at Black Lion Specialized Hospital. The motive of the request for a support letter on a rape case from the police is to facilitate partnership and linkage of health facilities with law enforcement agencies. The referral of some clients also implies the need for specialty surgery. However, such referral, according to health professionals, could be inconvenient for clients. Hence, some health professionals suggested that it would be good to have an integration of such specialty services in the Center at Gandhi Memorial Hospital. For instance, they pointed out the possibility of rape cases with fistula, female children raped via anal office and related other health damages coming to the Center. However, clients coming to the Center with fistula cases only provided with first aid, and thus referred to Hamlin Fistula Hospital for the service requiring a fistula surgeon.

Underlining the importance of referral linkages, some research participants also denounced the argument to integrate everything with the services of the Center or under Gandhi Memorial Hospital. One of the senior health professionals commented in this regard:

> *Establishing a fistula unit here in Gandhi Hospital demands surgeon on fistula with the corresponding equipment and materials. Gandhi Memorial Hospital, being a maternity hospital, cannot and should not avail everything. Hence, the feasible approach is to refer clients in*

need of further specialized serves such as psychiatric support on mental health disorders or surgical operations in cases of physical damage among other examples.

The rest referral cases, as indicated earlier, constituted those clients linked to organizations providing safe home services for clients. Rape survivors taken to safe homes would eventually get psychosocial care as well as legal support services, where the research participants considered this partnership as an area of complementarity.

Research participants working at the One-Stop-Center in Gandhi Memorial Hospital found partnership engagement at the Center helpful to address common challenges such as misunderstanding between health professionals and law enforcement personnel (judges, prosecutors, and the police). A committee established among the stakeholders operating at the Center also engages in addressing such misunderstandings through discussion. Moreover, notable partnership evidenced in the joint attempt of health professionals and prosecutors at the Center managed to have developed a manual explaining on commonly appearing issues as a challenge to the court. Prosecutors specifically collected various questions from colleagues at the different sub-cities and court requests for explanations regarding medical evidence. Finally, those issues of challenge in need of explanation submitted to a gynecologist, and that eventually led to the development of a manual disseminated to all sub-cities for a reference.

Some prosecutors indicated joint efforts to maintain the quality of medical evidence, where this also implied the need for mutual understanding. In other words, prosecutors at the Center were crosschecking medical evidence in collaboration with health professionals. As a result, they were sharing documents on medical evidence to the court after verifying on areas of concern or having a clear understanding.

- **Educational or primary prevention interventions of the *Center***

According to the research participants, the Center in Gandhi Memorial Hospital implements primary prevention interventions or educational programs on rape.

However, these interventions involved vital stakeholders, mainly public prosecution offices, the Federal Attorney General, and the mass media in Addis Ababa. Primary prevention interventions often focused on how to tackle the crime of rape and other forms of violence against women and children. The study participants from the law enforcement institutions, for example, noted that public prosecutors have been organizing educational activities and forums involving the community. Most of them underlined that public prosecution office is responsible as an institution to work on crime prevention programs including rape, while other institutions such as the court of law could have a complementary role.

Furthermore, research participants revealed instances where judges were providing professional explanations and educational messages broadcasted over the mass media for public consumption. Nevertheless, judges had the opinion that courts have limited engagement on primary prevention. This role of judges, however, is usually limited to selected issues and without mentioning the identity of individuals. Because releasing any legal case over the mass media needs the permission of the court. Reflecting on the existing practice, public prosecutors organize educational programs on rape prevention in line with internationally commemorated days such as the International Women's Day or March-Eight and the White Ribbon Day.

Most of the research participants from health backgrounds discussed that the existing primary prevention intervention on rape mainly refers to educational activities through mass media, and thereby, reaching the public as a whole. Besides, the Center at Gandhi Memorial Hospital produced print materials with educational messages focusing on rape prevention and distributed to individuals targeting households. Health professionals serving in the Center witnessed partnership with the mass media, where journalists came and took audio-video recordings on rape prevention and conducted awareness creation intervention for the public. As a result, they further mentioned that more people were coming to the Center as they heard of the service in Gandhi Memorial Hospital through mass media.

The majority of the research participants at the Center specifically recalled two television programs, namely "Chilot" and "Tenawo bebietwo" in Amharic, which in English is equivalent to "Court" and "Attend your health being at home",

respectively. Research participants acclaimed these television programs broadcasted over the national television, mainly in serving the purpose of primary prevention of rape. To put it as one of the participants stated,

> *There were growing visitors coming into the hospital. People, who used to keep their rape victimization a secret and thus remained hidden at home, increasingly came to the Center being surprised with the availability of such service.*

Prosecutors and health service providers at the Center noted the crucial role of mass media in community awareness creation about the services provided in the Center. Secondary sources also witnessed utilization of mass media, including series of national radio broadcasts and television shows. For instance, Parkes *et al* (2017:35) mentions the efforts of "Chilot" Television show. It disseminates information on prevention of GBV, including sexual violence based on "true story based dramas on legal cases".

4.3.1.2. Interventions regarding the expansion of rape prevention centers

Most of the rape survivors coming to the Center in Gandhi Memorial Hospital were from locations out of Addis Ababa due to the absence of such a facility in the regions providing integrated services in one place. Hence, study participants revealed encouraging initiatives to expand similar rape care centers. One of the health professionals at the Center witnessed such programs and said:

> *I heard that similar Centers are on the establishment in the cities of Dire-Dawa, Nazareth (Adama), Shashemane and Awasa (Hawassa). They are taking the experience from this Center found in Gandhi Hospital. The Center in Gandhi Memorial Hospital already engaged in the training of professionals from selected government institutions in these cities. This opportunity also allowed sharing their experience on rape prevention interventions to the trainees.*

Study participants noted the importance of scaling up the experience on rape prevention interventions at Gandhi Memorial Hospital and that of Black Lion Specialized Hospital within and beyond Addis Ababa. They mainly pointed out the benefits of expanding the initiative in reducing the burden on the two hospitals. More

importantly, rape survivors could have easily accessed to the service if such facilities were available at a nearby locations. Rape survivors coming from distant places usually face financial challenges for transportation and suffer from costly expenses to stay with their accompanying family members in Addis Ababa.

Experienced study participants further commented, “Having the government willingness and specifically designated body on rape prevention, expanding the service will not be a problem.” They explained that professionals from the regions could get training at Gandhi Memorial Hospital, where the Center can serve as a learning hub. To this end, they identified master trainers at the Center as potential resource persons for capacity building interventions on rape prevention. Research participants were optimistic on possibility of coordinating several rounds of training for professionals and expanding the experience into the regions. They affirmed that the Center could organize the required training in a week, where having the support of stakeholders like Federal Attorney General considered pivotal.

4.3.1.3. Existing interventions on the capacity building training of professionals

Research participants primarily mentioned the Federal Attorney General as the primary institution in facilitating on -the job capacity building training for professionals providing medico-legal services to rape survivors in the Center. Most of the research participants highlighted the need for basic training before deploying professionals to work with rape survivors. They reflected on capacity building training as helpful and essential inputs to all professionals at the Center to be skillful, knowledgeable, and effective in rape prevention in general and serving rape survivors in particular.

Research participants with more than five years of experience at the Center confirmed that the government trained all health professionals at the beginning of the program on how to provide services for rape survivors. Some of the health professionals also stated that the government was organizing various training a year ago. They specifically mentioned training contents such as rape case management and assessment as per national guidelines, and burnout management among professionals working with rape survivors. Social workers also had training on how to handle rape

cases not to negatively influence the effort of prosecutors to redress the rape survivor legally. One of the health service providers at the Center commented as follows:

> *There used to be regular training for health professionals in the past. However, currently, those who had the training previously are trying to orient and share basic skills for the newly recruited staff. Besides, the specialists in Gandhi Memorial Hospital serve as an opportunity for junior health service providers through consultation or referral on challenging cases. There is a chance to refer complicated cases beyond our expertise for Gynecologists in the same compound, and thus they do help us.*

On the other hand, prosecutors indicated that, in collaboration with health professionals, they have been organizing awareness raising workshops to prosecution officers. Such attempts of imparting knowledge to public prosecutors often focused on addressing frequently asked questions like what does virginity means, and whether there could be a pregnancy while a woman is still a virgin. Besides, such workshops were helpful to address frequent questions like what do we mean by the fact that there is a new penetration, does the finding of sperm in the medical evidence certify rape and related others.

4.3.1.4. The existing situation on the timeliness of reporting rape incidence

Research participants confirmed that rape survivors usually do not report the incidence of rape timely. The primary reason mentioned for the delay to report the occurrence of rape was that most rape survivors were coming from remote areas, mainly from the Oromia region. In addition to the distance factor, as the police officers accompanied rape survivors coming from the regions, they usually preferred their own convenient time. Besides, the police officers often got other priority assignments to handle. As a result, rape survivors coming under such challenging circumstances unable to timely report to the Center.

Furthermore, the lack of information among rape survivors and the community contributed to the delays of rape survivors coming from the regions. Socio-cultural factors, such as child marriage and stigma attached to sexual violence also contributing to the failure or delay of reporting rape incidence. These factors are in

line with the assertion of Mekuria *et al* (2015: 2) regarding the under-reporting of rape crime from the context of Ethiopia. The report by the Government of Ethiopia (2007:58) also reaffirms the pressure of stigma and lack of awareness, particularly in child cases of rape, contributing to the reduced motivation of disclosing rape. The challenge of reporting male rape appears more severe in Ethiopia where Haile *et al* (2013:1-2) reveals the high humiliation associated with male survivors of rape.

Nevertheless, the situation in Addis Ababa found relatively better, where study participants acclaimed grassroots level integration with the police in contributing to the timely reporting of rape survivors to the Center. Some health service providers also encountered occasions whereby community and family members were taking the initiative by themselves in reporting suspected cases of rape. One of the nurses said in this regard:

> *If the family is attempting to hide the fact of rape, some people were bringing a child and reporting that she was crying. They suggest that it is better to diagnose the child. Parents also bring cases for diagnosis if they find their child in a different condition or having a suspicion of rape.*

4.3.2. Challenges encountered in existing rape prevention interventions and programs in Addis Ababa

4.3.2.1. *Challenges on availing quality services to rape survivors*

- **Limitations on availing medical equipment and supplies**

The key question on medical equipment and supplies for rape prevention programs that all professionals underlined referred to the availability of Deoxyribonucleic Acid (DNA) testing equipment, the supplies, and trained human resources. Health professionals particularly mentioned that integrating a DNA test with the existing services of the *Center* in Gandhi Memorial Hospital could have played a substantial role in enhancing rape prevention interventions so far. Experienced and senior health professionals revealed that DNA testing involves multiple and helpful tests for the investigation of rape and related crimes. Health service providers at the *Center* explained that if there were DNA tests, they could have generated much more detail and helpful medical evidence, mainly to legally redress rape survivors. The sources of

medical evidence, according to health professionals, represent an examination of the samples taken from the rape survivor after the rape incidence. Medical evidence could be generated from the hair, closes, fingerprints, sperm cells, and relevant other body fluids among others.

The study participants stated that rape survivors usually report physical abuse and coercion, which could have involved physical contacts with the assailant. Hence, the survivor could have handcuffed, smothered on the mouth, choked on the neck, lacerations, and related other signs of injury. Once a sample of the above kind collected for the laboratory investigation, DNA testing allows generating powerful and confirmatory evidence by comparing the findings with the DNA of suspected assailants. One of the study participants in this regard reflected as follows:

> *The DNA test could have eased and facilitated several problems. I do believe that the DNA test could have easily identified the criminal and there will not be a reason to deny the rape. Moreover, if there were the DNA test, it could have also helped beyond legally redressing rape survivors, mainly for the active deterrence role of legal punishment and thereby the prevention of rape.*

Research participants with health background described technical challenges occurring at the Center due to the absence of DNA testing. For instance, if a rape survivor lately came to the Center after three or four days, where the wounds already healed, there could be no possibility with the existing tests at the Center to generate crucial medical evidence. One of the health professionals specifically indicated the current problem as follows: "It is not possible to avail forensic data that demands DNA examination. For example, if there is any evidence collected such as hair, sperm, and related others, it is not possible to determine the identity of those samples." Prosecutors in Addis Ababa faced this challenge of producing sufficient evidence before the court to testify against the alleged perpetrators, where substantial numbers of charges on rape were not successful (Ministry of Justice 2008:7). Besides, the problem appeared more severe where most rape survivors unable to access legal support services in Ethiopia (Yemane 2004:132).

Health professionals added that a recurring problem to keep the medical evidence as strong as possible has to do with the challenge of maintaining minimum standards of undertaking tests within 72 hours of the rape incidence. However, the real problem lies beyond the detection of the sperm cell, as the existing test result cannot establish the identity of the assailant. Health service providers argued considering the experience of other countries, and said, “Had it been in the advanced countries, the sperm cells can be compared to the DNA of the assailant.” Research participants from the law enforcement agencies particularly noted the challenge posed due to the absence of DNA testing, which represented the concern about the quality of medical evidence. A prosecutor complained in this regard saying that "existing medical evidence is only about the fact of whether there is deflowerment or not. The written medical evidence is only telling that there is either an old or new deflowerment." Prosecutors also understood the implication of the absence of DNA testing, particularly in verifying the identity of the suspected assailant. One of the prosecutors specified the effect as follows:

> *Due to the absence of the DNA test, the issue of rape is very much abused. Had there been the DNA test, it could have reduced our pressure and facilitated the process of law enforcement. Availing the DNA test could have reduced the burden or workload on health facilities.*

Regarding the possibility of abusing the issue of rape, prosecutors mentioned instances of false accusations among some women, where verification of such allegations still appeared difficult in the absence of the DNA test. Besides, false accusations on rape could have harmful health implications due to the unnecessary administration of some drugs like post-exposure prophylaxis for HIV prevention.

One of the health professionals pointed out, however, on the possibility of DNA testing through a private institution in Addis Ababa, namely the International Clinical Laboratories (ICL). The ICL established a mechanism whereby they send the samples abroad, and the DNA test results shared back. The ICL facilitated the DNA test service abroad with a cost of up to 5,000 Birr per head. Nevertheless, some health service providers at the One-Stop-Center regretted that they hardly attempted to collaborate with ICL. They thought that the challenge at the Center linked to budget

shortage. Despite their series of requests and unsuccessful attempts for the procurement of DNA testing equipment, some research participants still had a feeling that the Center could have integrated the DNA testing through mobilizing stakeholders.

