PREDISPOSING FACTORS AND LEVEL OF PREPAREDNESS AMONG IN-SCHOOL FEMALE ADOLESCENTS ON RAPE PREVENTION IN OSE LOCAL GOVERNMENT AREA, ONDO STATE

BY

Oluwaseun Hefsiba ADERANTI
B. Forest Resources Management (Ibadan)
MATRIC. NO.: 155299

A Project in the Department of Health Promotion and Education submitted to Faculty of Public Health

In partial fulfillment of the requirements of the degree of

MASTER OF PUBLIC HEALTH
(HEALTH PROMOTION AND EDUCATION)

Of the

UNIVERSITY OF IBADAN

JUNE, 2019

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

ABSTRACT

Rape is a problem of considerable proportion in Nigeria especially among female adolescents who reports their first sexual experience as being forced. Little or no primary preventive measure has been implemented to curb this act due to some weak legal policy to prosecute sexual assault perpetrators yet the crime remains under reported and under prosecuted. Therefore, this study is aimed at investigating the predisposing factors and level of preparedness among in-school female adolescents on rape prevention in Ose Local Government Area, Ondo State.

This was a descriptive cross sectional study that used 4-stage sampling technique to select 295 participants from in-school female adolescents attending public secondary school in Ose LGA. Data were collected using both quantitative and qualitative methods. Quantitative data was collected using a validated semi-structured interviewer administered questionnaire. Knowledge was assessed on a 20-point scale; score of <10 was rated poor, 10-15 as fair and >15 was rated good. Perception level was assessed on a 16 point scale with 0-5 as negative, >5-10 as moderate and >10 as positive. Preparedness level was assessed on a 10 point scale with 0-3 as low level preparedness, >3-7 as moderate level of preparedness and >7 as high level of preparedness. Concurrently, qualitative data are collected using an In-depth interview (IDI) guide. Quantitative data were analyzed using descriptive and chi square statistics at $p<0.05$ while qualitative data were analysed thematically.

Respondents were all females and the mean age was 14.2±1.9years. Some (55.6%) of the respondents had good knowledge, 67.1% had a good perception of rape, 93.9% of the respondents reported that demanding or collecting material things from boys or men could be one of the predisposing factors to rape while 62.0% had fair level of preparedness to rape prevention. Only 6.1% reported to have had forced sexual intercourse. Knowledge was found to be significantly associated with rape. Level of preparedness to rape prevention by in-school female adolescent was also significantly associated with the predisposing factor. The In-depth Interview revealed that there is a need to empower female adolescent with rape prevention intervention to reduce rape.

The study revealed factors that could predispose in-school female adolescents to rape and also increase their level of preparedness to rape prevention. Health promotion and education

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

strategies such as public enlightenment, rape awareness campaign, life building skills and bystander intervention are needed to address predisposing factors of rape and improve level of preparedness to rape prevention.

Key words: In-school female adolescents, rape, rape prevention intervention.

Word count: 400

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

DEDICATION

I dedicate this project to my creator, the source of my joy for upholding me all through the phase of the MPH programme and for the successful completion of this work.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

ACKNOWLEDGEMENT

I would like to express my profound gratitude to my supervisor, Professor Oyedunni S. Arulogun, for her guidance, motivation and critical review of this research work and her efforts in seeing the work being completed in due time. I am forever thankful and privileged to be under your tutelage in public health. I am forever grateful.

I also wish to thank my lecturers; Prof. O.Oladepo, Prof.A.J. Ajuwon Dr O. E. Oyewole, the AgHead of Department most especially for being supportive and helpful for my work, Dr. Y. O. John-Akinola, Dr. O.I. Dipeolu,Dr. M. M. Oluwasanu, Mrs. A.T. Desmennu, and, Mr. J. Imaledo who have all taught me and shared their wealth of professional experiences in building my capacity as a public health professional. I want to sincerely thank Dr. M. A. Titiloye and Prof. A.O. Oluwadare for encouraging me and challenging me to do the best in my projectand for their immeasurable contributions to my development and to my project work.

I am most grateful to my ever loving and wonderful parents Pastor and Deaconess R.F. Aderanti who supported me with everything they have and also to my siblings Mrs Abosede Majadeogbe and Mr. Joshua Aderanti, thank you for words of encouragement and love.

My appreciation goes to the entire 2016/2017 set for their support during the course of this study.I acknowledge every of my professional colleagues, Mr. Oyelere Abiodun, Miss Olamide Fasola, Miss Ola Oluwatosin, Miss Opeyemi Omoniyi, Mr. Olaniyi and Mrs Oyeyemi and family for your endless support and guidance. Finally, I am grateful to all the respondents for consenting to participate in the study.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CERTIFICATION

I hereby certify that this research work was carried out by Oluwaseun Hefsiba ADERANTI in the Department of Health Promotion & Education, Faculty of Public Health, College of Medicine, University of Ibadan.

……..

SUPERVISOR

Professor Oyedunni S. Arulogun

B.Ed., MPH, PhD (Ibadan), Dip HIV Mgt &Care (Israel), FRSPH (UK), CCST (Nig)

Department of Health Promotion and Education

Faculty of Public Health, College of Medicine,

University of Ibadan, Nigeria.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

TABLE OF CONTENTS

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER TWO: LITERATURE REVIEW

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

LIST OF TABLES

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

LIST OF FIGURE

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

LIST OF APPENDICES

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

ACRONYMS

CIA:	Central Intelligence Agency
HIV:	Human Immune Deficiency Virus
LGA:	Local Government Area
STI:	Sexually Transmitted Infection
UNDP:	United Nations Development Programme
WHO:	World Health Organization
CIA:	Central Intelligence Agency

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

OPERATIONAL DEFINITION OF TERMS

ADOLESCENT:	It is period of transitional stage from childhood to adulthood life or period of life from puberty to attainment of full maturity or adulthood.
IN-SCHOOL FEMALE:	Female adolescents going to school between the ages of 10-9 years.
RAPE:	Non-consensual or unlawful sexual intercourse and activity carried out forcibly or under threat of injury against the will usually a female or with person who is beneath a certain age or incapable of valid consent.
PERCEPTION:	The way a person thinks about or understands someone or something (Merriam-Webster dictionary).
PREDISPOSING FACTORS:	Defined as characteristics, experiences, or events that, if present, are associated with an increase in the vulnerability of one being a victim or perpetrator.
PREPAREDNESS:	Willingness or readiness to prevent rape incidence through education and life skills strategies.
PERPETRATOR:	Someone who has raped another person.
SEXUAL VIOLENCE/ASSAULT:	It is unwanted sexual acts that includes touching or fondling, verbal sexual abuse and rape.
RAPE SURVIVOR/ VICTIM:	Someone who has been raped by another person.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Sexual violence against women and girls is one of the most prevalent and least recognized human rights abuses in the world (Cooperative for Assistance and Relief Everywhere, 2010) Sexual violence encompasses a series of acts, including coerced sex in marriage and date rape, rape by strangers, gang rape, sexual harassment (including demands of sex for jobs or school grades), and rape of children, trafficking of women and girls, female genital mutilation, and forced exposure to pornography (Olle, 2004). However, rape happens to be one of the most serious crimes of all the types of sexual violence. The Nigerian criminal law, defined rape as unlawful carnal knowledge of a woman or girl without her consent or with her consent if the consent is obtained by force or by means of threat or intimidation of any kind, or by fear of harm or by means of false and fraudulent representation as to the nature of the act (Act Criminial Code, 1990).

The prevalence of rape is not peculiar to a certain country. It occurs throughout the world and happens in different circumstances and settings. Globally, it was reported that one out of three women will experience sexual violence in their lifetime (World Health Organization, 2005). Moreover, an estimated 150 million girls and 73 million boys have experienced forced sexual intercourse or other forms of sexual violence involving physical contact before the age of 18 years (Pinheiro, 2006). Data available in Sub-Saharan Africa (Jewkes *et al.*, 2011) suggests that rape is a problem of considerable proportion in sub-Saharan countries where up to one-third of adolescent girls report their first sexual experience as being forced.

Studies have shown that both male and female are both affected but adolescent girls are most vulnerable victim to rape on a larger scale (Borwankar, Diallo and Sommerfelt, 2008) particularly female aged 16-24years are four times likely to have experienced attempted rape or rape than women in all other age group (Ricket *et al.*, 2004). Also, 18.0%of the girls had experienced forced sex and 45.0%of them had experienced statutory rape in a study population among out-of-school adolescents in Iwaya, Lagos, Nigeria (Kunnuji and Esiet, 2015).

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

In a study conducted in KwaZulu-Natal in South Africa 91.0% of in-school female adolescents acknowledged the negative impact of rape to be contracting HIV/STI (De Vries *et al*., 2014). Also, many factors have been associated with increased risk for rape among adolescents and young female some of which are;young age, number of dating and sexual partner, drug use and alcohol (Ricket *et al.*, 2004; Oleribe, 2002;Adudans*et al.*, 2011) socio-economic hardships, male dominance in some part of the world which renders women powerless in relationships and submissive to men in engaging in forced sexual intercourse (Kennedy *et al.*, 2012). It is within this context that forced sexual intercourse leads to situations where it is effectively normalized and seen as what can be expected by some. This may further increase vulnerability of victim to sexually transmitted infections (STIs), Human immunodeficiency virus, unwanted pregnancies and complications in childbirths (Onah, 2010and Jewkes, 2001).