Furthermore, there were cases where the Center sometimes encountered shortages of laboratory supplies like VDRL reagents and HIV test kits. In such instances of shortages, the Center had to inform the rape survivors to look for those tests out of Gandhi Memorial Hospital. Service providers confirmed that clients would be inconvenient to look for services out of the hospital because of cost implications. Clients instead preferred to access all services within the Center because of the established mechanisms for rape survivors to get services free of charge.

- **Limitations on human resource capacity building training**

Experienced workers at the Center noted that the Addis Ababa Health Bureau and the Federal Attorney General provided training on integrated service delivery to rape survivors. However, they commented on trainings organized so far were insufficient. One of the health service providers witnessed, “There has been no training for health professionals who joined the Center as of last year.” Another health professional added on the limitation of training stating that:

> *There is only one health professional with properly scheduled training in the hospital. The rest of us depend on the training we had at medical school and the support from other staff through on-the-job skill transfer.*

Health professionals also indicated the need for more regular capacity building training in line with the changing dynamics in medicine and health. Some of them mentioned that they had the training long ago and thus they need to update themselves with existing developments. They also noted the limitation in exhaustively seizing and utilizing opportunities, where few professionals could manage to participate in the rarely available training programs. Service providers also witnessed high possibility of burnout among professionals due to the stressful nature of working on rape case by itself, and because rape survivors from the entire country overloaded the Center. Hence, research participants suggested retreat programs and training for professions

to cope up with challenging situations. Even though the existing trained professionals at the Center were exerting to share experience for the recently recruited staff, research participants still observed the gap of skill and knowledge among those deployed to serve rape survivors without training. One of the prosecutors, for example, recalled a case of rape whereby wrong medical evidence on virginity reported to the court due to lack of experience and training. This suspicious medical report verified latter on to the contrary through conducting a further test at Black Lion Specialized Hospital, which confirmed the deflowerment of the rape survivor.

Study participants noticed a gap to recruit and assign experienced and skilled professionals as opposed to the complex nature of rape crime. For instance, they underlined the need to maintain a balance between competing demands of redressing justice for the survivor while respecting the right of the suspected assailants. Research participants uncovered their concern on the risky practice of assigning fresh health professionals without training on management and assessment of rape. They also gave similar remarks on the assignment of police officers and prosecutors to work with rape survivors without training. Hence, some law enforcement personnel demonstrated unnecessary attitudes on the job, where such behavioral manifestations could be harmful to rape survivors.

Professionals working on the rape prevention interventions at the Center, mainly health service providers and prosecutors reported having limited knowledge on issues beyond their respective fields of study. For example, lawyers sometimes tended to influence health professionals to produce the type of evidence that they wanted. In such cases, research participants suggested that health professionals should fill their gap of awareness on legal issues. On the other hand, professionals from the law enforcement agencies lack orientation on the underlying health issues and rape-related medical languages. In this regard, study participants mainly pointed out the misunderstanding in the use and interpretation of languages due to professional differences.

Prosecutors noted that their work with rape survivors involves investigation of complex crime often committed secretly and thus requires skillful, knowledgeable, and experienced professionals to achieve better results. However, prosecutors

witnessed capacity related gaps as a reason for losing some cases at the court. One of the prosecutors, actively engaged in prosecuting rape cases at the court of law, reflected on her limited capacity saying, "As a professional, I do not believe that I have sufficient training". Another prosecutor affirmed the situation on lack of training as follows: "I never had any training related to cases of violence against women and children throughout my two years of work experience." Because of the limited training opportunities, junior prosecutors often resorted to consulting experienced prosecutors. One of the study participants also supplemented on the related challenge arguing that:

> *The investigation of cases on rape is different from the investigation of other regular crimes. However, organizing capacity building training could have reduced unnecessary failures of court cases on rape.*

- **Gaps to meet demands of rape survivors**

The prevalent gaps that research participants pointed out as areas for improvement to address the demands of rape survivors mainly constituted issues indicated under this section. Rape survivors generally need to change the environment or the place where the rape happened to them. Major issues of concerns raised here include limitations on meeting the desires of rape survivors to avoid the possibility of revictimization and to forget their trauma associated with the moment of rape. Rape survivors were unable to get their demands sometimes due to the limited safe homes available in Addis Ababa.

Rape survivors came to the Center from far places often accompanied by their parents and the police, mainly because of the need for medical evidence for legal purposes. Unfortunately, this drive of rape survivors for justice to prevail often jeopardized due to the absence of DNA testing at the Center.

Even though there were male survivors of rape coming to the Center and seek services at Gandhi Memorial Hospital, they were rather referred to Black Lion Specialized Hospital. The reason for the referral arrangement for male clients linked to the absence of diagnostic tools and specialized human resources at the Center. Research participants indicated that male rape survivors often complained of delays and high patient load at Black Lion. Furthermore, male rape survivors referred to Black Lion

could not get services by an organized team of law enforcement and health professionals as compared to the services in Gandhi Memorial Hospital.

Female rape survivors in cases of anal rape and pediatric clients also referred to Black Lion Specialized Hospital, whereas those in need of psychiatric care sent to St. Emanuel Mental Hospital because the Center in Gandhi Memorial Hospital was not addressing such medical cases. Besides, as St. Emanuel Mental Hospital is the only institution specialized in mental health, it is receiving patients from the entire country. Hence, rape survivors referred to the two specialized hospitals were dissatisfied, and thus preferred to get all the services within the Center in Gandhi. There were also extended delays in getting medical evidence particularly from health institutions providing specialized services, namely from Black Lion Specialized Hospital and St. Emanuel Mental Hospital. Consequently, court hearings on such cases of rape could delay for a long time, where the trial will not resume until collecting the medical evidence. Lawyers mentioned instances where some charges on rape cases adjourned several times until the specialized hospitals delivered written medical evidence to the court of law.

Some of the rape survivors referred to Black Lion Specialized Hospital disappeared or did not show up, as they could not afford to pay for service charges. The challenge in this regard mainly represents the absence of a mechanism in place so that rape survivors provided with services free of charge. Clients with concerns of confidentiality at the Center had no alternative to getting the service at another facility in Addis Ababa. Such instances could happen to rape survivors or their family members whenever they wanted to avoid a breach of confidentiality in a situation they came across someone they knew working in the Center.

In addition to the absence of technology to support the investigation of rape crime such as forensics and DNA examinations, the limited skills and knowledge among law enforcement personnel threatens the effectiveness of generating crucial evidence. As a result, substantial rape survivors denied justice. In other words, with the existing practice where the court decision heavily relying on circumstantial evidence supported by statements of medical professionals, the drive of rape survivors to be legally redressed remained hardly possible.

The problem of ensuring the protection of rape survivors from secondary victimization would be more severe in delayed cases as the court hearing adjourned several times. The court could adjourn the hearing on rape cases for several reasons, including delays of medical evidence, while some delays appeared for quite trivial reasons. For example, the court could postpone hearing on a rape case due to power interruption, the absence of the psychologist, or because of minor incidences like a failure of a recorder. The lengthy trial, particularly on rape cases, could exacerbate the possibility of secondary victimization on the rape survivor.

The secondary victimization occurs whenever prosecutors remind rape survivors to remember the details of the rape incidence. The prosecutors' intention in reminding the client is to ensure readiness of the rape survivor to effectively memorize and testify the details before the court. Prosecutors reiterated that rape survivors had to go through rehearsals to memorize pieces of informations on the rape incidence. The problem with such rehearsals of the rape survivors is because of its repetition during every occasion of the court hearing. Hence, the rape survivor would be urged repeatedly to think about what the assailant committed against her or him bit by bit. To put it as one of the prosecutors portrayed:

> *I have to remind the survivor whenever I testify witnesses. Because, if she forgets things, it could mean the case closed or the court could release the defendant free of charge. Thus, I could ask the survivor about what the assailant has done against her three or four times on a single case.*

The limitation on psychological care and counselling service depicted as a critical challenge where the issue not yet given priority. A prosecutor specifically described the situation saying, "Dropping a psychologist at each of the sub-cities does not necessarily mean that we have addressed the challenge." Other research participants also observed the lack of appropriate workplaces, where some psychologists were attempting to help survivors by sharing offices in police stations.

4.3.2.2. Challenges encountered in rape prevention interventions

- **Limitations on primary prevention interventions of rape**

According to the opinion of health professionals, the existing programs on rape prevention, including interventions implemented by Non-Governmental Organizations (NGO), focused on the post-occurrence or aftermath of rape. In other words, rather than educating the community on avoiding rape before its occurrence, most program interventions were attributed to responses or reactions following the incidence of rape. Existing interventions mainly concentrated on availing health care and legal support services to the rape survivors. Moreover, research participants argued that most of the rape prevention interventions so far depicted as urban biased despite the higher demand for such programs in rural areas.

Primary prevention interventions on rape lacked a specifically designed program on public awareness creation supported by dedicated mass media broadcasting educational messages on a regular basis. Health professionals justified that it is essential to teach the entire public as the challenge of rape affecting everybody irrespective of differences in gender, age, marital status, religion, or ethnicity as research participants mentioned among others.

As far as the law is concerned, there is a lot remained to be done for the public to have sufficient information and knowledge on the rights and responsibilities of individual citizens. Ensuring gender equality and avoiding any form of GBV and sexual coercion particularly deserves much intervention not yet undertaken. Health professionals and lawyers did not have broader engagements with mass-media agencies to address the public with educational messages on primary prevention. Research participants reflected, for example, that informing individuals and the public on the implication of violating the law could have restrained people from committing the crime of rape. However, the current engagement of mass-media agencies and coverage often represented event specific broadcasting such as court decisions on selected cases of rape.

Nevertheless, research participants at the Center identified one educational program, known as “Chilot”, working on crime prevention in general, has been conveying

messages to the public through the national television. Participants, however, indicated limitations on this Chilot program in depicting the reality, and thus overlooked the multiple challenges associated with rape cases. To put it as illustrated in the words of one of the participants:

> *The 'Chilot' television program not only limited to specific processes of court proceedings, but it tended to portray as if the court trial on rape cases were straightforward. The 'Chilot' program, as a result, conveyed a misleading message to the public as if legal prosecution processes were smooth. Besides, television programs, including 'Chilot', were not comprehensive enough to inform the public on the importance of timely reporting of the rape incidence, how to safeguard crucial evidence from damage, and thereby support the crime investigation process.*

Furthermore, awareness creation and educational programs on rape prevention hardly inform the family on primary prevention measures. This entails the need to closely support, inform and follow up of children, including boys on day-to-day basis. Even though working on sexuality education considered essential among professionals, the issue of sexuality remained not subject to open discussion at a family level. The challenge here is the taboo associated with sexuality due to cultural barriers and exacerbated by lack of such interventions in existing rape prevention programs.

- **Challenges on multi-sectoral involvement, referral linkage, and networking**

Research participants underlined that the engagement of different government institutions on the prevention of victimization of women and children to rape not as strong as expected. The involvement of stakeholders on rape prevention, particularly the mass media, local administrations, and educational institutions in Addis Ababa remained minimal as compared to the law enforcement and health institutions. The government-supported structures at the local level were not yet exhaustively involved in community awareness creation focusing on rape prevention. Research participants mentioned established structures at community level to engage in awareness creation. Such structures consisted of Health Extension Workers, Women and Youth Forums, as well as Women Development Army among others.

Study participants had reservations on the existing referral and networking practice, where a lack of follow up and weak feedback mechanism on referred clients characterized the existing partnership with stakeholders. Service providers at the Center disclosed the limited linkage with the non-governmental organizations where their role restricted in availing safe homes for needy rape survivors. However, existing shelter homes operate with challenges like insufficient package of services to rape survivors. Access to education at the shelter homes mentioned among the critical gap. In this regard, one of the prosecutors pointed out instances as stated below:

> *Rape survivors sent to some shelter-homes dropped their school. Ensuring access to education to the child survivors of rape at the safe homes often overlooked among partners. Most of the shelter homes quietly admitted rape survivors so long as the police or prosecutors sent them. The shelter homes were not taking into account the service packages like access to education.*

Health professionals at the Center revealed a lack of resource mobilization efforts through engaging stakeholders despite budget shortage to integrate essential services, mainly that of the DNA testing. One of the research participants regretted in this regard and said, “I think we have not done enough to address the challenge in consultation with concerned stakeholders.” Almost all of the health service providers and prosecutors at the Center also reflected that the engagement of partners on rape prevention lack joint intervention. Even though the stakeholders initially had a joint forum during the establishment of the Center, participants described the current situation attributed to lack of regularity of joint sessions.

The trend of partnership so far at the Center represented a situation where other institutions were coming to the Center and request for cooperation to work on rape prevention. For example, the mass-media agencies used to produce educational documentaries at the Center taking the initiative themselves and based on their demands. On the contrary, the Center rarely attempted to go to the mass-media agencies by producing a specially designed program on rape prevention. Nevertheless, addressing the broader public on the prevention of rape, according to the research participants, demand extensive engagement with the mass media.

Study participants underlined that concerned stakeholders operating in the Center had limited interventions to address common concerns namely demands for capacity building training for various professionals. More than half of the participants at the Center criticized the practice of training arrangements. They mainly indicated the limitation of engaging training participants with multi-disciplinary backgrounds from the different stakeholders working on rape prevention. The experiences in organizing training were either limited to few types of training focusing on specific services or restricted topics. Thus, there could be no room for exchange of views and knowledge among professionals from different specialization. This specifically refers to the rare training opportunities engaging health professionals together with lawyers working in the Center and elsewhere on rape prevention.

The stakeholders operating on rape prevention interventions had limited programs of economic empowerment for vulnerable groups to the risk of rape. They got minimal interventions on disseminating helpful information and imparting knowledge to reduce and avert the danger of rape among target groups. Research participants further mentioned the gap among stakeholders to engage in the capacity building of rape survivors on entrepreneurship and cope with skills training. They also commented that having such interventions through partnership and networking could have reduced frustration and contributed to nurturing hope among rape survivors.

Research participants witnessed minimal efforts among stakeholders to prevent repeated victimization of rape. All prosecutors indicated the limitation among law enforcement and mass-media agencies in sharing lessons from the experience of rape survivors with stories of repeated victimization. Even though the mass media engaged in rape prevention in collaboration with the Center, the existing experience showed that they did not actively involve rape survivors in such interventions.

- **Capacity related limitations on rape crime investigation**

Research participants boldly underlined the limited capacity of concerned institutions in investigating the crime of rape. According to prosecutors, investigation techniques employed to uncover the crime of rape found at lower level. This challenge corresponds to the argument of law enforcement officers heavily depending on circumstantial evidence to build their cases on rape crime. Even though the lawyers

pointed out the support of medical investigation to testify the rape case with sufficient evidence before the court, generating the required evidence remained a problem. The evidence generated and shared so far by the hospitals in Addis Ababa lacks quality and thus unable to identify the real assailant. The difficulty of meeting the legal requirement for sufficient evidence characterized the challenge of investigating rape crime among law enforcement personnel. One of the judges illustrated this challenge as follows:

> *Regarding the lower possibility of availing sufficient evidence and win the rape case before the court… being a covert crime, getting sufficient evidence is hardly possible. The rape survivor would be the only person who knows the fact. Unless we use circumstantial evidence, such a crime of rape remains undisclosed.*

Referring to the legal process in the judiciary system of Ethiopia, a study on the status of GBV and associated services in four districts including Addis Ababa witness the above limitations. The study reiterates that:

> "The onus of proof largely lies on the survivor and cases only go further than the police if there are eye *witnesses* to the crime. It is, of course, unlikely that a man will rape a woman or commit other forms of gender based violence with eye witnesses, so cases often are dropped" (Tsegahun 2008:50)

Most of the health professionals and prosecutors argued that the Center got limited capacity and inadequately equipped with the required technology on forensic crime investigation. This mainly refers to the absence of DNA testing. Lack of trained human resources to investigate rape crime using forensic technology also exacerbated the challenge. According to health professionals, even though law enforcement agencies still considered medical evidence shared by the Center helpful, those medical reports, however, had limitations to inform decisive proof. Participants, for instance, mentioned medical evidence from the Center could not reveal real identity of the assailant, but only limited to the finding of the sperm cells. Generating such medical evidence by itself relied on the timely reporting of the rape survivors without losing helpful evidence.

Health service providers described that helpful samples such as hair, sperm, fresh tear, and related others could have been collected to support the investigation. However, it was not yet possible to determine the assailant using those samples due to the absence of DNA testing in Addis Ababa. Health professionals also indicated that the finding of a sperm cell does not necessarily mean that such a finding confirms the suspected assailant. Challenging issues mentioned with the absence of a DNA test at the Center, for example, referred to the case where "a woman could have sexual intercourse with two or more individuals in a single day". Under such circumstances, it became difficult to determine the perpetrator or who committed the rape. The absence of capacity on rape crime investigation in this regard led the court decisions being heavily reliant on circumstantial evidence. Some prosecutors, as a result, were concerned about the punishment of innocent persons, which could involve imprisonment for up to 15 years and above.

Prosecutors had either limited practice or irregularity in collecting evidence by immediately going to the place where the rape crime was committed, which could involve taking photographs or pictures. Prosecutors mentioned rare experience or minimal practice of investigating rape crime by going to the house or the place where the rape incidence happened. Experienced prosecutors, however, advised the importance of investigating the place where the crime was committed. Undertaking crime investigation on the spot entails physical presence of the investigator, proper observation and searching of the place or house to find a clue. Such investigation could also be helpful to get hints that verify evidence collected from the words of testimonials.

Study participants criticized the crime investigation team at the sub-cities inadequately organized. Some prosecutors mentioned instances where responsible units missing while they were supposed to collect relevant evidence on rape. Some times, relevant personnel might not be available, while essential equipment such as photo-camera not available at the other occasion of filed investigation. Participants further noticed irregularity or weak practice in taking pictures of rape survivors coming to police stations with different wounds like lacerations on their faces. Consequently, the evidence appearing before the court often lack photographs depicting the physical damages inflicted upon the rape survivor. To put it as a

prosecutor illustrated the practice of collecting evidence on the spot immediately after the occurrence of rape and investigating the crime:

> *Occasionally, there is an attempt of collecting evidence at the place where the crime was committed. However, you may not be able to go with photo-camera. Sometimes, responsible units might not be available. There could be a possibility of taking photographs in cases where rape survivors come with unique and visible scratches. Nationally, let alone on the rape case, the investigation technique in other crimes is at a lower level and weak. Investigating the rape crime by going to the house of the survivor by itself is a rare practice. Nevertheless, investigators could have collected several pieces of evidence if they have gone to the place where the crime was committed. In this regard, the heavier dependence of evidence on what people testify in words characterizes the system by itself.*

- **Challenges associated with differences in professional background**

Research participants pointed out the misunderstanding and communication-related challenges occurring among health service providers and the law enforcement personnel. These kinds of challenges mainly occurred due to professional differences, and in cases where each claimed their independence and wanted unilaterally operating their jobs. Some mentioned a prevailing tendency of ensuring once own professional freedom by establishing a comfort zone. Prosecutors on the other hand argued that though health professionals can directly provide treatment based on the words of the patient, the situation would be different when it comes to the legal procedures. Law enforcement officers had to go through further investigation as they could not only rely on the testimony of the rape survivor. As a result, rape crime investigators need to verify the statements of the rape survivor with further evidence.

However, rape crime investigation often leads to a misunderstanding when health professionals claimed that they got their specific standard operating procedures. The lawyers, on the other hand, counter-argued that they had to stick to the criminal procedure code. For instance, public prosecutors claimed that they had to undertake their duty as per the criminal procedure, whereas medical professionals demanded non-interference in their health service delivery. One of the prosecutors observed a

situation where "everybody complaining of professional interference against the other." As a result, the two groups of professionals could find themselves divided along the side of their competing demands though both of them expected to serve rape survivors jointly.

Research participants reflected that a lack of knowledge could lead to misunderstanding among professionals with varying backgrounds or fields of study. For example, as a health service provider stated, "If the survivor is found intact or not deflowered, the police officers are urging not to include such a result in the medical evidence." By underlining that "professional ethics should be respected", health professionals understood that such a situation could happen due to a misunderstanding where police officers or prosecutors associated rape with virginity. Health service providers indicated that prosecutors and judges tend to consider sexual act as rape if it happened to a virgin or a woman who had no sexual history. They challenged such assertions among the lawyers and argued that having previous sexual history cannot nullify the rape of a woman. In other words, rape could happen to a woman who had the experience of sexual intercourse.

Furthermore, a common challenge among health workers and the lawyers represented the misunderstanding in written communications that mainly occurred due to the use of too technical professional languages. Miscommunication sometimes leads to adverse incidents. There were some experiences where judges issued forceful orders on the Medical Director or the physician to appear before the court and explain the matter. In addition to such instances of unnecessary intimidations on health professionals, delays by any means could hinder speedy trial and due process of the law. Such challenges, in turn, could affect both the survivor and the defendant. The problem in this regard emanates in the use of highly technical words or medical languages among health professionals that appear difficult to understand for the lawyers.

Most of the lawyers had the opinion that some medical expressions were not easy to comprehend despite the efforts to write medical evidence using understandable language. The challenge here was that law enforcement personnel could misunderstand the implication of medical examination results. For instance, as

opposed to the rape allegation and collected circumstantial evidence, the medical examination result could show the finding of an intact hymen. According to health professionals, even though medical report described the physical findings, like that of intact hymen, there could still be possibilities of rape such as through the anal office. The misunderstanding, in this case, had to do with the misconception among the lawyers in associating rape with vaginal sex as well as virginity.

Moreover, study participants pointed out that the lack of professional medical translators working at the hospitals contributed to the use of excessively technical words. As a result, this could lead to a misunderstanding of the medical evidence among law enforcement personnel. The usage of ambiguous words subjected to varying interpretations could also lead to debatable arguments on the side of either the defendant or the plaintiff. Prosecutors recalled that gaps in the proper interpretation of medical evidence on rape resulted in losing court cases.

- **Challenges attributed to actions taken by rape survivors**

Rape prevention interventions faced challenges attributed to the reactions of rape survivors themselves following the rape incidence. Prosecutors and health professionals expressed that rape survivors could come to the Center either after they lost or damaged potentially valuable evidence for the crime investigation. The loss of evidence could also happen due to the delay or failure of the rape survivor to timely report the rape incidence. Almost all health service providers at the Center underlined that lack of awareness among the community and the rape survivors contributed to the loss of evidence. Hence, one of the health professionals advised that:

> *The loss of evidence occurs following the incidence of rape where the survivor should have taken care of not to lose relevant indications (evidence). For example, the survivor should avoid washing their body as it quickly takes away some of the relevant samples to generate supportive evidence.*

Majority of the participants providing health service at the Center stressed the importance of reporting rape incidence to health facilities as early as possible. They warned that reporting rape incidence after 48 hours could result in disappearance of some evidence. For instance, some of the health professionals noted that fresh wounds

inflicted upon the rape survivor by the assailant might not last longer. Further delays in reporting means getting those fresh wounds cured, and eventually lose of helpful evidence. A health professional also mentioned a challenge on rape prevention referring to cases of abduction where rape survivors often forced to stay with the assailant for several weeks or months. In such instances, it would be difficult for health professionals to determine whether sexual penetration during the abduction involved new deflowerment or not. Besides, rape survivors could be less motivated to timely report the rape incidence due to the absence of rape management Center at their nearest location.

Furthermore, a prosecutor mentioned lack of commitment among rape survivors to push the case and seek justice, mainly once they got medical treatment services. As a result, some rape survivors would become hesitant and decline to cooperate with law enforcement officers. The lack of motivation also involved loss of hope among rape survivors, particularly at the moment they heard that the assailant disappeared or not incarcerated by the police. In such instances, rape survivors suffered from deep humiliation as they often felt that they have had nothing to do about the crime. Consequently, some think of themselves as if they were useless. The assertion of study participants with statements that rape survivors lose hope in the justice system corresponds to the government study report conducted in two towns of Ethiopia (Government of Ethiopia 2007:55-58). This government report, for instance, shows substantial cases of rape charges lost at the courts of law. Lost charges on rape in turn signify failure in the law enforcement endeavor to redress rape survivors.

4.3.2.3.The challenge related to the legal understanding of rape

The lawyers note the gap in the Criminal Code (414 of 2004) of Ethiopia, which narrowly interprets the crime of rape. The law understands rape in a situation where a woman forced to submit to sexual intercourse out of wedlock. The Criminal Code is not directly mentioning the rape of males, which instead uses phrases like sexual outrages, homosexual and other indecent acts. Some of the research participants did realize that the Ethiopian penal law failed to consider marital rape despite the futile debates on the issue. Hence, majority of the prosecutors argued for broader legal consideration on rape including forceful sexual acts committed in contrary of decency. Some further claimed to the level of considering acts of touching the genital

areas of a person as rape. According to the view of prosecutors, penalties sentenced against indecent acts or in cases of sexual outrages are less severe and thus lack deterrence effect. One of the prosecutors, for example, argued:

> *Even though the law does not consider some acts as rape, those acts referred to the contrary of decency, such as touching the genitalia by hand or penis, are mostly committed against children. However, punishment is not a way to convey a lesson for people. The penalty is so minimal or less severe and thus is not in a position to deter another person. If there were severe legal punishment, it would have hindered other individuals not to commit the crime of rape. Hence, due to the minimal punishment, perpetrators are only thinking of their release after short incarceration. Thus, in my opinion, the incidence of child sexual abuse has been increasing due to the less severity of the punishment against the assailant.*

Some prosecutors also believed that punishment sentenced against felonious acts to the contrary of decency could not convey a strong lesson to the public. Thus, these prosecutors believed that the legal punishment in such cases would have minimal deterrence role to play. The challenges discussed above referring to the legal interpretation of rape are in line with what Assefa (2011:14) shows where the law of Ethiopia does not similarly treat the rape crime against female and male survivors. Research participants from the law enforcement institutions pointed out limitation of the Ethiopian Criminal Code (414 of 2004) in understanding rape. They mainly noted the code defining rape only referring to female victimization and when committed out of wedlock.

4.3.3. Perception of individual professionals on existing rape prevention interventions and the associated thoughts

4.3.3.1. Views on the comprehensiveness of the existing rape prevention interventions

Research participants reflected their opinion on the incompatible level of existing rape prevention interventions when compared to the high incidence of rape cases. Prosecutors and judges, for example, mentioned high burden at first instant courts in

Addis Ababa due to several filed charges on rape cases. As a result, they emphasized the need to implement stronger prevention programs on rape in line with the severity of the problem on the ground. Health professionals also noted lack of interventions targeting parents or guardians. They underlined the importance of educational programs at the family level to closely monitor, follow up, and support children to avoid vulnerability or risk of rape. Research participants also concerned about the weak in-school curricular and co-curricular activities. They witnessed reduced roles of the different clubs that used to work actively in the past on prevention of gender-based violence, HIV, and related problems.

Research participants had the opinion that the Center could not implement comprehensive rape prevention interventions with the available medical equipment, supplies, and technology. Health professionals emphasized that fulfilling modern equipment such as DNA testing could have enabled the effectiveness of their work and ensured comprehensiveness of intervention. The DNA testing particularly mentioned valuable to generate evidence in legally redressing the rape survivors. Having the above limitations, health professionals believed that the Center could not able to provide comprehensive services as per the WHO standards. Concerning the DNA testing, health workers felt desperate and said that they had not done enough in mobilizing resources. They particularly regretted on their minimal role in leveraging stakeholders to address budget shortage for integration of DNA testing. Prosecutors added that the absence of the DNA testing forced criminal investigation to rely on circumstantial evidence. As a result, the challenge in producing sufficient evidence often led to the release of rape perpetrators, and sometimes to the punishment of innocent people.

Study participants working in the law enforcement agencies had the opinion that the mass media lack to convey the complete picture to the public regarding rape. Participants believed that mass-media coverage often limited to issues of women-focused prevention interventions. As a result, media overlooked to consider engaging male and community as much as possible. In other words, the mass media usually conveyed messages in a very simplified way despite the fact that the law enforcement process on rape cases involved complex challenges. One of the prosecutors, for example, argued against the Chilot television program by saying that:

> *The message conveyed through the Chilot Television program portrays to the public as if the process were quite easier. I do not believe that the Chilot television program shows the reality of evidence related issues.*

Most of the prosecutors thought that despite the mass-media efforts, the approach so far had a severe gap. One of them complained about the poor status of awareness creation interventions on rape prevention and said, "It is much said than done. The major undertaking is still on the legal prosecution". Studies also reflect the aforementioned limitations of the mass-media involvement in primary prevention interventions, particularly referring to capacity related gaps in properly reporting cases of sexual violence (Parkes *et al* 2017:35).