At the societal level, there are policies in place to prosecute sexual assault perpetrators, yet the crime remains under reported and under prosecuted, largely because of the blame and stigma assigned to victims (Alemika, 2013;WHO, 2002; Grubb and Turner, 2012). The ongoing high incidence of rape suggests that novel prevention strategies are needed. Data from the United States indicate that empowerment and self defense is simple and effective tool to prevent incidence of sexual assault including rape. Thus, women and children who undergo this training are more likely to report having confidence and control over their lives and less likely to experience sexual assault than those who never did.

However, this type of intervention has hardly ever been implemented and evaluated in developing countries (Cummings, 1992; Brecklin and Ullman, 2005; Hollander, 2014; Sarquinst *et al.*,2014). Therefore, this study hypothesized that an individual-level of willingness to prevent rape through empowerment intervention for adolescents could reduce the incidence of rape among in-school female adolescents in Nigeria.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

1.2 Statement of problem

Rape is an alarming public health issue among adolescents and women worldwide and there have been reports on constant menace of rape especially among children and adolescents almost on daily basis in the media. In a study conducted among adolescents attending public schools in the Oworonshoki region of Lagos,(Shittu *et al.*,2007) reported that 1 out of every 5 sexually active teenager has experienced forced sex before the age of 18years. Ohi*et al.*,(2002) identified that, 24 to 40% of female adolescents were found to be sexually active and 22% had their first sexual experience through rape or coerced sex.

More than 22.0% of Nigerians are adolescents half of whom dwell in rural areas (CIA, 2016). However, very minimal efforts have been made especially in rural settings to address rape incidence. Several researches have focused on secondary and tertiary preventive strategies neglecting primary preventive strategies, perhaps the most important (WHO, 2010).Thus, primary preventive intervention has hardly ever been implemented and evaluated in developing countries (Cummings, 1992; Brecklin and Ullman, 2005; Hollander, 2014 and Sarnquist *et al.*, 2014).

However, Ose Local Government Area is a rural area in southwestern part of Nigeria having more male in school than female (Ministry of Economic Planning and Budgeting, 2010). Factors which may be due to inability to afford cost of formal education, preference of male education and it may also be that female victims of forced sex drop out of school more regularly than boys due to increased risk of getting pregnant(Freudenberg and Ruglis, 2007).Secondary data obtained from existing records in Model Comprehensive Health Centre Ifon, documented rape victims who sought medical care from October, 2016 to April, 2018 to be 12.

Rape incidence observed by the researcher during her course of stay as a Youth corp member in Ose Local Government Area interested her area of research as there is little or no previous studies carried out in this local government on the level of preparedness to rape prevention. Therefore, this study investigated on predisposing factors and level of preparedness among in-school female adolescent of rape prevention in Ose Local Government Area, Ondo State.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

1.3 Justification

This study focused on in-school female adolescents in Ose Local Government Area to highlight the significance of an increased understanding of rape, factors that influence rape and level of preparedness to rape prevention at individual setting. Students might learn to identify what constitutes rape, reject commonly held myths about rape and victims and begin to adopt free belief systems that might decrease the incidence of rape by willing to participate in any educational and/or life skills strategy.

Also, it would help decrease the devastating consequences of rape on adolescents which includes drop out from school due to unwanted pregnancy, sexually transmitted diseases, shame and guilt. Obtaining information from the students would allow them to voice out and break silence about rape and make them report suspected perpetrators to authorities and seek for help where necessary. This would further help in increasing the documentation of reported rape cases for official statics of rape and sexual reproductive health and wellbeing. Above all, the society at large would be able to develop control measures to curb rape incidence both at local and national levels.

1.4 Research Questions

1. What is the level of knowledge, sexual experiences and consequences of in-school female adolescents on rape in Ose Local Government Area, Ondo State?
2. What is the perception of in school female adolescent on rape and rape prevention in Ose Local Government Area, Ondo State?
3. What are the perceived factors that can predispose in-school female adolescent to rape in Ose Local Government Area, Ondo State?
4. What is the level of preparedness among in-school female adolescents on rape prevention in Ose Local Government Area, Ondo State?

1.5.0 Broad objective

The purpose of this study was to investigate the predisposing factors and level of preparedness among in-school female adolescents on rape prevention in Ose Local Government Area, Ondo State.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

1.5.1 Specific objectives

1. To assess the level of knowledge of in-school female adolescents on rape in Ose Local Government Area, Ondo State.
2. To evaluate the perception of rape among in-school female adolescents in Ose Local Government Area, Ondo State
3. To identify factors that can predispose in-school female adolescents to rape in Ose Local Government Area, Ondo State.
4. To determine the level of preparedness among in-school female adolescents on rape prevention in Ose Local Government Area, Ondo State.

1.6 Research hypotheses

Ho_1: There will be no significant association between participant's age and level of preparedness to rape prevention among in-school female adolescents in Ose Local Government Area, Ondo State.

Ho_2: There will be no significant association between participant's level of knowledge and level of preparedness to rape prevention among in-school female adolescents in Ose Local Government Area, Ondo State.

Ho_3: There will be no significant association between predisposing factors to rape and level of preparedness to rape prevention among in-school female adolescents in Ose Local Government Area, Ondo State.

Ho_4: There will be no significant association between predisposing factors to rape and rape.

1.7 Study variable

Independent variables: Socio demographic variables such as age, class, religion, ethnicity, living pattern, father's level of education, mother's level of education, father's occupation, mother's occupation, number of wife father has and number of children in the family.

Dependent variable: knowledge of rape, consequences of rape, sexual experiences, perception of rape, predisposing factors and level of preparedness to rape prevention.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER TWO

LITERATURE REVIEW

2.1 The Prevalence of rape among adolescents

The prevalence of rape can be determined through self count report of cases and statistics collected from both victim and perpetrator by police and victim care facilities (WHO, 2010). Globally, one out of three women will experience sexual violence in their lifetime (World Health Organization, 2005). Moreover, an estimated 150 million girls and 73 million boys have experienced forced sexual intercourse or other forms of sexual violence involving physical contact before the age of 18 years (Pinheiro, 2006). A WHO Multi-country study on women's health and domestic violence against women, found out that 3–24% of the respondents investigated had their first sexual experience forced, and that for a majority of respondents this occurred during adolescence. Likewise in 10 of the 15 settings studied, over 5.0% of women reported that their first sexual experience was forced and likewise more than 14.0% reported forced first sex in Bangladesh, Ethiopia, Peru province and Tanzania (Garcia-Moreno, 2005).

Data available in Sub-Saharan Africa Jewkes*et al.*,(2011) suggests that rape is a problem of considerable proportion in sub-Saharan countries where up to one-third of adolescent girls report their first sexual experience as being forced(Anderson and Whitson, 2005). Sexual report in a survey of over 280 000 school pupils in South Africa 9.0% of both girls and boys up to the age of 15 years reported forced sex in the past year thus, rising to 13.0% for males and (16.0% for females by age 19 years. Studies have shown that both male and female are both affected but adolescent girls are most vulnerable victim to rape on a larger scale. In corroboration is a study conducted in Nigeria, Alemika (2013) reported that only 22.9% of respondents who had experienced rape reported the offense to the police.

A survey conducted by Federal Ministry of Health (2009) identified sex, rape, sexual assault and sexual violence by men as some of the health concerns among female in-school adolescents. In correspondence to this survey Ahonsi (2013) posited that the fundamental bases of reproductive ill health among female is embedded in discriminatory social structures and stereotypes. For example, there is high tolerance for non-consensual sex (including rape) with girls by older men in communities, educational institutions, and work settings. In a recent study conducted among

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

secondary school in Port Harcourt Eke, Opara and Tabansi, (2011) 4.6% of them had been raped, of which 62.5% were by close acquaintances. However, similar investigations among secondary school in North Eastern Nigeria reported 5.1% (Ajuwon *et al.*,2006) 4.0% among female apprentice (Ajuwon *et al.*, 2002) and 6.0% in young hawkers in three selected cities in south western Nigeria(Fawole*et al.*,2002).

2.2 Knowledge about rape among adolescent

The Nigerian criminal law, defined rape as unlawful carnal knowledge of a woman or girl without her consent or with her consent if the consent is obtained by force or by means of threat or intimidation of any kind, or by fear of harm or by means of false and fraudulent representation as to the nature of the act (Act Criminal Code, 1990). World Health Organization, (2005) defined rape as a subset of sexual violence by which a sexual act is forced against someone's will.