Research participants from high court believed and expected courts not to engage in prevention-related activities such as in community mobilization or educating the public about rights and responsibilities. They rather argued public prosecution offices are responsible to work on rape prevention through engaging the community. One of the high court judges defined the role of the court and said, "It is not mandatory for the court to work on prevention." The judge, however, indicated that community awareness creation on prevention of rape and other crimes is the duty of prosecutors, the police, and the civil society among others. Nevertheless, the rest participants among the lawyers mentioned that the court of law has a role of prevention in deterring and reducing rape. For instance, one of the lawyers reflected in this regard as follows:

> *A decision of a judge would have its own role to play on the prevention of rape. If the defendant is a dangerous rapist, a sentence of the perpetrator with imprisonment means a reduction of rape. Then every court decision will have its own contribution.*

Research participants from the law enforcement agencies underlined the demand for medical evidence in addition to the testimonies given by the family and the rape survivor. Testimonies by the survivors include the rape case of children. Law enforcement agencies considered medical evidence as a major input for decision making despite the gaps in the forensic lab or the absence of DNA testing. Similarly,

prosecutors recognized the lack of necessary medical equipment and trained human resource, which in turn influenced the comprehensiveness of intervention on rape prevention. Besides, prosecutors viewed that most of the medical evidence was not as detail as required. Prosecutors generally felt that they did not have a strongly organized intervention on collecting evidence and proper investigation of rape crime as expected. Consequently, one of the highly experienced prosecutors perceived the existing situation as stated below.

> *Currently, unless and otherwise, the rape survivor informs on the identity of the assailant, there is no way to determine the perpetrator based on the sperm cell. After all, there is no direct or straightforward evidence to be found in rape cases. Currently, it is the medical evidence that can only serve as direct evidence, which appears supportive in showing what has happened at what time and the signs on the damages. Besides the medical evidence, the secrecy nature of rape crime often implies the use of circumstantial evidence such as testimonials who might have heard the survivor screaming.*

4.3.3.2. Reflections on why rape occurs or why perpetrators commit rape

Some of the professionals working at the *Center* reflected that the question of why people commit rape appeared very stressful and difficult to explain. One of the health professionals expressed her view as follows: “I cannot argue that rape is occurring because of this and that. The survivors are often attacked by their family or the people around them.” Similarly, one of the prosecutors revealed the difficulty in this regard, and uttered the challenge as follows:

> *If you are asking my opinion, the issue of sexual violence against children has always remained confusion to my understanding. To mention one of my unforgettable cases, a 10th grade perpetrator with 16 years of age sexually abused three children of his neighbors aged five, six and seven years. At this moment, I cannot answer why such incidence has happened. However, being terrified with the incidence, we have further asked the assailant and learnt that there was a gap from the side of parents. The perpetrator said that he used to watch a movie of every kind and always stays at home. His parents, however, uttered about the decency of their boy saying that ‘he is our good son*

who prefers to stay at home when he returns from school'. Nevertheless, the boy did all the terrible things at home against the three children.

A lawyer also gave an opinion on the difficulty of determining the cause of rape considering cases happening against boys. This lawyer considered male rape entirely to the opposite of the culturally accepted sexual practice of heterosexuality in Ethiopia. As a result, this research participant appeared to have externalized the problem by referring to such assailants as "those who might have come from other countries." This lawyer had also a feeling that "the problem might be adopted from abroad". However, the same lawyer witnessed to the contrary by arguing, "Rape of male could also be committed by individuals who appeared peaceful or decent citizens". The rape of male children in Ethiopia also appeared extremely outrageous to some research participants. Such participants found incidence of male rape by far contradicting with the existing conservative cultural practices and religious beliefs. In this regard, one of the research participants replied, "You do not know why rape of male happened". The same participant considered sexual abuse of boys by Ethiopians as "something very disgusting!"

Despite the above difficulties of research participants, some of them provided their opinion on why rape occurred based on their experience in supporting rape survivors. Some health service providers and prosecutors mentioned that they did ask rape survivors about how the rape crime happened, and what caused the perpetrator to commit the rape. Hence, they reflected on the witnesses of rape survivors and stated alcohol intoxication and drug abuse of the assailant as major driving force or causative agent of rape. Moreover, they pointed out day parties among teenagers accompanied by alcohol drinks as triggering factors. One of the prosecutors particularly substantiated this with a case story and said,

I very well remember a rape case where the perpetrator, being under the influence of the drug, raped his niece who was only 12 years old. The assailant himself testified the incidence before the court with a heavy pain of guilt, where he was not even able to utter words.

The public at large tended to overlook or tolerate rape due to the influence of patriarchal and customary practices promoting male dominance. Research participants considered the society highly influenced by the traditional and religious values that tend to promote female subjugation. Lack of knowledge on the ill after effects of rape on the survivor also considered to have exacerbated the problem. Lack of awareness on vulnerability of children to rape also attributed to loose parental control or follow-up of children to avoid the risk of rape among children. Influences of illegal movies, such as exposure of young people to sexually explicit or pornographic materials, and peer pressure were also among contributing factors to the risk of rape.

Research participants revealed misconception among assailants regarding the issue of sexual consent. Perpetrators lack the proper understanding that they must respect the consent of the woman until the very end. As opposed to the legal provision on consent to sex, prosecutors mentioned that some defendants unwittingly argued before the court. Some defendants could ask a nagging question like "Do you think I have brought her up to my hotel bedroom to feed her?" A prosecutor indicated an example in this regard and stated that:

> *The refusal to sexual intercourse by the woman once she went to the place of the man involves the thinking of the assailant that the court would decide in his favor. The assailant is considering that the woman should not have to say no as long as she has willingly gone with the man up to his room.*

The incidence of rape often remained undisclosed and a secret as rape survivors scared to expose assailants or even to utter about the incidence at all. Such lack of motivation among rape survivors to disclose incidence of rape, including to their family and the community, only served perpetrators not to face justice. The failure of reporting rape incidence could have also encouraged an assailant to commit further rape. Study participants also indicated lack of open discussion on sexuality-related issues with children at the family level because of cultural taboo. The existing situation of rape, as participants argued, might have been different if individuals had opportunities to discuss sexuality issues transparently with people around them. Those closer people can be family members, friends at school or with peer groups among others. To put it as one of the research participants stated:

> *Let alone at the societal and family levels, rape remained a rarely discussed issue among the professionals, which I think has contributed by-itself for the occurrence of rape. As there is no practice of open discussion, people do not express their interest! Lack of knowledge has a significant contribution in this regard. If there were practices of open discussion, including on sexuality-related issues, there might be a situation where the assailant could have acted differently.*

Most research participants considered the school curriculum not effectively addressed topics on sexuality-related matters and thereby prevention of GBV including rape. Besides, extracurricular activities of students through different clubs in schools lack engagement on educational issues with the significance of primary prevention.

The fact that women remain among the economically disadvantaged and not self-reliant considered to have highly contributed to the subjugation of women to sexual exploitation and rape. According to some research participants, women depicted as not empowered, rather heavily relying on the men as breadwinners in a patriarchal society, including in Ethiopia. Females still unfairly treated in our society as compared to males, where degrading views prevailed towards women. The issues of women empowerment and enabling them to assume socially powerful positions remained areas not yet addressed very well. Some of the powerful positions mentioned include participation in the decision-making processes, and in politics among others. Therefore, as the women remained voiceless in the community, and they tend less likely to achieve their demands. Moreover, as long as women remained poorly skilled in self-defense, they would become more vulnerable to rape or related other GBV practices.

Research participants also reflected views on the reduced role of religious institutions and dwindling socio-cultural and moral values and identified such changes as contributing factors to rape. Participants mentioned the declining influence of the social and spiritual values on the individual community members these days because of the changing mode of life. As a result, participants noted for the possible impact of the complex social changes in increasing crime rates in general and rape in particular.

4.3.3.3. Perception about who is to be blamed for the crime of rape

Research participants indicated that perpetrators constitute diverse group of individuals. For instance, assailants could vary by their age composition, ranging from youngsters up to matured adults including the elderly. When viewed from the context of proximity to the rape survivor, perpetrators of rape could constitute strangers, sexual partners, close family members, or relatives. Furthermore, rape could be committed at the workplace, school environment, at home, at religious places, in health institutions, in prison centers, at refugee camps, and in several other settings. Therefore, rape involves diverse categories of people as perpetrators and it could occur under numerous circumstances and settings. Hence, there could be no specific group of people or type of individuals blamed responsible for the crime of rape.

Some research participants, however, had a distinct opinion and reacted differently to the question "who should be blamed and held liable for the crime of rape?" For some participants, the individual who committed the rape must be liable and accountable to his/her crime. Some prosecutors also had opinions that various agents could be involved in building personality of individuals. Among those socializing agents, the family, the school, the community, religious and other social institutions got decisive roles. Consequently, such research participants, referring to multiple factors leading to rape, considered the government and the entire society as responsible for the failure in protecting rape crime.

Some of the participants mentioned a situation where, except for the case of children, the raped person should be accountable. The situation mentioned here referred to a case where a woman might have agreed initially but changed her mind or said no latter on. The opinion reflected in this regard was that a woman should not have gone with the assailant from the very beginning. The argument further noted that refusal of the woman for sex under such circumstances could have led the man to commit rape. One of the health service providers specifically argued in this regard as follows:

> *There can be a situation where the rape survivor is liable or responsible, except for the cases of children. Because there are cases where the woman agrees and gives in first, but she might then say no. Thus, he [the assailant] can sexually force or rape her. The blame can be [in this case] on the woman because she is looking for it in the first*

place. They [rape survivors] do tell us the truth while we ask them, saying that 'I wanted and gone with him initially, but latter I just said no, and he did rape me'. Hence, she is responsible! One can ask that 'After you had the desire and went with him, then why you triggered him to forcefully rape you?' Thus, she should not go with him from the very beginning! In this case, her refusal led him [the assailant] to commit rape against her.

Some study participants also blamed the lenient and passive legal measures taken by the court against assailants on rape cases. Hence, such weak legal actions mentioned to have contributed in hampering the deterrence role of punishment. Participants having this opinion cited cases of repeated assailants as justification. According to their view, weakness in the enforcement of the existing laws also contributed for perpetrators to commit rape repeatedly.

4.3.3.4. Opinion whether the ideological stance of professionals influence their work on rape prevention

Research participants reflected their opinion on whether the individual ideological stance of professionals had an impact on their job. In other words, participants serving in the law enforcement agencies and health care facilities revealed their views on the influence of personal ideology on rape prevention intervention. The ideological stance, in this case, referred to the individual position or view of a professional regarding gender-based violence, mainly rape. The focus in this issue is the influence of personal ideological views of professionals about gender-related issues on their day-to-day work of rape prevention interventions. Participants reflected on the two extremes of ideological views, which are the radical feminist view and that of the conservative ideology. Examples of the two extreme views given to the participants, where some of the statements employed for illustration of radical feminist view are as follows. Rape is a matter of dominance driven offence, and thus it is a crime of power and control rather than one motivated solely by sexual desire. Hence, enact stronger punishment against perpetrators to prevent rape not to happen again. On the other hand, proponents of conservative ideology supporting patriarchy or male domination embrace opinions of the following kind. They argue that a woman should act as per

the societal norm to avoid rape. They think that acts of the rape survivors are motivating perpetrators.

Therefore, study participants expressed their opinion, mainly based on their experience of rape prevention interventions at their corresponding institutions. The opinion of research participants consisted of three major categories. Most of them had the view that conservative ideology prevailed in the day-to-day work of individuals engaging in rape prevention interventions. Some of the other participants argued influences of radical feminist views. However, the third category had the opinion that though individuals could hold either of the two extremes, such ideological views have no room to influence interventions. According to the opinion of the third groups, individuals holding either of the two extremes have no influence specifically on the court decision.

- **Opinions on the influence of conservative ideology on rape prevention interventions**

Professionals working at the Center expressed their opinion that though they were not accepting such views, "some people think that perpetrators are motivated by the acts of the rape survivors". Hence, those individuals having such views usually advise that women should adhere to the social norms and that would reduce the risk of rape. People under the influence of conservative ideology often ask questions like "why she has acted like that or dressed in such a way". A prosecutor, for instance, shared an observed experience with the visible influence of conservative ideology on the work of professionals. Some professionals, for example, changed their feeling when rape survivors testify that the rape incidence happened as they had a drink with boyfriends or related experiences.

One of the research participants referred to those professionals influenced by personal ideological views attributed to "a situation of automatically shifting the burden on the survivor." In other words, investigators under the influence of such personal beliefs reflected a presumption of guilt in their work. A prosecutor mentioned such an instance saying:

> *If the survivor replies in her testimony by uttering 'I went to the hotel as he asked me to come at night at 11 p.m.', then there could be a*

traumatizing interview with statements like 'so you went to his place intentionally! That means you wanted it!

Other prosecutors also noted similar experiences, where one of them, for example, heard an investigator asking the following questions. "Why you [the rape survivor] went at that time? Don't you know that this [rape] would happen?" Tsegahun (2008:50) witnesses possibilities of the influences by such social values or ideological stance where some officers could shift the burden on the rape survivor. The presumption of such officers, as the same author shows, rooted to their assumption that the survivor must have urged the perpetrator to commit the sexual intercourse. Health service providers further asserted the existence and possibilities of conservative ideological influences. They indicated reflection of conservative views among professionals with a pretext of "avoiding divorce and preference to maintain family integrity". In a situation or being under such ideological influences, conservative social values could alter the decision of professionals. One of the study participants associated such challenges hindering the attempt of legally redressing rape survivors. As a result, the participant commented, "out of the total criminal investigations reported to the police, minimal cases could succeed with sufficient evidence and a guilty verdict."

Moreover, some participants considered stereotypical attitudes of professionals were as harmful and negatively influencing rape survivors. For example, a health worker explained that if professionals were unable to avoid reflecting their personal value judgement, rape survivors could be discouraged to disclose information about the incidence. Such biased treatment of clients could also affect the image of the Center or institutions working on rape prevention as dissatisfied clients disseminate negative information to the community. Some lawyers reflected the influence of conservative ideology during the assignment of individuals to work on sexual violence related crime. As a result, few legal personnel showed interest to work at the women and children unit of public prosecution office in Addis Ababa. One of the public prosecutors working on rape cases of women and children uncovered that male colleagues gave a nickname to the unit as "the bench with no evidence". The same prosecutor further indicated, "Male colleagues sometimes utter critiques using words like you are throwing a man into the jail for 20 years based on hearsay!" Even though

such statements informally appeared as a jock, this prosecutor witnessed the influence on colleagues hesitating to work at the unit.

- **Opinions on the influence of the radical feminist view**

Some of the study participants were proponents of the view calling for stronger punishment against perpetrators to prevent the crime of rape. One of the prosecutors substantiated the radical feminist ideology influencing the views among professionals saying, “Some people argue for stronger punishment on rape.” A prosecutor witnessed that professional lawyers could have such opinions, where some legal personnel argue for “the maximum level of punishment”. Such lawyers were specifically mentioning rape crimes with extreme cases such as the rape of children and outrageous sexual acts through anal office among others.

Another prosecutor further argued, despite some improvements, the existing reality shows that society still reflects male superiority. Hence, addressing the views of male dominance implied the need for strong punishments against perpetrators. Thus, the same prosecutor had the opinion that the existing legal punishments in cases of rape were not sufficient.

- **Opinions reflected against the possibility of ideological stance to influence professionals**

Some study participants declined the concern that personal ideological views can influence interventions on rape prevention. These participants particularly mentioned that legal systems already in place have no room for individual baize to determine court decisions and medical services. In this regard, some prosecutors discussed that decisions could not be given based on personal beliefs be it feminism or conservative ideology because there will be accountability. Though individuals might have various personal ideological views, professionals had to deliver assignments as per the established procedures and guidelines. If individuals undertaken their jobs based on their own or personal beliefs and values, they could be held responsible. As a result, the opinion here presumed no possibility of influence due to the ideological views of individual workers in the court decisions linked to rape cases. More specifically, a judge at the higher court mentioned that:

> *Even though lawyers have such a view [feminism or conservative ideology], it is difficult to alter the punishment. The maximum penalty is already determined based on which a perpetrator can be penalized. Thus, there is no room to sentence a different penalty against an assailant. However, there were varying penalties during the previous sentences before 2002. Hence, a procedural manual developed on how to decide about penalties. For example, even though the article states that rape crime is punishable from five to fifteen years, the penalty is not the same for every type of offense. Varying offense includes rape committed at night, cases of gang rape, survivors below 13 years of age, or in case of above 22 years. The procedural manual on a penalty has clearly indicated the reasons for the severe penalty. Hence, the chance of bypassing these benchmarks would be very minimal for a certain lawyer, unless to deliberately make a mistake.*

One of the research participants reflected against the radical feminist view by equating with the notion of justice in ancient times that used to claim "an eye for an eye". The argument of this research participant was that the court could imprison the assailant for life or may sentence death penalty. However, such harsh measures could not serve the purpose of rape prevention. What counted more for rape prevention would be working on community awareness creation, and thus, priority should be given to education rather than focusing on punishment. A prosecutor, who disagreed with the claims of the radical feminist view, had the opinion that strong punishment would not stop the crime of rape. The prosecutor added that the current penal code stipulated strong punishments against perpetrators of rape and related sexual violence as compared to other crimes. Considering the lower socio-economic and educational level of the public, the existing legal penalty against rape crime appeared proportional to most legal personnel.

4.3.3.5. Opinion on whether there existed a need for gender oriented care for rape survivors

Research participants providing services at the Center in Gandhi Memorial Hospital witnessed that female rape survivors preferred to female health professionals. However, the Center established a mechanism in cases where rape survivors refused

male professionals to treat them. In such cases, the Center assigned female professionals. If no female physician found at the Center, female nurses accompanied a male physician and attempted to address the need of the client as appropriate. One of the prosecutors also agreed with the notion that there might be a need to provide gender-oriented care for rape survivors. This prosecutor justified from experience where those male rape survivors sometimes unwilling to see male health professionals. The same prosecutor also agreed with a view that rape survivors preferred female health professionals. To put the related opinions as one of the health service providers stated:

> *Male health professionals are also providing service. However, if a survivor asks for a female provider, assigning female professionals would be more helpful. Rape survivors could even ask to get treatment only by female professionals. As clients presumed men as their assailants, they are not usually willing for the male health professionals to examine their private body parts. Survivors are scared and do not want another man to examine or see their bodies. However, in the case of female professionals, clients could have the opportunity to discuss issues freely*

On the other hand, some rape survivors still preferred male health professionals to that of female providers. One of the study participants witnessed in this regard and said, "Some exceptional clients are freely interacting with male service providers." There were also cases of sexual violence committed by female perpetrators. A research participant considered such clients less likely to complain about having male health professionals.

Some research participants underlined to consider the existing shortage in terms of professional mix by gender despite of the varying opinions on providing gender-oriented care. One of the senior health professionals strongly argued that "creating access to health facilities and providing the service" remained a priority issue in Ethiopia. This participant had the opinion that the health system should achieve the required level of access, including availability of sufficient mix of professionals by gender. Then, it would be possible for health system to address preference of rape survivors to be served by either a male or a female health professional.

4.3.3.6. View on how to avoid the risk of rape

Health professionals and psychosocial service providers mainly discussed that they were dealing with the issue of avoiding the risk of rape particularly during the counselling sessions with rape survivors. They indicated that the counselling service intended to avoid future victimization of rape survivors. The counselling sessions included an assessment of risk factors, which relied on the experience of the client. In other words, rape survivors encouraged to describe the circumstances they think exposed them to the rape incidence. Such encouragement allowed professionals to support clients to think of helpful alternatives or solutions to avoid risk of rape in the future.

Counsellors also suggested options for rape survivors to reduce victimization, which included up to the level of changing the risky type of work if possible. A health professional indicated here that "the survivor will be informed to prevent herself from risk, like to avoid walking in the dark or working at night." In cases where a guest or stranger committed rape, professionals also advised parents who came to the Center with the rape survivors to avoid mistakes in the future. Counsellors also informed family members to use separate bedrooms whenever they host guests at home. Health professionals also advised parents and child survivors of rape to avoid deceitful gifts from a stranger or anyone whom the child did not know.

Opinions of the research participants given on how to avoid the risk of rape showed that the burden is on the rape survivor. However, in cases of child survivors of rape, the counsellors primarily held parents or guardians responsible for safeguarding their minors against possible threats of rape.

4.3.4. Priority areas identified for intervention to enhance rape prevention

The research participants identified priority areas of intervention and suggested consideration of responsible and concerned institutions working on rape prevention. The study participants suggested programmatic priority issues and focus-areas for intervention on primary prevention of rape and improvement in the legal environment. These consisted of designing comprehensive rape prevention programs, encouraging evidence-based interventions, strengthening multi-sectoral engagements, and reviewing the pertinent laws for effective rape prevention.

Research participants further identified priority areas for intervention particularly on enhancing the capacity of institutions working on rape prevention. This includes ensuring quality service provision, availing the required medical equipment and supplies, and capacity building of the human resource. The sections below discuss priority areas of intervention that research participants recommended for the government and relevant other stakeholders to enhance rape prevention.

4.3.4.1. Priority areas identified for consideration on primary prevention interventions of rape

Study participants preferred to implement educational programs focusing on primary prevention of rape rather than interventions after the incidence of rape. Their justification in this regard was that latter intervention involved huge ill after effects on the rape survivors and only limited to access those managed to report the case. More importantly, earlier intervention with education better allows reaching the public at large. Implementing primary prevention programs on rape at grassroots level considered helpful in creating a cultural situation that despises GBV, and eventually avoid the incidence of rape at all. According to one of the high court judges, “If the resource is to be allocated, it has to be invested before the occurrence of rape.”

Health professionals underlined on the minimal effect of a facility based intervention when compared to the nationwide scale of the problem. They witnessed that clinical and legal intervention at the Center would be a matter of helping an individual survivor of rape, i.e. after the occurrence of the damage. One of the physicians said, “It is about ensuring health care for the survivors”, and thus the coverage of intervention at the Center appeared so small. According to some participants, in order to address a nationwide challenge, the government and concerned stakeholders should design and implement primary prevention programs on rape with broader scope. Hence, they identified priority areas for intervention such as to jointly design comprehensive primary prevention program. To this effect, establishing a team of experts composed of concerned stakeholders from the government institutions appeared vital. The research participants identified potential stakeholders to join hands in the design of primary prevention program, including hospitals, law enforcement agencies, mass media, and local administrative units among others.

Moreover, study participants pointed out to develop and disseminate evidence-based educational messages on the prevention of rape through engaging mass media. Participants advised for the strong involvement of mass media agencies on rape prevention. Besides, such interventions should be evidence-based or research supported and specifically designed to address critical challenges and factors attributed to rape. They suggested for the mass media to revisit the existing approach that usually conveys event oriented messages on rape incidents confined to the context of women. In other words, the media must push the limit beyond the agenda of the women so that the public would have a comprehensive understanding. Hence, mass media should give coverage on the challenge of rape and related sexual violence as public health concern, violation of human rights and a matter of development.

Encouraging innovative and target specific primary prevention interventions suggested to address socio-cultural barriers of gender equality at selected catchment areas with high incidence of rape. Such interventions would engage community gatekeepers, community-based organizations, religious institutions, and mass-media agencies among others. Hence, erroneous views, norms, and practices on GBV, sexual reproductive-health and rights' violation would be subject to question. Challenging harmful social norms and barriers to gender equality represented rejecting tendencies that overlook or tolerate rape and other forms of GBV. Such forms of violence refer to practices like marriage through abduction or inheritance, child marriage, and female genital cutting or mutilation to mention among others.

Priority areas on primary prevention require strengthening civics and ethical education in schools with effective integration of topics on civic virtue, citizenship, and gender equality. Topics on interpersonal relationship, sexuality and reproductive health, and rights, prevention of harmful practices including GBV also represent among focus areas. Enhancing co-curricular and extracurricular activities like reinvigorating student clubs in schools could play a pivotal role in supporting subject matters integrated into the formal school curriculum. One of the senior health professionals underlined the high value of teaching children in school starting from an earlier age in order to develop a desired culture and norm. This professional mentioned gender equality, life skills, and relevant other issues to be considered at schools. Concerning the challenges of cultural practices and norms, research

participants suggested the need to create new ways of thinking and teach desired norms among young people as early as possible.

Research participants pointed out to reinforce joint consultation forums and platforms to exchange and share lessons among health professionals, lawyers and concerned other stakeholders working on rape prevention. Professionals considered such joint engagements as commendable inputs to facilitate and ensure proper communication, disseminate lessons learnt and share best practices. Organizing joint forums among stakeholders also praised to create common understanding and maintain uniformity of standards among potential benefits.

In addition to the primary prevention interventions on rape, research participants identified complementary areas of intervention that tend to focus on secondary and tertiary prevention interventions on rape. They suggested exploiting the existing government structures at the local level, indicating the already established platforms in the health sector. The health extension program and women development army named among others as potential opportunities to access every household with helpful information on rape prevention.

According to research participants, information dissemination at local level should indicate, but not limited to, the benefits of timely reporting rape incidence, and addresses on where to report. Indicating necessary precautions on what to do and not to do following the rape incidence also underlined as crucial information. Besides, they noted disseminating target specific information to raise community awareness on psychosocial, mental and other health damages inflicted upon rape survivors.

4.3.4.2. Focus areas identified for intervention to ensure access to quality services

Research participants underlined to enhance access to quality services in the health facilities operating on rape prevention. This demands to avail necessary medical equipment and supplies, including establishment of forensic laboratory. The demand for access to quality services on rape prevention also entails establishing several rape prevention centers out of Addis Ababa. In this regard, participants highly valued the importance of ensuring accessibility of the service to rape survivors as most of them

coming from the regions. Health professionals justified that substantial number of rape survivors coming to Addis Ababa from distant regions had to bear the heavy cost of accommodation, food, and transportation. Some health professionals had the opinion that the government should speed up the recent initiative of establishing rape care centers in selected regional cities. In this regards, one of the health service providers at the Center advised as follows:

> *The first priority should be on expanding rape centers at different places because the rape survivors are coming from remote rural areas. As there is no such a Center in all regional towns with complete service elements including legal support ... physical examination opens for 24 hours, survivors coming from very far locations. Hence, the wound of the survivor will no more be fresh by the time she arrives here at the Center due to transportation problems. They might not able to come timely because they could not afford the transport cost.*

Research participants also pointed out the need to address the heavy burden on the Center through scaling up the same experience and integrate the service at selected health facilities in the regions. As a result, health professionals indicated the possibility of addressing quality related challenges. Otherwise, the heavy client load at the Center could compromise providing up to the expected quality of medico-legal services to rape survivors.

Availing the necessary medical equipment and supplies, particularly the DNA testing service appeared among the boldly underlined and critical issues at the Center. For research participants, integrating DNA testing demand action with sense of urgency. While urging the government to integrate DNA testing at the Center, health professionals and the lawyers revealed multiple benefits to the rape survivor and implementing institutions. Among the benefits of integrating the DNA testing, medical personnel mentioned ensuring the provision of quality health services to the rape survivors. Furthermore, integrating DNA testing is crucial to substantiate medical evidence with confirmatory tests, and thereby support efforts to legally-redress rape survivors.

4.3.4.3. Identified focus areas on human resource capacity building

Strengthening the human resource capacity recurred among the strategic recommendations of study participants. This priority area of capacity building referred to professionals working at the Center in Gandhi and Black Lion Hospitals among concerned others engaging in rape prevention. They noted that capacity building training should focus on areas where there existed limitations. Hence, research participants suggested for continuous and refresher training of professionals to fill gaps in skills and knowledge while providing psychological support to rape survivors. Hence, most of the research participants at the Center highly acclaimed the value of regularly organizing training for professionals working on rape prevention due to the high staff turnover. Some health professionals strongly argued on the need of on the job training to update with the fast-changing dynamism, particularly in medicine. Besides, research participants suggested for due consideration of assigning or recruitment of experienced and interested professionals to work on rape prevention.

As the existing rape prevention interventions engaged a multi-disciplinary pool of professionals, research participants underlined the importance of organizing basic and refresher training and orientations. Participants also noted the value of consultation forums to share lessons, solve challenges and reducing duplication of efforts. As a health service provider advised, “professionals from the law enforcement agencies should be oriented on basic medical languages related to rape.” Likewise, some other research participants noted the importance of training on medico-legal issues for health professionals and the lawyers. Others also recommended capacity building and enhancing the knowledge of law enforcement personnel in forensics. Participants further suggested training of concerned other professionals, including journalists, on development of educational materials and tools on primary prevention interventions.

Scaling up the experience of Black Lion Specialized Hospital in deploying a professional legal advisor to work with medical professionals suggested as a helpful solution. Assigning legal advisors at hospitals acclaimed to ease communications while sharing written medical evidence with judges and other lawyers. Assigning a professional translator at health facilities implementing programs on rape prevention could be helpful to facilitate communications between medical professionals and the lawyers. The professional translator would ensure proper communication by avoiding

the use of ambiguous words while sharing written medical evidence to law enforcement agencies.