However the legal definition of rape may vary in different countries. In a study conducted in KwaZulu-Natal in South Africa 91.0% of in-school female adolescent acknowledged the negative impact of rape to be contracting HIV/STI (De Vries *et al*., 2014). Likewise in a study conducted in Nigeria found that adolescent had broad knowledge of rape including definition and health consequences (Shittu *et al*., 2007; Ogunyemi, 2000 andEke, Opara and Tabansi, 2011). This is probably because it seems to be more common in our environment than actually reported. Rape can take place at any age including during childhood and at anywhere.

However, the most common perpetrator can be parents, caregivers, acquaintances and strangers, as well as intimate partners (Jewkes*et al.*, 2002 and Anderson and Ho-Foster, 2008). Likewise, this sexual assault is common to both male and female and the perpetrators are sometimes people they know (McGregor, 2006 and WHO, 2010).Most sexual violence is perpetrated by a single perpetrator who is known to the victim. However a survey in South Africa negates these findings, of over 1,300 women in three provinces found that women's first experience of rape was perpetrated in by a stranger (43.0%), an acquaintance (21.0%), someone from school (9.0%), relative(9.0%), partner(8.0%) and others (11.0%)(Mathews *etal*, 2009;Jewkes *et al.*,2002).

Similarly, in a recent Nigeria self reported study Eke, Opara and Tabansi, (2011) conducted among estimated 1050 secondary students indicated that 58.9% knew that rape could take place anywhere,

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

only 4.0% knew that intercourse between an adult and a minor is also rape, 37.5% have been raped by unknown person and 12.5% by friends.

2.2.1 Consequences of rape in childhood and adolescence

Sexual abuse in childhood and adolescence has consistently been found to have notably relationship with increased health risks and health-risk behaviours in females (Mangioloi, 2009). Rape can result in short term or long term effect on the survivor. Among the more common consequences of rape are those related to reproductive, mental health and social well being.

2.2.1.1 *Pregnancy and Gynecological complications*

Pregnancy may result from rape, though the rate varies between settings. It is less likely that an adolescent girl who has been forced into sex will use condoms or other forms of contraception, increasing the likelihood of her becoming pregnant (Jewkes *et al.*,2001and Jewkes and Morrell, 2010). In South Africa it was found that pregnant adolescents were over twice as likely to have a history of forced sexual initiation as non-pregnant adolescents (Onah, 2010 and Jewkes *et al*., 2001).

Similar findings in the United States have reported increased rate in pregnancy related to rape among adolescents (Silverman, Raj and Clements, 2004). As a result, gynecological complications may arise related to forced sex include vaginitis, pregnancy, hypoactive sexual desire, urinary infection, dyspareunia, chronic pelvic pain and sexually transmitted diseases (Cherry and Hategekimana 2013 and Oshiname, Oguwale and Ajuwon, 2013). Estimates from Nigeria have suggested approximately 23.0% of adolescent girls have begun childbearing while 54.0% have given birth to a child by age 20. Hospital based studies also show that adolescent girls make up over 60.0% of women treated for complications from unsafe abortion many resulting in death or permanent injury or infertility (Federal Ministry of Health, 2009).

2.2.1.2 Sexually transmitted diseases

HIV infection and other sexually transmitted diseases are recognized consequences of rape. Adolescent girls are particularly susceptible to HIV infection through forced sex, and even unforced sex, because their vaginal mucous membranes have not yet acquired cellular density sufficient to

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

provide an effective barrier that develops in the later teenage years (Van Decraen *etal*, 2012; Young, Furman and Jones, 2012; Adudans *et al.*,2011and Smith *et al.*,2010).

2.2.1.3 Mental health and suicidal attempts

Sexual violence has been associated with a number of mental health and behavioral problems in adolescence and adulthood (Anteghini*et al.*,2001).A study of over 20,000 schoolchildren aged 13–15 years in Namibia, Swaziland, Uganda, Zambia and Zimbabwe identified that 23.0% reported having experienced sexual violence rape in their lifetime. Such experiences were moderately-to-strongly associated with poor mental health and suicidal behaviour (Brown *et al.*, 2009).A meta-analysis of the prevalence of child sexual abuse and its lifetime health consequences showed that child sexual abuse contributes significantly to depression, alcohol and drug use and dependence, panic disorder, posttraumatic stress disorder and suicide attempts (Ezzati *et al.*, 2004).

2.3 Perception about rape among adolescent

The specific types of perception that predominate will vary among individuals and across specific circumstance. One emotion that many individuals experience is guilt (Van der Wal,2000). There is a feeling of remorse about what was done and what was left undone. This may reflect in a belief that certain actions may have prevented the event. Anger and irritability are often felt by individuals dealing with major life problems. The anger experienced may be morally justified, such as anger felt by a rape survivor towards her assailant. One of the most frequently encountered emotional responses following a major life trauma like rape is fear and anxiety (McCann, 1998). When the circumstances to which individuals are exposed involve significant threat to life, health or to important property, it is likely that those individuals will feel apprehension, worry and concern for some time following the event.

Eke *et al.*, (2011)summarized the perception of the respondents about rape among secondary school students in Port Harcourt. It was reported that majority (83.0%) of them had a good general perception of what rape is, only 40 students (4.0%) knew that intercourse between a male or female adult and a male or female below 16 years of age, as well as intercourse under coercion (5.4%) are also considered rape. About 40.0% of the students perceived that rape was rampant in the age group 16-19 years bracket. Four hundred and forty-two (42.1%) students believed that any male can rape a child. However, 286 respondents (27.3%) believed that the offender is usually a stranger while the

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

neighbor (16.8%) topped the list of close acquaintances who could rape a child. Majority of the students (58.9%) knew that rape can take place anywhere.

Adolescents' perception of rape has an influence on the incidence of rape in a community. The perception of respondents on measures that can be put in place to curb rape occurrences include: female students should be stopped from putting on indecent dresses on campus, having a stiff penalty for rapists and the introduction of dress codes on campuses. The adolescents also perceived that adequate sensitization on the evil of rape; alcohol prohibition on campuses, enlightenment campaign and even ensuring adequate security on campuses would not help in curbing rape incidents (Allison & Wrightsman, 2008).

2.4 Predisposing factors to adolescent rape

2.4.1 Individual factor

2.4.1.1 Young age

Young age has consistently appear to be a risk factor for being either a perpetrator or victim of sexual violence including rape and for a woman experiencing intimate partner violence (Harwell and Spence, 2000; Romans *et al*., 2007 and Vest *et al*., 2002). Female adolescent have been found to be more at risk of rape than older women (Jewkes, Sen and Garcia-Moreno, 2002). According to Heise, Pitanguy and Germain, (1994) data from justice systems and rape-crisis centres in Chile, Malaysia, Mexico, Papua New Guinea, Peru and the United States, between one third and two thirds of all victims of sexual assault are aged 15 years or under. Certain forms of sexual violence, for instance, are very closely associated with young age, in particular sexual violence taking place in schools and colleges.

2.4.1.2 Education

The relationship between individual educational attainment and economic status were correlated with forced sex among women (Adudans *et al.*, 2011). Low level of education has remained consistent across studies (Boy and Kulczycki, 2008; Chan, 2009; Dalal, Rahman and Jansson, 2009; Johnson and Das, 2009; Martin, Taft, and Resick, 2007 and Tang and Lai, 2008). For example, women who report lower levels of education are 2 to 5 times likely to experience rape

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

sexual violence compared to women with a secondary level of education or higher (Boy and Kulczycki, 2008; Dalal *et al*., 2009 ; Martin, Taft and Resick, 2007 and Tang and Lai, 2008).

Moreover, some studies revealed that some women initiate sex because they are forced by their partners. This happens both in first sexual encounter to subsequent sexual acts. Moreover, inequality among men and women with men having control power over women predispose adolescent women to rape (Cherry and Hategekimana, 2013)

2.4.1.3 Exposure to child maltreatment

Child maltreatment is one factor consistently identified across countries as a risk factor for both victimization and perpetration of intimate partner violence and sexual violence. Meta-analysis found that children who witness violence between their parents or more are 3times more likely to increase sexual violence towards women as they become adult (Abrahams and Jewkes, 2005; Jespersen, Lalumiere and Seto, 2009). A number of primary studies in Low Middle Income Countries found that childhood exposure to violence (particularly intra-parental violence and sexual abuse) was positively associated with the experiencing of intimate partner violence and sexual violence by females (Martin, Taft and Resick, 2007; Söchting, Fairbrother and Koch, 2004 and Vung and Krantz, 2009). Such exposure to violence during childhood may increase the likelihood of violence acceptance either as a victim or perpetrator in future partnerships and high-risk situations.

2.4.1.4 Exposure to sexual and violent materials

Media consumption of sex related materials may increase the sexual behavior and attitude of perpetrators and non perpetrators. Violent pornography saw in television, music, games and online exposes young people to sexual risky behavior including sex, kissing, fondling and physically hurting another person while having sex (Tolman *et al.*,2007; Chandra, Martino and Collins, 2008 ; Brown, Butchart and Meddings, 2009).