4.3.4.4. Strengthening multi-sectoral engagement on rape prevention

Research participants noted to strengthen the engagement of multiple stakeholders on rape prevention, where concerned agents mainly constitute governmental, civil society and community-based institutions. Among the government institutions, the major stakeholders on rape prevention in Addis Ababa consisted Gandhi Memorial Hospital, Black Lion Specialized Hospital, and the Federal Attorney General as discussed earlier. However, Federal High Courts, Women & Children Affairs' Office, mass media (television and radio), sub-city administrations, and educational institutions also mentioned to strengthen effort on rape prevention.

- **Enhance joint platforms engaging multiple government institutions as partners**

Research participants pointed out the importance of engaging multiple stakeholders at different levels in implementing integrated prevention programs on rape prevention. For example, prosecutors suggested for the mass-media agencies to closely work with stakeholders at all levels. Stakeholders include local administrative units, higher learning and educational institutions, specialized health facilities and professionals working on rape prevention, parliamentarians and relevant other opinion leaders. In addition to expanding government-owned safe homes in Addis Ababa, concerned institutions should closely work with shelter houses owned by civil society organizations. Partnership engagement on safe homes suggested helpful to ensure availability of up to the standard services, including access to education for rape survivors. The specific recommendation here for the government was to set up a clear direction on how to admit rape survivors to a certain safe home.

One of the research participants stressed that the government should provide a minimum standard in availing a full package of services. Such standards would guide stakeholders to provide quality services, and avoid secondary victimization. Participants strongly claimed to ensure access to education at safe-homes and create a mechanism to avoid repeated rehearsal of rape survivors prior to every court hearing occasion. More importantly, active participation of rape survivors should be an

essential element in the process of designing, implementing and monitoring rape prevention programs.

Organizing joint platforms on review of progress, sharing of lessons, reviewing of challenges, and facilitation of consultative meetings among stakeholders represent major issues in need of intervention. Research participants indicated the significance of collaboration between medical professionals and law enforcement personnel to enhance the investigation process on rape. Unless medical staff closely works with prosecutors, legally redressing rape survivors would be more problematic. Organizing regular and periodic joint forums suggested as crucial in facilitating communications, boosting partnership, nurturing team spirit, and eventually achieving rape prevention. To this effect, establishing responsible organs from concerned stakeholders appeared crucial to organize such joint forums and handle issues involving two or more partners.

- **Enhancing the involvement of civil society on rape prevention**

The involvement of civil society, such as professional associations underlined as essential to feel gaps in technical skills and knowledge among professionals. Enhancing civil society considered helpful in designing comprehensive prevention programs, quality medical services, and legal support to rape survivors, as well as in informing policymakers based on research. Furthermore, research participants viewed that actively involving the civil society or non-governmental organizations could support existing interventions. Some indicated potential areas for support such as in addressing resource gaps for procurement of required medical equipment and supplies, including for the DNA testing and forensic lab.

Engaging civil society organizations also mentioned helpful to cover medical, legal, and related expenses as deemed necessary, such as in the case of male survivors of rape. This issue of engaging the civil society particularly related to referral cases of rape survivors to the Black Lion Specialized Hospital. Availing services free of charge for the referred male clients demand to establish mechanisms in collaboration with the civil society.

Research participants recommended reviving the role of civil society organizations to work with government institutions on primary prevention of rape rather than being limited to secondary prevention interventions. Hence, potential areas for NGO involvement comprised human resource development and funding of research-oriented programs and projects. More importantly, participants preferred NGO involvement in documentation of program implementations, and dissemination of lessons learnt and scaling up of best practices including policy advocacy.

- **Involving community-based institutions on rape prevention**

At the community level, study participants indicated the importance of involving religious institutions, community-based organizations, and influential people as change agents. They mainly called upon supporting interventions focusing on attitudinal and behavioral changes on rape prevention. One of the participants strongly suggested the use of religious and cultural values to revers influencing factors causing rape and other forms of sexual violence.

The justification of involving religious institutions attributed to their stronger role in governing the day-to-day life of community members. The argument here is that people often tend to abide by the teachings of their religious leaders. Hence, research participants observed the potential of religious and community leaders in rape prevention. Accordingly, working with religious institutions considered essential in the Ethiopian context to realize desired changes in attitudes, norms, and practices among community members.

4.3.4.5. Issues identified and recommended for change in the legal environment

Despite the progress on prevention of crimes related to GBV and sexual abuse of children in Addis Ababa, research participants underlined the need to implement existing laws effectively. To this effect, lawyers identified enhancing the capacity of law enforcement agencies as a priority. Most of the research participants sought changes in the legal environment and specified priority areas as discussed below.

Health professionals and law enforcement personnel emphasized to address existing misunderstandings of the law and practices of court hearings. The crime of rape, for

example, often associated with forceful sexual penetration of the female by the male assailant. Thus, the law should reconsider the existing narrow interpretations regarding the crime of rape, and broaden the legal framework to entertain further criminal acts of sexual violence as rape. They also sought to reconsider the unnecessary emphasis and wrong presumption given to virginity as decisive evidence in the courtroom to determine rape.

Improving court trial proceedings on cases of child survivors of rape identified as a critical issue. To this effect, law enforcement agencies should consider testimony or the words of a child survivor as sufficient evidence. Physicians argued that in the case of rape of children under the age of 13 years, it appeared reasonable for the court to consider words of children as sufficient evidence.

In line with the above drives for change, research participants also noted the need of establishing favorable policy and legal environment including for active engagement of NGOs. The establishment of such conducive-environment entails reconsideration of the existing legal framework that restricts the scope of interventions for civil society organizations. Thus, having such changes, there will be an encouragement of program interventions, particularly on advocacy and right related issues including promotion on gender equality.

4.4. Applying the social-ecological model to enhance the rape prevention interventions and programs

Having the view that rape is a preventable challenge, the social-ecological model underlines the "importance of primary prevention" (Basil *et al* 2016: 9). The model informs the need for designing and implementing comprehensive rape prevention interventions. According to this approach, rape prevention interventions and programs involve implementation of activities addressing influencing factors at various levels, namely "individual, relationship, community, and societal". Hence, the technical package of the CDC on prevention of sexual violence constitutes strategies focusing on primary prevention of rape. The key issue in primary prevention is averting the

crime before it happens. The approach also pays attention to tackling "the immediate and long-term" damages of rape (Basil *et al* 2016:7).

Research participants also revealed their thoughts and argued that it is possible to prevent the crime of rape. To this effect, they underlined the importance of a multisectoral approach and cooperation among the various stakeholders to jointly design and implement comprehensive programs on rape prevention. More importantly, the research participants suggested strong rape prevention programs to tackle the various factors influencing the crime of rape to happen. In this regard, most of the participants mentioned drug and alcohol abuse, cultural values and religious beliefs promoting male dominance. The economic dependency of women and poverty also mentioned as critical factors among others.

Research participants noted on the value of educating the public to address lack of knowledge on the various harms of rape. Thus, they suggested improving the role of educational institutions to teach children from their early ages on gender equality. Hence, they took education as pivotal in creating a norm that despises rape and other forms of sexual violence. The view of research participants on the importance of education for rape prevention corresponds to the priority of social-ecological model on primary prevention. This mainly refers to the strong emphasis of the model on primary prevention to tackle rape not to happen at all from the beginning (Dills *et al 2016:6).*

In addition to the essential interventions on primary prevention, health professionals and prosecutors advised on secondary and tertiary kind of interventions focusing on preventing immediate and life-long impacts of rape. Hence, they suggested improving access to quality medico-legal services for rape survivors and scaling up of the experience in Gandhi Memorial Hospital within and beyond Addis Ababa. More importantly, participants working at the One-Stop-Center unanimously demand for the establishment of forensic laboratory equiped with the DNA testing and trained human resource.

4.5. Conclusion

Chapter Four dealt with the research findings presented in line with the study purpose and the objectives as well as addressing the research questions. Thus, the sections in this Chapter described the situation on the nature of rape prevention interventions and programs in Addis Ababa. The findings also gave insights by identifying the challenges or areas for improvement to enhance rape prevention efforts by the government institutions. The Chapter substantiated with findings on the need for designing and implementing comprehensive rape prevention interventions and programs as underlined by the social-ecologic model. The next section, Chapter-Five, further summarized the research findings and the recommendations given to enhance rape prevention.

CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1. Summary of the major findings of the study

The research findings, as described in Chapter-Four, represented the five major themes or parent nodes drawn from the analysis of qualitative data, which also correspond to the five research questions. Furthermore, details of the research findings presented by the subtopics or the sub-nodes, and discussed in line with the corresponding child-nodes as they emerged from the data analysis. To briefly summarize the discussion on the research findings by the corresponding research question:

i. The study result on the nature of rape prevention interventions showed that rape survivors from the entire country came to Addis Ababa to get integrated medical and legal services at the One-Stop-Center established in Gandhi Memorial Hospital. Thus, this Center served as the only institution implementing rape prevention interventions even though some other health institutions supporting through referral linkage.
ii. The implementing institutions on rape prevention interventions in Addis Ababa attempted to address problems of rape survivors coming from the entire country through the One-Stop-Center. In this regard, Gandhi Memorial Hospital and the Federal Attorney General played the lion's share by jointly addressing the problems of rape survivors. However, clients referred to other hospitals for specialized services encountered challenges because of a lack of specific intervention or arrangements for rape survivors.
iii. Regarding the perception of professionals on the comprehensiveness of the rape prevention interventions, the study result indicated secondary interventions remained focus of interventions so far. Hence, inadequate and limited interventions on primary prevention characterized existing efforts in addition to the lack of multi-sectoral response.
iv. The government agencies implementing rape prevention interventions encountered challenges to avail DNA testing service and medical supplies in addition to shortage of capacity building training. The lack of resource to avail DNA testing remained a critical challenge to generate sufficient evidence and

legally redress rape survivors. The challenge to timely report the rape incidence and loss of crucial evidence also exacerbated the challenge of rape prevention interventions. Law enforcement institutions also need to ensure prevention of secondary victimization of rape survivors because of prolonged and repeated court hearing process.

v. The study also gave insights on possible priority areas for future interventions on rape prevention in line with solving the identified challenges of implementing institutions and thereby enhancing interventions on rape prevention. Furthermore, the study set out recommendations for the consideration of concerned government institutions and relevant stakeholders in the future, mainly through encouraging research as well as the design and implementation of comprehensive rape prevention programs.

5.2. Concluding remarks

The concluding remarks below attempted to draw the study findings summarized based on the major thematic issues corresponding to the first, the second and the third research questions. Hence, these concluding remarks mainly represent the views of the research participants, where secondary sources also substantiated data from primary sources.

5.2.1. On the nature of rape prevention interventions and programs

Even though rape is a nationwide challenge in Ethiopia, the One-Stop-Center at Gandhi Memorial Hospital is implementing the only integrated program on rape prevention intervention in Addis Ababa. The current intervention at the Center highly inclined to secondary prevention interventions on rape, such as in providing health care, generating medical evidence and availing legal support to the rape survivor. However, as far as the intervention on primary prevention of rape is concerned, there is a long way to go.

The study findings show diverse factors leading to commit rape as well as the risk of rape and other forms of sexual violence. This implied to tackle the various influencing factors at different levels, where the most notable causes of rape include socio-

cultural and religious values upholding patriarchal practices, and cultural taboo to discuss sexuality. Further factors comprise of economic dependency of women, lack of knowledge on the multiple impacts of rape, alcohol intoxication, drug abuse, and limitation of educational interventions on topics of gender-equality, sexuality, and rights. In this regard, reviewing the various studies in Ethiopia, Emebet (2016:50) concludes that "Personal, economic, social and structural factors are associated with the incidence of sexual violence."

The findings on the nature of rape prevention interventions and programs showed that the One-Stop-Center in Gandhi Memorial Hospital found the only government institution implementing integrated medical care and legal support services to rape survivors. The Center also works on educational programs in collaboration with the mass media despite the limitations in the design and intensity of the intervention. However, the Federal Attorney General took the lion's share and significantly contributed to interventions focusing on primary prevention of rape through engaging mass media agencies.

The Center established referral mechanisms with other health facilities in Addis Ababa for clients to access some specialized services beyond its capacities. Thus, Black Lion Specialized Hospital and St. Emanuel Mental Hospital mainly hosting referred clients for surgical procedures and higher-level psychiatric care, respectively. The Center mostly linked the referral of male survivors of rape to Black Lion Specialized Hospital. The Center also established referral networking with Hamlin Fistula Hospital for female clients as deemed necessary.

The study findings witnessed the potential opportunities and possibilities for the expansion of rape prevention centers within Addis Ababa and to the regions in Ethiopia. The experience of the Center, the available expertise and composition of professionals appeared a glimmer of hope to materialize encouraging drives to expand. There were already promising developments by the government to scale up similar initiatives into selected health facilities in Ethiopia. In this regard, the "National Strategy and Action Plan on Harmful Traditional Practices against Women and Children" shows the problem in accessing the required services for the affected group and considers the need to increase access. The national strategy particularly

states, “There are insufficient psycho-social and legal support services for women and children affected” (MoWCYA 2013:25). The strategy also considers to “expand psycho-social support and safe house services for women and children affected” (MoWCYA 2013: 35).

The Federal Attorney General identified as the primary institution in organizing capacity building training for professionals working in the Center on medical care and legal support services to rape survivors. At the beginning of the program, during the establishment of the One-Stop-Center, professionals used to get basic training before their deployment to work with rape survivors. However, the findings show a lack of regular capacity building training for health professionals and the legal personnel working at the Center. Consequently, professionals felt that they were not up-to-date as opposed to the fast-changing dynamics in medical science and the legal environment. Participants also noted their limited knowledge on issues beyond their respective fields of study, whereby this in turn created miscommunications.

The challenge of timely reporting rape incidence accompanied by lack of information and knowledge among rape survivors and the community often resulted in loss or damage of valuable evidence. The loss of helpful evidence because of delays and unnecessary measures like washing the wounds or the body after the rape can negatively affect investigation of the rape crime. However, rape survivors coming from Addis Ababa were more likely to timely report rape incidence as compared to those coming from remote areas.

5.2.2. On how implementing institutions respond in addressing problems of rape survivors

Despite the encouraging efforts to avail medico-legal support to rape survivors at few facilities in Addis Ababa, severity of the problems on rape requires scaling up of comprehensive interventions. This particularly refers to strengthening interventions at Gandhi Memorial Hospital implemented in collaboration with the Federal Attorney General. The implementing institutions faced several challenges in their attempts to address the problems of rape survivors. The research findings on the difficulties to meet the demands of rape survivors on quality services and related issues summarized below.