In correlation, Ybarra and Mitchell, (2013)suggest a clear association between consumption of sex rated materials and penetration of broad range of sexually violent behaviors including those who have seen sex movies in their friends house or theirs, read about sex on magazine and gone to adult website or online where the main topic is about sex. Whereas, perpetration of any sexual violence, forced sexual violence and coercive sexual violence through exposure to sex rated materials were

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

reported to be non-violence forced sex 11.0%, with violence 6.0% and coercive sex but non violent 11.0% and coercive sex with non-violence to be 9.0% respectively.

In other hand, 3.0% of the key informants strongly believed that high exposure to pornography materials, through television and other written materials, increases the degree of child sexual abuse in the society. They added that pornography negatively affects moral values (Okello-Wengi, 2005).

2.4.1.5 Alcoholism

According to Pilgrim*et al.*, (2012), Lawyer*et al.*,(2010) and Esere *et al.*, (2009) suggested that there was a relationship between excessive alcohol use and sexual victimization and re-victimization of an individual by moderating the behaviour of a person. Studies revealed that, alcohol has different effect on girl victims by making them submissive first, weak and less able to resist sex while in boys or perpetrators, it makes them loud and courageous (Van-Decraen *et al.*,2012). On the other hand, gang rapes are committed usually when the perpetrators are drunk (Jewkes *et al.*, 2011).

However, the findings in Elwood *et al.*, (2011) were contradictory with the above research findings about alcoholism and rape posited that it is substance abuse that increases a women's risk of sexual victimization not alcohol. Moreover, the fact that alcohol use is socially acceptable at some levels; thus it is possible that subjective ratings of alcohol problems by participants are less accurate than those of drug problems. That may be the reason why the study's findings suggested that family substance or drug abuse predispose a person to rape (Elwood*et al.*, 2011; Esere *et al.*,2009). In a recent study identified that out of 137(26.3%) takes alcohol and 99(19.0%) of the respondents usually hawk after leaving school. Seventeen (3.3%) usually attend night parties while 15(21.7%) had sexual intercourse at night parties (Olugbenga- Bello, Adebimpe and Abodunrin, 2009).

2.4.1.6 Drug use

According to Adudans *et al.*,(2011) as suggested in Young, Furman and Jones, (2012) and Seto *et al.*,(2010) individual drug use predisposes a person to rape as the individual might have friends or partners who use drugs making them vulnerable to rape, after an initial incident of rape, adolescent's risk of subsequent incidents of rape increase more and more. On the other hand, family drug use could influence adolescent rape as parental substance use maybe associated with less supervision, exposure to dangerous situations and poor development of social and coping skills.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

2.4.1.7 Adolescents with internalizing factors

Young, Furman and Jones, (2012), in this study posited that adolescents who have less confidence in their ability to protect themselves are more vulnerable to rape thus, likely to suffer internalizing symptoms of distress such as low self-esteem, feelings of sadness or hopelessness, depression and anxiety. Generally, rape experience is associated with greater possibility of antisocial behaviour and more frequent sexual behaviors are in turn at greater probability of engaging in risky sexual behaviour (Adudans *et al.*, 2011 and Seto *et al.*, 2010).

2.4.2 Family factor

2.4.2.1 Family history, parental education and type of parental care

In a study conducted in south western Nigeria, Abu and Akerele, (2006) found variables like family history, low or no parental education and type of parental care could affect sexual behaviour of adolescents. They further stated that if teens feel parental support, feel a connection to their parents and are rightly supervised by them, they are less likely to have early sexual exposure and become pregnant. They also observed that many parents subject their adolescents children especially females to child labour and make them hawk in market places, street and motor parks in a bid for living. This exposure may increase the vulnerability of adolescents to victimization or perpetration of sexual abuse from older males.

Owuamanam and Bankole, (2013) found that, owing to a consistent breakdown of the family unit, that there is a decrease in parent/adolescent communication and time sharing which results in lack of sex education within the home. Also, families who spend a quality amount of leisure time together with their children were at lower risk for delinquency and sexual violence than those whose families spend little time together (West and Farrington, 1977). In general, lack of family interaction and involvement in children's lives seems to add to the risks for future delinquency and violence.

2.4.2.2 Family disharmony

Rape can occur in any kind of family, it is clear that prevalence rates are much higher in disorganized families. These families are more likely to contain children with low self-esteem reflecting prior emotional and physical abuse. Approximately only 10% of the key informants indicate that these children are less likely to resist sexual advances by a family member or someone

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

outside the family who offers them sex in exchange for emotional attachment (Okello-Wengi, 2005).

2.4.2.3 Family honour and sexual purity

According to Jewkes, Sen and Garcia-Moreno, (2002) identified that families who concentrate more on restoring lost honour associated with rape often blame women without punishing men. Thereby creating an environment in which rape can occur with impunity. In the other hand, such families will always try to protect their women from rape and probably put their daughters on contraception to prevent visible signs should rape occur, in this sense the social pressure to control young men or persuade them that coercive sex is wrong is rare. While, in some countries, family members are often supported to do whatever is necessary including murder of the victim to reduce the "shame" associated with a rape or other sexual transgression.

2.4.3 Community-level Factor

2.4.3.1 Poverty and Economic Factor

High prevalence of rape has been linked to high level of poverty especially in Sub-Saharan African countries where parents encourage children in to labour in order to improve the standard of living of the household. For example, some families go to the extent of surrendering their children for sexual abuse in return for basic commodities like sugar, milk, telephone and sometimes a monthly stipend. Studies have shown that more than 51.0% of the population in Sub-Saharan Africa live below the international poverty threshold of US$1.25 per day (UNDP, 2009).

Furthermore, is a study involving 24 countries in Sub-Saharan Africa, sexual exploitation was noted to be on the rise and was linked to labour, child prostitution, sex tourism, and the production of pornography (Malow, Devieux and Lucenko, 2006). However, the scale of prevailing poverty renders children vulnerable to working on the streets being to sexual abuse from many individuals, including from passers-by and in some cases from those who offer them shelter (Mandalazi, Banda and Umar, 2013)

2.4.3.2 Weak community sanctions against rape

There are considerable variations between countries in their approach to sexual violence legislation. Various factors operate largely at local level (within families, schools, workplaces and

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

communities) there are also influences from the laws and norms working at national and even international level. Some countries have legal procedures, for perpetrators and strong response in supporting victims However, even in countries with the best law; the conviction rate for sexual violence is minimal.

On the other hand, there are countries with much weaker approaches to sexual violence including rape where conviction of an alleged perpetrator on the evidence of the woman alone is not allowed, where certain forms or settings of sexual violence are specifically excluded from the legal definition, and where rape victims are strongly deterred from bringing the matter to court through the fear of being punished for filing an "unproven" rape case (Jewkes, Sen and Garcia-Moreno, 2002).

2.4.4 Societal level-factor

2.4.4.1 Race

Adudans *et al.*, (2011) suggested that most rape cases are found among African population because of gender inequality. Similarly findings suggested that African American adolescents reported higher rates of sexual abuse by a parent or caregiver than Caucasians, but this finding became non-significant when income and parent education were included (Elwood *et al.*, 2011).

2.4.4.2 Male dominance

Lalor, (2004) posited that nature has given men a physical advantage over women and some use it to make women succumb to their will forcefully by engaging them in forcible sexual intercourse. The patriarchal structure and ideas of the society have continued to restrict women's opportunities and favoured men to maintain the position of power in the society (Crittenden and Wright, 2013) The direction of much of this violence towards women and girls might be explained by sex inequalities, a culture of male sexual entitlement, and the climate of relative impunity for rape (Jewkes, Sen and Garcia-Moreno, 2002).

Male dominance nature is particularly common to African male which makes women and girls in Africa vulnerable to and experience gender based violence on a large scale (Borwanka, Diallo and Sommerfelt, 2008). The increased acceptance of this nature has effect on the socio-economic hardships and limit women's power within relationships and in some instances lead to reduced

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

ability to engage in safe sexual practices (Kennedy *et al*., 2012). It is also within this context that child sexual abuse leads to situations where it is seen as normal and what can be expected by some.

2.4.5 RELATIONSHIP FACTOR

2.4.5.1 Multiple partners

According to Bramsen *et al.*, (2012) reported that in Denmark, the number of sexual partners one has can predispose a person to first time peer on peer rape. Rape can be used as a weapon of war (Cherry and Hategekimana 2013). In correlation with a study by Pilgrim *et al.*, (2012) sexual coercion among girls was high in girls who reported multiple partners. Several studies reported a strong association between women's perceived multiple sexual partner and sexual violence (Chan, 2009; Dalal, Rahman and Jansson, 2009; Johnson and Das, 2009; Tang and Lai, 2008 and Vung and Krantz, 2009).

2.4.6 The setting of rape incident

For many adolescents setting where sexual violence is experienced more is in school. The research done in Africa, identified the role of teachers in facilitating or perpetrating sexual coercion in return for good grades or for not failing pupils, in the Democratic Republic of the Congo, Ghana, Nigeria, Somalia, South Africa, Sudan, Zambia and Zimbabwe (Omaar and de Waal, 1994).Studies suggest that environments such as schools, colleges, homes, and bars to mention a few are favorable environments for sexual abuse and rape and that rape can occur to anyone and anywhere (Krivoshey *et al.*, 2013 and Lawyer *et al.*, 2010).

2.5 Preparedness level towards rape prevention.

Preparedness to rape prevention in this study is the willingness of in-school adolescents to undergo education and life skills strategies to prevent rape victimization or penetration. Prevention efforts that address these common factor have been developed, adopted and tested to work in developed countries thus, less discussed in developing countries (Cummings, 1992; Brecklin and Ullman, 2005; Hollander, 2014 and Sarnquist *et al.*, 2014). However, little or no studies have been conducted in the area of preparedness to rape prevention.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Also, very minimal efforts have been made, especially in rural settings to address adolescent sexual and reproductive health concerns, or to provide the required sexual and reproductive health services (Abiodun*et al.*,2016). There is also an imbalance in programmes focusing on community and societal strategies compared with programmes addressing individual and relationship factors. It is therefore important to identify the preparedness level of adolescents to rape prevention in rural setting in order to develop or adapt, test and evaluate many more prevention programmes in developing countries, and to discover what does and does not work in a much wider range of settings or environment (WHO, 2010).

2.5.1 Public health approach to primary prevention of rape

A public health approach to primary prevention of sexual violence including rape is perhaps the most important. The ability to identify underlying causes rather than focusing upon more visible "symptoms" (the secondary and tertiary prevention). This allows for the development and testing of effective approaches to address the underlying causes and so improve health. These strategies include school based programs to prevent dating violence, rape awareness and knowledge programmes for school and colleges, education as opposed to skill training on self defense strategies for schools and rape prevention programmes.

2.5.2 Rape awareness

Anderson and Whiston, (2005) evaluated 69 education programmes for college students on sexual assault, and found little evidence of the effectiveness of such programmes in preventing such assaults, or in increasing levels of rape empathy or awareness. However, the programmes examined were found to increase basic knowledge about rape and to beneficially change attitudes towards it.

The limitation to this study included use of behaviour as measure of outcome only which led the authors to conclude that more research using such outcomes was needed before definitive conclusions could be reached. However, evaluation studies indicate that rape awareness and knowledge programmes based on imparting such information rarely work (Schewe, 2007).

2.5.3 Self defense strategies

Breitenbecher and Scarce, (2001) posited that educating women on effective self-defense strategies with teaching them actual self-defense skills has been found to be effective. In corroboration with this study is an intervention carried out among in-school female adolescents in Nairobi upon

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

enrollment prevalence of sexual assault is 22.9%. However, the intervention measured the effect of empowerment and self defense skill to have reduced from a prevalence of 17.9% to 11.1% at follow up (Sarnquist *et al.*, 2014).

Study reported that 52.3% stopped perpetrator from forcing them to have sex using skills learned in the intervention, 45.4% of the adolescents used only verbal skills, such as yelling to attract attention, and 29.2% escalated their strategies to include both physical and verbal skills in warding off a perpetrator. Only 25.3% primarily used physical skills to avoid assault. Adolescents who underwent training in assault prevention strategies were more able to protect themselves from sexual assault and harassment, and more likely to disclose assaults that did take place, than those who did not receive training. Similarly, Ullman and Knight, (1993), identified that women who fought back forcefully are less likely to experience rape or other sexual assault. Although, number of other approaches have been tried for which there is presently very limited evidence of effectiveness.

2.5.4 Educating young people

Educating young women on how to avoid high-risk situations such as hitchhiking, abusing alcohol or becoming involved with older men has also led to mixed results and it has been associated with greater acceptance of rape myths. To avoid the encouragement of victim-blaming, it is fundamental that such education is delivered to female-only audiences. Similar, programmes in United States identified the effectiveness of this program on school and college populations. In the real sense, it is paramount to educate young people on appropriate and inappropriate sexual behaviour at a time when their sexual identities are forming and their attitudes to romantic partners are beginning to take shape (Schewe, 2007).

2.5.5 Bystander Intervention

Bystander Intervention is one of the more recently developed strategies consistently identified in developed countries as a means for educating adolescents about sexual assault. This strategy, addresses audience members not as potential perpetrators or victims of sexual assault but as bystanders. This approach teaches students how to support a friend or loved one who discloses sexual assault and instructs students how to confront friends who express sexist attitudes and how they can potentially intervene with friends in risky situations. (For example, at a party where a friend has had too much to drink)

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

The implied goal of these rape-prevention programs is to change participants' attitudes, beliefs, and behaviors regarding sexual assault. Foubert, (2000) and Coker *et al*., (2011) documented positive changes in rape myths and likelihood of raping among college fraternity members. Similarly, Schewe, (2004) posited positive outcomes for rape prevention were more associated with students discussing how to help who has been assaulted.

2.5.6 Media awareness campaigns

Media campaign is a common strategy to primary prevention of intimate partner and sexual violence. Campaign is aimed at raising public awareness (i.e., about the magnitude of the problem, about intimate partner violence and sexual violence as violations of women's human rights and about men's role in ending violence against women); providing accurate information; dispelling myths and stereotypes about intimate partner violence and sexual violence; and changing public opinion. Such campaigns have the potential to reach large numbers of people (WHO, 2010). An example is a Soul-city media awareness programme in South Africa, a multi-level intervention was developed in collaboration with National coalition for over six months in order to prevent sexual violence.

The approach aimed for impact at multiple levels from individual knowledge, attitudes, self-efficacy and behaviour; to community dialogue, shifting social norms and the creating of an enabling legal and social environment for change. The project combined with other educational opportunities emerges change in knowledge, attitudes and beliefs related to intimate partner and sexual violence. In the other hand, good campaigns can increase knowledge and awareness, influence perceptions and attitudes and foster political will for action, evidence of their effectiveness in changing behaviour remains insufficient (Whitaker, Baker and Arias, 2007)

2.5.7 Other consideration

2.5.7.1 Communication, assertiveness and limit setting

The construct of communication skills has been included along with other interventions in at least three different rape-prevention programs that have been evaluated and published. Each of these programs has indicated some level of success in changing knowledge and attitudes (Foubert and McEwen, 1998; Proto-Campise, Belknap and Wooldredge, 1998). In addition, addressing healthy relationship skills, a construct that might include communication skills and problem-solving skills,

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

was positively associated with successful outcomes in Schewe's (2004) evaluation of 29 sexual assault prevention programs. Likewise, Assertiveness interventions such as saying affirmative 'NO' on verbal consent practices may be useful for addressing this form of assault (Jozkowski and Peterson, 2013;Jozkowski *et al.*,2014).

2.5.7.2 Avoidance of High-Risk Situations

Early research identified high-risk Muehlenhard and Linton, (1987) and Ullman, (1997) posited that educating women on high-risk situations for sexual assault e.g. use of alcohol, hitchhiking, attending parties, dating in isolated locations, being involved with older men important part of efforts to reduce the incidence of rape among program participants. Gray *et al.*, (1990) and Hanson and Gidycz, (1993) was able to successfully increase women's perceptions of their vulnerability to rape and increase their intentions to avoid risk-taking behavior through risk-reduction program.

2.5.7.3 Using Multiple, Interactive Presentation Methods

Heppner *et al*., (1995) compared a standard video and lecture presentation to an interactive drama and found that students in the interactive drama program were moremotivated to hear the message, were more able to recognize consent and coercion, and were more likely to demonstrate behavioral changes.Schewe's (2004) evaluation outcome of sexual assault prevention programs showed more positive outcomes than lectures, videos, and drama. For effective learning to take place among students, educators should use several presentation methods. It enhances students' memory for information when they hear it, see it, write it, read it, speak it, and do it.

Lastly, several programmes for preventing sexual violence have been proposed that have as yet been neither widely implemented nor evaluated. These include providing universal rape prevention education, and parent education in sexual violence prevention, throughout schools and workplaces; educating teachers and coaches about sexual violence and its prevention; and changing organizational practices to include activities such as mandatory training in the prevention of violence against women (WHO, 2010).

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

2.6 Conceptual framework for predisposing factors and level of preparedness to rape prevention.

The Health Belief Model

The health belief model represents how health is affected by various factors. In this study, the factor considered is predisposing factors and level of preparedness among in-school female adolescents on rape prevention in Ose Local Government Area, Ondo State. According to this model, "the likelihood of taking action is a function of the interaction between perceived vulnerability, the perceived seriousness of the threat, and the individuals' beliefs that they can be successful in overcoming the threat" (Gidycz *et al*., 2001). Programs designed for women have focused on creating scripts for women to follow when they are in threatening situations, teaching women that they are strong and capable, as well as teaching them physical maneuvers to defend themselves. These steps follow the Health Belief Model. This model was beneficial when examining women's own reports concerning their experiences with sexual assault and their participation in prevention programming.