Absence of the DNA testing service, the equipment, supplies, and trained human resource represented among the critical gap of the current rape prevention intervention at the Center. As a result, the existing medical test service at the Center cannot establish the identity of the assailant based on samples taken from the rape survivors. This challenge created heavy dependence of the law enforcement agencies on circumstantial evidence as far as the trial of rape crime is concerned.

The Center in Gandhi Memorial Hospital had limitations to meet the demands of rape survivors, particularly in cases of referrals to other specialized hospitals in Addis Ababa. The problems with referrals to other specialized hospitals mainly associated with the high patient load, lack of arrangement for rape survivors to access services free of charge and no priorities given to cases of rape.

As the court hearing on rape cases usually adjourned several times, including for the reasons related to the delays of medical evidence expected from the specialized hospitals, protecting rape survivors from secondary victimization appeared problematic. Rape survivors suffer from secondary victimization due to the repeated practice of prosecutors reminding their clients about the rape incidence preceding the court hearings.

5.2.3. On the comprehensiveness of rape prevention interventions

The conclusion to draw from the study findings on the comprehensiveness of rape prevention interventions in Addis Ababa mainly constituted challenging issues as evidenced in the perception of research participants and the reviewed secondary sources.

The focus area of existing rape prevention interventions generally attributed to reactions with the aftermath of the rape incidence rather than the implementation of specifically designed interventions or programs with the nature of primary prevention. Professionals working at the Center confirmed on the absence of a comprehensive program or project specifically designed and implemented on rape prevention. The review of secondary data from Gandhi Memorial Hospital confirmed the need to design and implement a holistic rape prevention program with multisectoral

involvement. The UNFPA (2016:9) report on “Good Practice and Lessons Learned” shows the needs to avail integrated services. The same report lists “shelters, legal aid, and medical and psycho-social support” for the survivors. It also notes that the Ethiopian policy framework laid “a multi-sectoral approach” for various actors to engage therein.

Rape prevention interventions so far concentrated on availing health care and legal support services to the rape survivors. The limited primary prevention interventions on rape lack a specifically designed program such as that of a universal intervention targeting the public. Besides, educational messages with the significance of primary prevention of rape not broadcasted continuously and on a regular basis with a dedicated program through mass media.

There were limitations on multi-sectoral involvement, referral linkage, and networking among government institutions and relevant other stakeholders. As compared to the partnership-efforts evidenced among the law enforcement agencies and health institutions operating on rape prevention in Addis Ababa, the engagement of other stakeholders remained minimal. For instance, there has been limited involvement of educational and religious institutions, the mass media, the civil society, and professional associations. Those government agencies actively working in the Center had limited interventions to address common issues of concerns such as on their gap of human resource capacity building. Despite the budget shortage to integrate essential services on rape prevention at the Center, resource mobilization effort appeared minimal. Stakeholders also had limited programs focusing on the economic empowerment of women and public awareness creation that directly involve target groups such as rape survivors and other identified groups vulnerable to the risk of rape.

Rape prevention interventions in Ethiopia faced difficulties associated with the legal interpretation of the crime of rape. In this regard, the Criminal Code of Ethiopia is not even mentioning some forms of rape, such as male rape, spousal rape, and child rape. The Criminal Code instead preferred to use phrases like sexual outrages, indecent acts and related other blurred expressions rather than directly referring to those criminal acts as child rape or male rape. The issue of marital rape, on the other hand, appeared

as a subject of debate in the jurisprudence of law schools in Ethiopia where the Criminal Code hardly entertains rape in wedlock. More importantly, prevention interventions focusing on marital rape appeared to have had no legal support in Ethiopia, and thus stakeholders encountered difficulties to operate under such legal circumstances.

5.3. Recommendations

The researcher would like to present the recommendations into three categories based on the major findings of the study and their implications referring to the programmatic, policy and research focus areas.

5.3.1. Program oriented recommendations

The major recommendations on programmatic priority areas to enhance rape prevention interventions and programs, particularly for the responsible government institutions and relevant stakeholders include:

a) Design and implement comprehensive prevention programs on rape and other forms of sexual violence by involving stakeholders in Addis Ababa, including the mass media, and relevant professional associations.
b) Enhance and implement simultaneous interventions on rape prevention by identifying the influencing factors for the occurrence of rape. These particularly refer to interventions at the levels of the individual, interpersonal-relationships, institutions, and the society- i.e., considering the cultural, policy and legal environment.
c) Enhance co-curricular and extracurricular activities in schools and relevant other platforms including religious and community based organizations to address socio-cultural barriers of gender equality and change harmful value practices.
d) Strengthen partnership and networking platforms through enhancing multi-sectoral engagement and encouraging joint consultative forums among the stakeholders on the prevention of rape.
e) Mobilize resources through engaging development partners and civil society to address the pressing challenges of the government institutions

implementing rape prevention. The focus here is on ensuring quality medico-legal services through availing vital equipments and supplies. To this effect, leveraging resources appeared priority to avail the DNA testing, the human resource capacity building, and expansion of integrated rape prevention into other regions of Ethiopia.

f) Documentation of promising and best practices and thereby exchange of lessons on rape prevention for scaling up of best practices and avoiding duplication of efforts among the stakeholders.

5.3.2. Policy related recommendations

a) Work upon evidence based advocacy for the review of the school curriculum and integration of substantive contents and the teaching methodologies with relevant courses. The appropriate courses or fields of study would emphasize on topics of civic virtue, citizenship, rights, gender equality, interpersonal relationship, sexuality, reproductive health, and rights.

b) Encourage the role of civil society organizations to support efforts of the government institutions on primary prevention of rape by creating a favorable policy and legal environment. Thus, civil society organizations will be actively engaged in the promotion of rights and advocacy against gender-based violence; and thereby, contribute to the rape prevention interventions and programs.

5.3.3. Research related recommendations

The researcher noted that time and financial constraints, as indicated under the study limitation, inhibited to include further issues of research inquiry and consider broader views from diverse groups of research participants. This particularly referred to the gap of the study being limited to the perspectives of professionals working on rape prevention interventions. In other words, considering the views of rape survivors, their family members, community leaders, and the perpetrators regarding rape prevention interventions remained an area of further investigation. Moreover, as the study findings demand changes in the Criminal Code of Ethiopia, which entails to conduct further research and generate evidence for consideration of broader legal interpretation on rape.

Therefore, the following are the major recommendations calling for further research with particular consideration of enhancing rape prevention interventions and programs.

a) Conduct research on rape prevention interventions and programs considering the views of rape survivors, perpetrators of rape, community leaders, and family members of the rape survivors and the perpetrators.
b) Review the pertinent laws in Ethiopia and encourage further studies that can support concerned stakeholders through evidence-based advocacy to positively influence policy makers, and thereby enhance rape prevention interventions. Encouraging research-based deliberations on existing laws in line with addressing the pressing challenges of rape could be helpful to settle controversial views on rape and thereby improve the criminal code. Taking such measures with the legal improvement would allow exhaustively utilizing the potential capacity and strengthening the contribution of the law enforcement agencies in the prevention of rape.

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APPENDICES

Appendix 1: Research participant information sheet

Date: dd/mm/yr.

Title: Situation Analysis of Perceptions on Comprehensiveness of Rape Prevention Interventions by Implementing Agencies in Addis Ababa

Dear Madam/Sir,

My name is Difabachew Setegn Hailegeorgis and I am conducting research with my supervisor Mr. Leon Roets, a Program Convener: Postgraduate Program of Social and Behavioral Studies (HIV/AIDS) in the Department of Sociology, towards MA in Sociology at the University of South Africa (UNISA). We are inviting you to participate in a study entitled: "Situational Analysis of Perceptions on Comprehensiveness of Rape Prevention Interventions by Implementing Agencies in Addis Ababa."

PURPOSE OF THE STUDY

This study is expected to collect important information that could help to further understand and describe the situation of existing rape prevention interventions in Addis Ababa as well as getting insights on challenges of efforts that has been undertaken so far. Along with this, the study has a drive to illuminate on existing approaches of rape prevention interventions and give insight to stakeholders with more alternative approaches. Besides, with the findings of the study, the researcher wants to contribute with recommendations for the improvement of rape prevention interventions.

WHY ARE YOU BEING INVITED TO PARTICIPATE?

Dear prospective study participant, please be informed that you are being invited after a formal request of your esteemed institution for support to conduct interview with relevant experts and to get access to secondary resource materials or documents. You are, therefore, selected and invited to participate in the study following formal communications and approval of concerned bodies at your respective institution. Your

institution is considered in this study due to its active engagement on rape prevention interventions among relevant agencies in Addis Ababa. Those institutions identified for this study include two government hospitals in Addis Ababa, the Federal Attorney General, and the Federal High Court. More specifically, your selection as prospective participant is purposively undertaken using inclusion criteria such as those who have served for at least five years, well-experienced, senior professionals and practitioners or implementers with the expertise demonstrated in working at those institutions considered in this study. Hence, maximum of 15 study participants will be participating in this study from the selected institutions (at least 4 at each), where identification of appropriate and prospective participant is undertaken with due consultation of your respective institution.

THE NATURE OF YOUR PARTICIPATION IN THIS STUDY

As a prospective study participant, this researcher would like to make sure that the nature of your participation is entirely based on your free will and full consent. The reason of your participation in this study is to provide information, where you can also decline to respond or not to provide information for question(s) you may feel you should not provide answer. This study involves audio recording or taping while conducting in-depth interview to capture opinion of study participants properly. The researcher uses a general interview guide to ensure that all essential issues are addressed. Open-ended issues and questions will be raised and asked through the in-depth interview. To maintain uniformity and convenience, the in-depth interview will be undertaken in Amharic, which may take 30 to 45 minutes to complete with one participant. The researcher would also like to inform you kindly that the place and time schedule for the in-depth interview should be at the convenience of your choice.

YOU CAN WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE

Please also be informed that participation in this study interview session is entirely voluntary. Besides, there is no penalty or loss of benefit for non-participation to this study. Hence, if you decide to participate in this study, it is voluntary and you are under no obligation to consent to participation. You are free to withdraw at any time and without giving a reason. Moreover, if you do decide to take part in the study, you

will be given this information sheet to keep and be asked to sign a written consent form.

THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY

Though participation in this study does not involve direct benefit to study participants, it gives study participants an opportunity to contribute in addressing the societal challenge of rape. They can mainly help in improving rape prevention intervention programs. Without participation of concerned actors and stakeholders, it is hardly possible to understand and describe existing rape prevention interventions as well as providing workable recommendations to fill gaps and improve programs or interventions. Moreover, practitioners on the field can inform decision makers and policy designers, in addition to providing ideas that possibly inspire researchers and stakeholders further engage on addressing the challenge with evidence-based interventions. This, in turn would strengthen research-based interventions on rape prevention, and eventually, link the scientific community with the society in addressing societal level challenges such as rape.

ARE THERE ANY NEGATIVE CONSEQUENCES ON YOU IF YOU PARTICIPATE IN THE RESEARCH PROJECT?

Though you are informed that, as prospective study participant, you can refuse to answer any question you may find inconvenient to answer and can still remain in the study, you can possibly have your own opinion and belief to convey that might appear unpleasant for others or disappointing to other people or agencies. This researcher would like to make sure that there would not be any risk that may come from others identifying your participation in the research. Hence, in order to avoid possible concerns, the researcher will safeguard anonymity of study participants including through maintaining confidentiality at all levels. To this effect, you will not be mentioned by name in any of this study report. Besides, the researcher formally confirms in writing to maintain confidentiality at all levels by signing the consent form enclosed herewith.

WILL THE INFORMATION THAT YOU CONVEY TO THE RESEARCHER AND YOUR IDENTITY BE KEPT CONFIDENTIAL?

This researcher would like to explain the extent to which confidentiality of information you convey would be maintained, and the level of your identity kept anonymous. Please be informed that you have the right to insist that your name will not be recorded anywhere and that no one, apart from the researcher and identified members of the research team, will know about your involvement in this research. As your name will not be recorded anywhere, no one will also be able to connect you to the answers you give, and thus this measure will keep your anonymity. Your answers and the information you convey will not be recorded in your name, rather they will be given a code number or a pseudonym and you will be referred to in this way or anonymously in the data, any publications, or other study reporting methods such as research report, journal articles and conference proceedings.

Your answers may be reviewed by people responsible for making sure that research is done properly, including the research supervisor and members of the Research Ethics Review Committee. Otherwise, records that may identify you like interview record will be available only to people working on the study, unless you give permission for other people to see the records. Furthermore, your privacy will be protected in any publication of the information, such as the study report may be submitted for publication, but you will not be identifiable as a participant by your name or other means in such a report.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

The researcher will store hard copies of your answers for a period of five years in a locked cupboard or filing cabinet at UNISA, in Pretoria or Addis Ababa as appropriate for future research or academic purposes. Electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies and electronic records of your answers to the in-depth interview will be destroyed after five years as deemed necessary. Hard copies will be shredded and incinerated whereas electronic records will be permanently deleted from the hard drive of the computer by using a relevant software program.

WILL YOU RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

Please be informed that your participation in this research will not involve any payment or reward offered, financial or otherwise.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the postgraduate student proposals for Theses/Dissertations in the Department of Sociology in the College of Human Sciences, University of South Africa. A copy of the approval letter is enclosed herewith this research participant information sheet for your information.

HOW WILL YOU BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Difabachew Setegn Hailegeorgis on mobile phone: +251 (921) 619504 or Fax: +251 (11) 467 1084; Email: difabachews@gmail.com; or website: http://www.fgaeet.org. The final research findings are expected to be available and accessible for study participants and other interested stakeholders as of June 2017. Should you require any further information or want to contact the principal researcher about any aspect of this study, please contact Difabachew Setegn Hailegeorgis: - a Team Leader: Adolescent and Youth Program at Family Guidance Association of Ethiopia (FGAE). His address is Kirkos Sub-city; Kebele02/03; DebreZeit Road; Email: difabachews@fgaeet.org/ difabachews@gmail.com; Tel: +251 (11) 467 2300; Fax: +251 (11) 467 1084; Mobile: +251 (921) 619504; P.O. Box 5716, Addis Ababa, Ethiopia.

Should you have concerns about the way in which the research has been conducted, you may contact supervisor of the research project: Mr. Leon Roets: - Program Convener: Postgraduate Program of Social and Behavioral Studies (HIV/AIDS), Department of Sociology, UNISA; Email: Roetshjl@unisa.ac.za; Tel +2712 429 6975; Fax 086 2699877; Pretoria, South Africa. Alternatively, you may contact the chairperson of the Research Ethics Review Committee of the postgraduate student proposals for Theses/Dissertations in the Department of Sociology, College of Human

Sciences at UNISA, Prof ME Rabe – Master's and Doctoral Coordinator and Chair of the Departmental Higher Degree Committee.