The Health Belief Model is based on the following six constructs

- **Perceived Susceptibility**: This involves beliefs about the chances of getting raped. For example, it is the in-school female adolescents opinion of their risk to getting raped that motivates them not to practice multiple boyfriends or get drunk at party.
- **Perceived Severity**: Beliefs about the health consequences of rape.For example, their views on question like "Rape cannot make one have HIV/STI".
- **Perceived benefits:** Beliefs about the effectiveness of taking actions to reduce the risk or seriousness of rape. It is of the in-school female adolescents opinion of the advantages of adopting a healthy lifestyle that will make them take actions to prevent rape.
- **Perceived Barriers**: Beliefs about the material and psychological cost of taking action to prevent the occurrence of rape. It is the in-school female adolescents opinion on these materials and psychological factor that can discourage or hinder the adoption of life skill strategy
- **Cues to action:** These are external factors such as related information from media, promoting the desired behavior to prevent rape occurrences. The external influencer

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

activates readiness to and also triggers behavioral change in individuals in making decisions to prevent rape.

- **Self- efficacy:** Confidence in the ability of the in-school female adolescents to engage in activities that will help prevent incidence of rape. Self efficacy is achieved when perceived benefit outweighs perceived barriers.

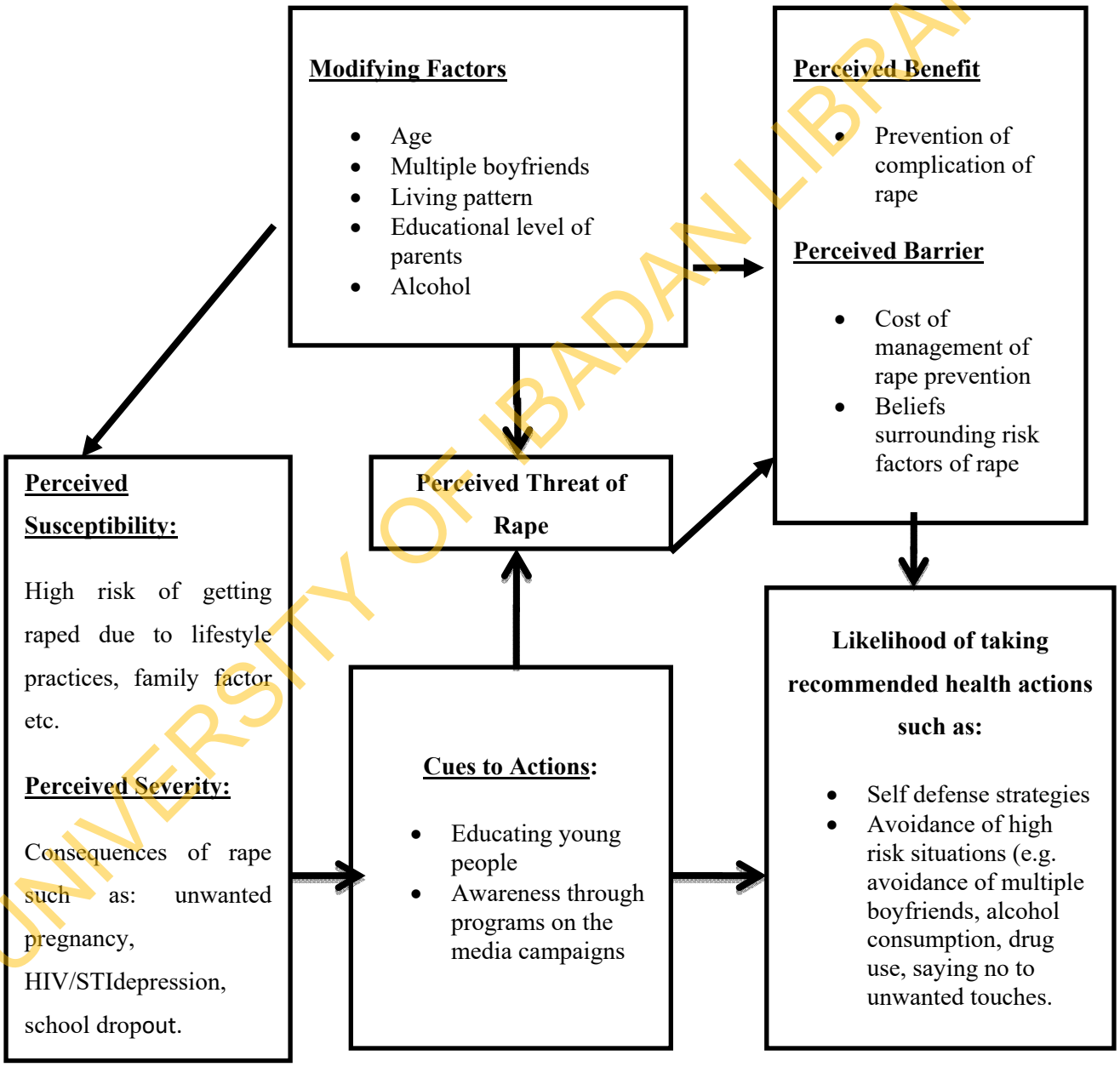


Figure 2.1: The Diagrammatic Application of the Health Belief Model to the study.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER THREE

METHODOLOGY

3.1 Research design

For this study, the researcher used both quantitative and qualitative descriptive study in determining the predisposing factors and level of preparedness on rape prevention among in-school female adolescents aged between 10-19 years in Ose Local Government Area.

3.2 Scope of study

This study was conducted in Ose Local Government Area based on the prevalence of rape among adolescents. This study consisted of seven public Secondary Schools. Junior and Senior Secondary School female adolescents were considered for the study because they fall between the age brackets of 10 to 19 years which is needed for the study.

3.3 Description of the study area

Ose is a Local Government Area (OseLGA) in Ondo State. It has an area of 1,465 km² and density of 132.8/km^2. Population of 144,139 at the 2006 census projected to be 194,600 in 2016 at an annual growth rate of 3.05% per annum. Geographical coordinates of Ose LGA is at latitude 7° 3' 17.8"(7.055°) north and longitude 5° 44' 35.9"(5.7433°) east. It consists of twelve administrative wards namely Ekamarun district (Okeluse, Ijagba, Umoru, Ute,Ikaro,Arimogija, Ifon), in the north and the Irekari district(Idoani, Idogun, Afo, Imeri) in the south.

The major language of this region is Yoruba while the major activity is cocoa and plantain farming Educational institution in Ose LGA includes 40 private primary schools,9 private secondary schools, 54 public primary schools and 24 public secondary schools. The schools in Ose LGA are coeducational. Medical and health establishment in the LGA includes 1 general hospital, 2 private hospital, 4 comprehensive health centres, 9 basic health centres, 1 private clinic, 3 maternity and 3 health post. There are 3 post offices and 12 Hotels. Judicial and corrective institution present is 1 high court, 2 magistrates and 3 customary courts.Ose River is one of the prominent rivers in Ondo State that formed natural boundaries between Owo and other neighboring local governments.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3.4 Study population

The target population for this study wasin-school female that fall within the age bracket of 10-19years. The number of adolescents within 10-19years is 34,744; Junior and Secondary students are usually all within the adolescent age group. Enrolment in public secondary schools in Ose LGA indicated that the percentage of male to female in secondary schools is high. However, the number of public junior and senior secondary schools in Ose LGA is 24.Femalein JSS1-SSS3is (3040) respectively(Ministry of Economic Planning and Budget, 2010).

3.5 Sample size determination

In a study conducted on rape prevention through empowerment in Nairobi among in-school female adolescent upon enrollment the sexual assault prevalence was 22.9% in the intervention group and 19.5% in the standard-of-care (SOC) group. Annual sexual assault rate in all the neighborhoods combined decreased from 17.9/100 person-years at baseline to 11.1 at follow-up (Sarnquist *et al.*, 2014). The sample size for this study was determined using (Cochran, 1977) formula.

$$n = \frac{Z^2 pq}{d^2}$$

Where n is the sample size

P = 22.9% q = 1 – P

d is the margin of sample error tolerated in percentage (5%being the maximum accepted value)

Z=1.96 P= 22.9%= 0.229(Sarnquist *et al.*, 2014) q= 1-p= 1-0.229= 0.771

$$n = \frac{1.96^2 \times 0.229 \times 0.77}{0.05^2}$$

n= 271

For a non- response

$$n_{adj} = \frac{n}{1-p}$$

Where p=10%

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

n_{adj}= 301.11 approximately 301.

A total of 301 questionnaires were administered but 295students responded for the study.

3.6 Sampling procedure

A multi stage sampling technique was employed to select students from the schools. Ose LGA is divided into two (2) districts. The number of public secondary schools in Ose LGA is 24 and a total of 3040 female secondary students.

Stage 1**:** Ose LGA was divided into two districts based on availability of at least a secondary school in each district. Selection of schools from public secondary schools across each district was done using balloting to make a total of seven (7)public secondary schools.

Stage 2: Proportionate allocation was used to determine the number of female participants needed in each school.

$$\text{No. of participants in School A} = \frac{\text{No of Female students in School A}}{\text{Total female students in public secondary schools in Ose LGA}} \times sample\ size$$

Stage 3**:**Systematic random sampling was used to determine the number of participant from each class.

$$\text{Class A} = \frac{\text{No. of female student in each class}}{\text{No. of participants in School A}}$$

Stage 4**:** Simple random sampling through balloting with replacement was used to select the required number of students from the selected schools.

3.7 Methods and instrument for data collection

Quantitative data

Quantitative data was collected through the use of interviewer administered questionnaire. The interviewer administered questionnaire was prepared based on the objectives of the study. Semi structured questionnaire (quantitative data)·the instrument for quantitative data collection was pretested among in-school female adolescents in Akure North. It consisted of a combination of open and closed ended questions. The semi structured questionnaire was divided into 5 sections.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

a. Socio demographic character (Age, Class, Living pattern)
b. Knowledge about rape, sexual experiences and consequences
c. Perception about rape
d. Predisposing factors to rape
e. Level of preparedness to rape prevention

Qualitative data

In-depth interview was conducted for respondents that indicated rape experience (attempted or completed rape) in their questionnaire. Questions were framed to give insight into preparedness to rape prevention.

3.8 Recruitment of Research assistant

Three female research assistants was recruited and trained. The training focused on the objectives of the study, sampling process, interviewing skills, and ethical issues that should be taken into consideration during the study.

3.9 Validity and Reliability of instrument

The content validity of the instrument was established through judgment of experts and lecturers in the Faculty of Public Health. The instrument was given to them to justify the validity of the content in terms of clarity, appropriateness of the language and ability to elicit the accurate information for the attainment of the stated objective. The results were modified based on the inputs.

The reliability of the instrument was determined by pre-testing the instrument among in-school female adolescents in Akure North Local Government Area, Ondo state in Nigeria. Copy of the study instrument was administered to thirty (30) respondents. After the pre-test, the data gathered were checked for errors and completeness. Each questionnaire was numbered for easy recall and a coding guide was prepared to facilitate entry of the data into the computer software. The data were then subjected to descriptive statistics which were basically frequencies. The reliability coefficient was placed on Cronbach Alpha of not less than 0.5.Following the pre-test, the instrument was reviewed and ambiguous questions were removed. Also, questions considered by the respondents as not clear were either removed or revised. Chi square analysis was used to test the hypotheses stated. A p-value of less than 0.05 was considered to be statistically significant.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

The knowledge of respondents was determined and their knowledge scores categorized as poor, fair or good. A 20-point knowledge scale was used to facilitate the assessment of their knowledge, where scores of (0 -<50 percentile) i.e. (<10 points) were grouped as poor, (50 -<75 percentile) i.e. scores of (10 -15 points) were grouped as fair and 75 percentile and above i.e. scores of (>15 points) were grouped as good knowledge. Perception scores were categorized as negative, moderate or good. A 16- point perception scale was used to facilitate the assessment of their perception. (0 – <50percentile) i.e. (0-5 points) was categorized negative, (50 -<75 percentile) i.e. scores of (>5 -10 points) was categorized as moderate and 75percentile and above was categorized (>10 points) good. The respondents' level of preparedness score was categorized as low, moderate or high. A 10-point scale was used to facilitate the assessment of their level of preparedness to rape prevention, where scores of (0 -<50 percentile) i.e. (0-3 points) were grouped as low, (50 -<75 percentile) i.e. scores of (>3 -7 points) were grouped as moderate and 75 percentile and above i.e. scores of (>7 points) were grouped as good. The data are presented in tables in chapter 4.

3.10 Data collection procedure

The data was collected by the researcher and with the help of three (3) female research assistants who were trained prior to the administration of the questionnaire. The participants were met in their various classes and the researcher provided correct and understandable information to them about the research. This was necessary in order to obtain informed consent from every participant. The informed consent forms (attached to the questionnaire) were distributed to the research participants after they have known about the study. After the copies of the questionnaire had been filled, the researcher checked for completeness and errors before leaving the location of data collection.

3.11 Data management and analysis

Serial numbers were written on the copies of the questionnaire for easy entry and recall. A coding guide was developed along with the data collection tool in order to facilitate its analysis. Statistical Package for Social Sciences (SPSS) version 21 was used to analyze the data obtained from the questionnaire. Using the coding guide, the data collected were carefully entered into the statistical software and analyzed using descriptive statistics such as frequency, mean and inferential statistics such as Chi-square test to measure significant difference among different variables of interest. The results obtained from the SPSS analysis was summarized and presented in tables.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3.12 Procedure for Thematic Analysis of Qualitative study

The anonymity of participant in the discussion was protected in the report. The In-depth interview was tape recorded and transcribed and went through several phases of analyses. A preliminary analysis was conducted in order to get a general sense of the data and reflect on its meaning. The responses from the In-depth interview were grouped together, coded and analysed according to the objectives of the study. The findings were described, interpreted and reported in narrative form.

3.13 Ethical considerations

Ethical approval was sought from Ondo State Health Research Ethics Committee (OSHREC) Ministry of Health. The study followed the ethical principles guiding the handling of human participant in research:

- The principle of respect for persons: The participants was treated as an autonomous person; therefore the participants can decide to voluntarily take part in this study
- The principle of justice
- The principle of beneficence: This study ensured that no harm is done to the participants rather the benefits will be highly maximized
- The principle of non- maleficence: No harm was done to the participants regardless of the benefits that may follow this study.

Prior orientation of participants was carried out regarding objectives and possible impact of the study, emphasizing the right of the subject to non-participation. Adequate information about the research was given to the research participants with a form requesting for their informed consent, which was treated formally and were adequately informed that they could withdraw from the research at any point in the research with all information given being used for the purpose of the research only.

3.14 Inclusion criteria

Inclusion criteria for the study was that the participant;

- Must be a resident of Ose LGA
- Must be a female adolescent between 10-19years
- Must be attending a public secondary school in Ose LGA

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3.15 Limitation of the study

Due to the sensitive nature of the study, the female adolescents were not free to disclose information about their sexual experiences. However, respondents were assured of non disclosure of identifier and confidentiality in all information provided.

There was limited time for the researcher to conduct the in-depth interview for those who identified to have experienced forced rape. However, the researcher pleaded with the school authority for more time and some granted her while some did not. There was a language barrier in communication; this was resolved by translating the questionnaire to Yoruba.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER FOUR

RESULTS

4.1 Respondents' socio-demographic characteristics

The study focused mainly on the predisposing factors and level of preparedness to rape prevention among in-school female adolescents from JSS1 to SSS3 aged 10 to 19 years as depicted in Table 4.1a. Out of 301 that were enrolled for this study, 295 (98.0%) participated by returning the questionnaire. The mean age of the participants was 14.2±1.9years.

Most of the participants (94.6%) were Christians and 75.9% were Yoruba. Majority of the participant (95.3%) were single and 66.4% were living with both parents. More than half of the respondents' mother (50.8%) had secondary school education while 47.1% of the respondents' father had secondary school education. Major occupation of the participants parents were farming and trading as followed respectively (49.8%, 53.6%). About 95.9% of the respondents' father had one to three wives while 59.0% of the respondents' family had one to five children.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.1a: Respondents'socio-demographic characteristics (N=295)

Socio-demographic variables	Frequency	Percent
Level of education		
JSS1	31	10.5
JSS2	48	16.3
JSS3	59	20.1
SSS1	56	19.0
SSS2	51	17.3
SSS3	50	16.9
Age group		
10-14	167	56.6
15-19	128	43.9
Mean age=14.2± 1.9		
Religion		
Christian	279	94.6
Muslim	15	5.1
Traditional	1	0.3
Ethnic group		
Yoruba	224	75.9
Igbo	29	9.8
Hausa	2	0.7
Others*	40	13.5
Marital status		
Single	281	95.3
Already had a boyfriend	14	4.7
Living pattern		
Both parent	196	66.4
Father alone	14	4.7
Mother alone	58	19.7
Relative	7	2.4
Grandparent	12	4.1
Guardian	8	2.7

**Other tribes: Kogi (13), Idoma (1), Delta (16), Edo (8), Irobo(2)*

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Table 4.1b: Socio-demographic characteristics of Respondents (N=295)

Socio-demographic variables	Frequency	Percent
Father's level of education		
No formal education	30	10.2
Primary education	31	10.5
Secondary education	139	47.1
Vocational education	45	15.3
Tertiary education	50	16.9
Mother's level of education		
No formal education	33	11.2
Primary education	35	11.9
Secondary education	150	50.8
Vocational education	46	15.6
Tertiary education	31	10.5
Father's occupation		
Civil servant	35	11.9
Trading	57	19.3
Artisan	50	16.9
Farming	147	49.8
Professional	6	2.0
Mother's occupation		
Civil servant	18	6.1
Trading	158	53.6
Artisan	28	9.5
Farming	65	22.0
Housewife	26	8.8
No of wife father has		
1-3	283	95.9
4-6	12	4.1
No of children family has		
1-5	174	59.0
6-10	104	35.3
≥11-15	17	5.8