Thank you for taking time to read this information sheet and for participating in this study.

With Best Regards,

Difabachew Setegn Hailegeorgis

Appendix 2: Consent to participate in the study

I, _____, confirm that the person, named Difabachew Setegn Hailegeorgis, asking my consent to take part in this research, entitled: "Situation Analysis of Perceptions on Comprehensiveness of Rape Prevention Interventions by Implementing Agencies in Addis Ababa", has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read and the researcher had explained to me, and thus I understood the study as explained in the information sheet.

I had sufficient opportunity to ask questions and thus prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications, and conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the in-depth interview and given my consent to the researcher to use audio recording or taping.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname ……

Participant Signature……Date……

Researcher's Name & Surname……

Researcher's signature……..…Date……

Appendix 3: Request for permission to conduct research

Title: Situation Analysis of Perceptions on Comprehensiveness of Rape Prevention Interventions by Implementing Agencies in Addis Ababa

Date: <dd/mm/yr. >

[Name of the Selected Institution]
Addis Ababa

Dear Madam/Sir,

My name is Difabachew Setegn Hailegeorgis and I am doing research with my supervisor Mr. Leon Roets, a Program Convener: Postgraduate Program of Social and Behavioral Studies (HIV/AIDS) in the Department of Sociology, towards MA in Sociology at the University of South Africa. We are kindly requesting permission to conduct research at your esteemed institution inviting at least five experienced professionals to participate in a study entitled: "Situation Analysis of Perceptions on Comprehensiveness of Rape Prevention Interventions by Implementing Agencies in Addis Ababa".

The aim of the study is to get an insight and describe the situation of rape prevention interventions in Addis Ababa. The researcher also needs to have further understanding on the challenges of rape prevention interventions, and thereby, contribute with recommendations on areas for improvement in informing stakeholders to enhance rape prevention interventions.

Your institution has been selected because of its active engagement on rape prevention interventions in Addis Ababa. Institutions identified so far for this study include two government hospitals, the Federal Prosecution Office and the Federal High Court. The study will entail collecting qualitative data from selected study participants working in those institutions through an in-depth interview, where participation is entirely voluntary. At least five experienced professionals, with more than five years of service on rape prevention interventions, will be participating on in-depth interview at each institution. Besides, the study requires review of relevant studies, reports, proceedings, programmatic or project plans, operational manuals and

guidelines on implementation, strategic and policy related documents among other secondary sources. The researcher will not mention names of study participants in any of the study report and during data collection. To this effect, the researcher will formally confirm signing a consent form with study participants ensuring that their confidentiality and anonymity maintained at all levels. Study participant can also refuse to answer any question he or she finds inconvenient to answer and still can remain in the study.

The benefits of this study are to illuminate on existing approaches of rape prevention intervention and give insight to stakeholders with more alternative approaches. Thus, study findings will come up with recommendations to contribute in filling gaps for the improvement of rape prevention interventions. The study report will also support in informing decision-making and provide ideas to inspire researchers and stakeholders for further study to address the challenge of rape with comprehensive and scientific prevention intervention approaches.

Potential risks are anticipated in line with the sensitive issue of rape, which might hinder some study participants to openly convey information and honestly reflect their perception. Because, some participants may feel that the researcher might evaluate their opinion and that they will be considered chauvinist or not respecting gender equality.

Feedback procedure will entail debriefing sessions during and after the in-depth interview with study participants allowing them to express their feelings and thoughts towards the interview and the research. Depending on availability of financial support, the researcher will organize dissemination workshop on the study findings to stakeholders' representatives including participants from institutions considered in the study. A copy of the study report will also be submitted to relevant stakeholders.

Therefore, I hereby, kindly request for the support of your esteemed institution to conduct the research in facilitating access to relevant documents and conduct in-depth interview with professionals on rape prevention interventions.

Yours Sincerely,

Difabachew Setegn Hailegeorgis
Student Researcher at the University of South Africa; and,
Team Leader on Adolescent & Youth Program at Family Guidance Association of Ethiopia
Email: difabachews@gmail.com, 42947138@mylife.unisa.ac.za, difabachews@fgaeet.org
Mobile: +251 (921) 619504

Appendix 4: General guide for in-depth interview

I. Demographic profile of the study participant:

- sex: _____; Age: _____;
- Professional background: _____;
- Position of Responsibly: _____;
- Years of relevant experience: _____;

II. Discussion on existing nature of institutional interventions (programs or projects) focusing on rape prevention in Addis Ababa:

- the nature of existing program operations/ project activities on rape prevention interventions, including in terms of service needs of rape survivors (psychosocial, health care and legal support) or the current status of prevention interventions;
- The level of integration of services and interventions, partnership, community involvement, media engagement and agenda of focus in message dissemination, counselling & social support through institutionalized interventions (comprehensiveness of programs/ projects);
- Whether there is implementation of program/ project activities targeting individuals, community, institutions, the society at large and the policy environment (comprehensiveness of interventions/programs);
- If there are prevention interventions by various forms of rape[6]; how about effectiveness?
- If there is a specifically designed and implemented approach depending on the nature of the problem (comprehensiveness of interventions/programs);
- Would you explain [from your experience] on the reasons/ factors behind delay or failure to report the rape incidence by the survivors to service delivery facilities and law enforcement agencies? (Challenges to maintain timeliness of reporting rape incidence).

[6] **Forms of Rape** mainly involve: forcible rape, date rape, acquaintance rape, spousal rape, statutory rape, rape of men, rape while sleep or under influence of alcohol, sexual coercion in return to certain benefit, gang rape and systematic rape among others.

- In this regard, in order to improve timely reporting of rape incidence, what specific interventions would you advise for the concerned/ responsible agencies?

III. Areas for improvement or gaps (if any) in order to enhance existing institutional interventions on rape prevention in Addis Ababa:

- For the provision of quality psycho social, health care and legal support services to rape survivors and to implement related prevention interventions (for comprehensiveness of interventions/programs), mainly:
  - in addressing the major needs of rape survivors;
  - in terms of availing medical equipment and supplies;
  - with regards to referral linkage system;
  - pursuant to the networking and partnership engagement with stakeholders;
  - in the efforts of implementing rape prevention interventions (limitations observed on the programs/ projects/ activity undertakings including prevention approaches such as efforts of community awareness creation and mobilization;
  - Whether there are specific challenges that professionals face in implementation of rape prevention activities example, in terms of capacity building trainings, human resource assigned…;

IV. Discussion on issues referring to the perception of individual professionals (medical treatment, psychosocial care, and legal support providers) working at the government institutions on comprehensiveness of rape prevention interventions:

- Why the violence of rape by itself occurs? (probe on personal views as to the possible causes or risks of rape);
- Why do you think perpetrators commit rape? (if not addressed above);
- Who is to blame for the crime of rape or for the causes of rape (if there is any one to be blamed)?

- Whether there should be gender oriented or segregated arrangement of care takers, i.e. whether female rape survivors should be treated by female care takers, while the male survivors to be addressed by male service providers;
- Whether the ideological stance of professionals serving in law enforcement agencies and health care facilities, particularly a position towards which individuals stand on gender related issues, has an influence on their day-to-day works of rape prevention interventions. For example, in cases where individuals could have the following sentiments as their own ideological values:
    - "Rape survivors should act as per the societal norm to avoid rape";
    - "Perpetrators are motivated by the acts of the rape survivor";
    - "Societal values, orientation, and culture like patriarchy leads to rape";
    - "Stronger punishment against perpetrators should be enacted to prevent further rape".

V. Professional suggestions / advises/ recommendations on what should be done to enhance rape prevention intervention efforts so far, mainly:

- **For government institutions** in terms of:
    - Psychosocial support, health care, and legal support services,
    - Rape prevention interventions through public mass media, community mobilization, in-school intervention, etc
- **For other stakeholders/ partners**: civil society, private mass media, Community Based Organizations (CBOs), Faith Based Organizations (FBOs), champions as change agents/ celebrities, etc.

If there is any other issue the study participant wants to share/convey:

Appendix 5: Approval of research ethical clearance

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

Note:
The reference number [top right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the College of Human Sciences Research Ethics Review Committee.

Kind regards,

Professor AH Mavhandu-Mudzusi
Chair: CHS Ethics Review Committee
Department of Health Studies
Tel: 012 429 2055
Cell: 082 406 2494
Email:mmudza@unisa.ac.za

Professor RMH Moeketsi
Executive Dean: College of Human Sciences

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

The proposed research may commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the CHS Ethics Review Committee. An amended application could be requested if there are substantial existing proposal,*

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Appendix 6: Research support letters from UNISA

UNISA university of south africa

01 DECEMBER, 2016

UNISA-ET/KA/ST/29/01-12-16

Gandhi Memorial Hospital
Addis Ababa

Dears Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to certify that Mr. Difabachew Setegn Hailegiorgis (student number 42947138) is a Masters student in the Department of Sociology at UNISA. Currently, he is at the stage of data collection for his thesis entitled "***Situational Analysis of Perceptions on Comprehensiveness of Rape Prevention and Interventions by Implementing Agencies in Addis Ababa***."

This is therefore to kindly request your cooperation in providing the student access to data sources. Attached, please find the ethical clearance that he secured from his department at UNISA. We would like to thank you in advance for all the assistance that you would provide to him.

UNISA REGIONAL LEARNING CENTRE
PO BOX 13836 ADDIS ABABA ETHIOPIA
TEL +251-114-350141
+251-114-350078
FAX +251-114-351243
MOBILE +251-912-191423

Sincerely,

Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

University of South Africa
Regional Learning Center
P.O. Box: 13836, Addis Ababa, Ethiopia
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www.unisa.ac.za

UNISA university of south africa

01 DECEMBER, 2016

UNISA-ET/KA/ST/29/01-12-16

Black Lion Specialized Hospital
Addis Ababa

Dears Madam/Sir,

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Sincerely,

Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

University of South Africa
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UNISA university of south africa

01 DECEMBER, 2016

UNISA-ET/KA/ST/29/01-12-16

Federal High Court Lideta Criminal Bench
Addis Ababa

Dears Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to certify that Mr. Difabachew Setegn Hailegiorgis (student number 42947138) is a Masters student in the Department of Sociology at UNISA. Currently, he is at the stage of data collection for his thesis entitled "***Situational Analysis of Perceptions on Comprehensiveness of Rape Prevention and Interventions by Implementing Agencies in Addis Ababa.***"

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Sincerely,

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UNISA university of south africa

21 JANUARY, 2017

UNISA-ET/KA/ST/29/21-01-17

Federal Attorney General Women and Child Multi-Sectoral Coordination
Addis Ababa

Dear Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to certify that Mr. Difabachew Setegn Hailegiorgis (student number 42947138) is a Masters student in the Department of Sociology at UNISA. Currently, he is at the stage of data collection for his thesis entitled "***Situational Analysis of Perceptions on Comprehensiveness of Rape Prevention and Interventions by Implementing Agencies in Addis Ababa***."

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Appendix 7: Profile of research participants

Table 1: Research participants by age, gender, experience, & occupation

SN	Research Participants (by Interviewee Code)	Age	Gender	Experience in years	Occupation
1.	Interviewee GMH-001	40	Female	5	Nurse
2.	Interviewee GMH-002	35	Female	6	Nurse
3.	Interviewee GMH-003	27	Female	3	Physician
4.	Interviewee GMH-004	27	Male	2	Physician
5.	Interviewee GMH-005	45	Male	15	Gynecologist
6.	Interviewee BLH-001	45	Female	15	Pediatrician
7.	Interviewee BLH-002	43	Male	2	Legal Advisor/ Lawyer
8.	Interviewee AL-AWCA-001	29	Female	3	Prosecutor
9.	Interviewee AL-AWCA-002	29	Female	2	Prosecutor
10.	Interviewee FHC-J 001	34	Male	11	Judge
11.	Interviewee FHC-002	32	Female	3	Judge
12.	Interviewee FAG-Prosr-001	32	Female	11	Prosecutor
13.	Interviewee FAG Prosr-002	29	Female	3	Prosecutor
14.	Interviewee FAG SOW–003	31	Female	3	Social Worker

Appendix 8: Node structure generated from NVivo 10

Name: Memos\\Node Structure

Description: The nodes are structured mainly based on the research questions.

The parent nodes are structured based on the four major questions asked during the in depth interviews. Furthermore, the child nodes are structured in line with the focus areas of the replies of research participants as well as the emerging questions raised by the researcher while data collection.

Thus, the nodes are mainly structured into four questions and the sub-nodes, namely:
Q1. On existing situation or nature of institutional interventions focusing on rape prevention in Addis-Ababa:

A. One-Stop-Center: -
    - About the One-Stop-Center;
    - Available Services;
    - Brief description about clients served in the Center;
    - Referral Linkage & Partnership of the Center;
    - Educational or Primary Prevention Interventions of the center;
B. Training of Professionals;
C. Existing situation on timeliness of Reporting Rape Incidence;
D. Expansion of Rape Care Centers;

Q2. Areas for improvement to enhance existing institutional interventions on rape prevention in Addis Ababa:

A. Challenges on Quality Services:
    - Medical Equipments and Supplies;
    - Human Resource Capacity Building;
    - Meeting Demands of Rape Survivors /Services required but not available
B. Limitation on Rape Prevention Interventions:
    - Primary Prevention Related Interventions;
    - Multi-sectoral Involvement [on rape prevention];
    - Rape Investigation Capacity;
    - Challenges Associated to Professional Differences;
    - Challenges Associated with Rape Survivors themselves.
C. Legal Understanding of Rape in Ethiopia

Q3. Perception of Individual Professionals on Issues Linked to Rape Prevention Interventions:

A. Comprehensiveness of the Rape Prevention Intervention;
B. Opinion on Why Rape Occurs;
C. Who is to blame;
D. Influence of Ideological Stance of Professionals;
E. Gender Oriented Care for Rape Survivors;
F. Views on How to Avoid Risk of Rape;

Q4. Recommendations of professionals to enhance efforts on rape prevention intervention so far:

A. For Government Institution: -

a) Primary Prevention Interventions;
    - Implementing primary prevention interventions at grassroots level;
    - Specifically designed program for the mass media on primary prevention of rap
    - Secondary and tertiary prevention interventions
b) Avail Quality Services, Medical Equipments, and supplies;
c) Human Resource Capacity Building and Trainings of Professionals;
d) Strengthen Multi-Sectoral Engagement;
e) Enhance Evidence Based Interventions on Rape Prevention
f) Policy Related Recommendations;

B. For Civil Society & Other Stakeholders