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.2 Respondents' knowledge of rape

Table 4.2.1, shows that 54.2% truthfully accepted that rape is a forceful sexual intercourse between one's partner while 23.7% accepted that rape is a sexual intercourse under coercion, 82.4% supported that girls are vulnerable victims to rape, 34.2% had no idea of what age a girl can be raped, 1.4% established that a girl can be raped at 0-5years while 13.2% supported that a girl can be raped at any age. Also, 80% of the girls supported that rape can occur anywhere and 61.7% acknowledged that the perpetrator could be anybody. Majority of the students (96.6%) honestly supported that rape can cause to unwanted pregnancy followed by vaginal bleeding 94.6% and marriage 66.4%. This implies that most students (55.6%) show good knowledge of rape (Table 4.2.2).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.2.1a: Respondents' Knowledge of rape (N=295)

Knowledge of rape variables	Frequency	Percentage
Meaning of rape		
Forceful sexual intercourse without consent of one's partner	160	54.2
Sexual intercourse between an adult male and a female below 16years	11	3.7
Sexual intercourse between an adult female and a male below 16years	4	1.4
Sexual intercourse under coercion	15	5.1
All of the above	70	23.7
None of the above	35	11.9
Who can be raped		
Baby	10	3.4
Girl	243	82.4
Boy	13	4.4
I don't know	29	9.8
At what age can a girl be raped		
0-5years	4	1.4
6-10years	34	11.5
11-15years	62	21.0
16-19years	55	18.6
I don't know	101	34.2
At any age	39	13.2

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.2.1b: Respondents' Knowledge of rape cont'd. (N=295)

Knowledge of rape variables	Frequency	Percentage
Where can a girl be raped		
Home	16	5.4
School	19	6.4
Neighbors' house	19	6.4
Relatives house	5	1.7
Anywhere	236	80.0*
Who can rape a girl		
Boyfriend	49	16.6
Father	3	1.0
Male stranger	49	16.6
Neighbour	2	0.7
Step father	3	1.0
Houseboy	4	1.4
Houseboy	4	1.4
Uncle	3	1.0
Anybody	182	61.7*
Consequences of rape		
Unwanted pregnancy	285	96.6*
Suicidal attempt	254	86.1*
Vaginal bleeding	279	94.6*
Death	268	90.8*
Marriage	196	66.4*
Mental problem	202	68.5*
Depression	240	81.4*

**Correct responses*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.2.2: Respondents' overall knowledge score of rape (N= 295)

Knowledge score	Frequency	Percent
Poor(<10)	14	4.7
Fair(10-15)	117	39.7
Good(>15)	164	55.6
Total	**295**	**100.0**

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Respondents' sexual experiences

Table 4.2.3a shows that, few of the participants (12.5%) reported to have boyfriend while 89.2% had one boyfriend and 10.8% had more than one boyfriend. 10.2% of the girls reported to have had sexual intercourse before at varied ages respectively 0-8years (6.7%), 9-13years (50.0%) and 14-19years (40.0%).

Few of the participants (16.0%) reported to have experienced forced sexual intercourse, 33.3% based on willingness, and 3.3% based on peer pressure and 3.3% based on engagement in marriage. Majority of them who reported their first sexual experience as been forced knew their perpetrators. Few of the respondents reported that 27.8% of the perpetrators were brother, 22.2% were their boyfriends while 16.7% were Area brothers. Less than half of the respondents (44.4%) said they had forced sex at their house, 22.2% happened at their boyfriend's house and 16.7% occurred at Area brother's house as shown in (Table 4.2.3b).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.2.3a: Respondents' sexual experiences

Sexual Experiences of Respondents	Frequency	Percent
Have a boyfriend (N=295)		
Yes	37	12.5
No	258	87.5
How many boyfriend (n=37)		
1boyfriend	33	89.2
>1boyfriend	4	10.8
Ever/ had sexual intercourse		
Yes	30	10.2
No	265	87.5
Age had first sexual intercourse		
0-8years	2	6.7
9-13years	15	50.0
14-19years	13	43.3
Had sexual intercourse in the last six months		
Yes	12	40.0
No	18	60.0

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.2.3b: Respondents' Sexual Experiences

Sexual Experiences of Respondents	Frequency	Percent
Reason for starting sexual intercourse (n=30)		
Based on willingness	10	33.3
Peer pressure	1	3.3
Engagement in marriage	1	3.3
Forced sex	18	60.0
Ever been raped before		
Yes	18	6.1
No	277	93.9
Relationship with perpetrators (n=18)		
Relative	1	5.6
Brother	5	27.8
Area brother	3	16.7
Boyfriend	4	22.2
Neighbor	1	5.6
Driver	1	5.6
Brother's friend	1	5.6
Father	2	11.1
Places had forced sex		
Hotel room	1	5.6
Classroom	1	5.6
My house	8	44.4
Boyfriend's house	4	22.2
Area brother's house	3	16.7
In the bus	1	5.6

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.3 Respondents' perception of rape

Table 4.3.1 shows that 73.9% of the students agreed that wearing dresses that are revealing can cause rape while 71.2% disagree that collecting material things from boys cannot cause rape. Majority of the students 90.5% agreed that school dropout is a severe consequence of rape while 94.6% disagreed that rape cannot lead to HIV/STI. Also, 35.9% felt that rape prevention is too risky, 7.1% to be time wasting while 9.2% agreed that it is difficult to learn self-defense skills. More than half 54.9% of the students agreed that readiness to preparedness to rape prevention was that government should encourage mass media campaign while 69.2% were not in support that public enlightenment at schools, social clubs, churches and mosque of rape prevention should not be allowed This implies that many of the respondents (91.9%) had good perception of rape and preparedness to rape prevention (Table 4.3.2).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.3.1: Respondents' perception of rape (N=295)

Perception of rape	Agree (%)	Disagree (%)
Susceptibility on chances of getting raped		
Wearing dresses that are revealing can cause rape	218(73.9)	77(26.1)
Collecting material things from boys/men cannot cause rape	85(28.8)	210(71.2)
Severity of rape consequences		
Rape can lead to school drop out	267(90.5)	28(9.5)
Rape cannot lead to HIV/STI	16(5.4)	279(94.6)
Barrier to rape prevention		
It is risky	106(35.9)	189(64.1)
It is time wasting	21(7.1)	274(92.9)
It is difficult to learn self-defense skills	27(9.2)	268(90.8)
Factors that activate readiness to preparedness		
Government should encourage mass media campaign against rape	162(54.9)	133(45.1)
Public enlightenment at schools, social clubs, churches and mosque of rape prevention should not be allowed	91(30.8)	204(69.2)
Pre assault self-defense skills should be encouraged in schools	136(46.1)	159(53.9)

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.3.2: Respondents perception level of rape (N=295)

Perception level	Frequency	Percent
Negative (0-5)	11	3.7
Moderate(>5-10)	86	29.2
Good (>10)	198	67.1
Total	295	100.0

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.4 Predisposing factors of rape

Table 4.4 shows that 96.3% of the students supported the statement that having more than one boyfriend can predispose a female to rape while 93.9% of the participant agreed that girls who demand material things from boys can be predisposed to rape. Most of the participant (91.2%) supported the girls who are not firm to say no to unwanted touches from boys could be predispose to rape while 94.9% were of the opinion that girls who hawk for their parents can be vulnerable victims to rape.

Also, 94.9% agreed that watching of sex movies online or Television can influence a boy or man to rape a girl, 44.4% disagreed that watching of home video cannot make a boy rape a girl, 95.6% admitted that girls who drink too much at party can be vulnerable to rape while 77.6% admitted that walking a male friend home who had had too much to drink can be a predisposing factor to rape.

However, 79.3% of the participant supported that television programmes can increase awareness of rape prevention, 86.4% agreed that punishing offenders can reduce rape occurrence and 82.4% supported that parental care and advice can reduce rape occurrence.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.4: Respondents' predisposing factors to rape

Predisposing factors to rape	Frequency	Percent
Having more than one boyfriend	284	96.3
Girls who demand material things from boys/men	277	93.9
Girls who are not firm to say no to unwanted touches from boys	269	91.2
Girls who hawk to meet parental financial need	280	94.9
Television and radio programme can increase awareness of rape	234	79.3
Punishing offenders can reduce rape occurrence	255	86.4
Watching on sex movie online/ Television	284	96.3
Girls who drink too much at party	282	95.6
Friends who drink/use drugs can rape	275	93.2
Parental care and advice can reduce rape	243	82.4
Watching of home video can make a boy rape a girl	164	55.6
Walking a male friend home who had had too much to drink can cause rape	229	77.6

**Multiple responses*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.5 Level of preparedness to rape prevention

Majority of the respondents (90.8%) could do something in order to prevent rape occurrence. More than half of the respondents (63.4%) agreed that to be more aware of what is going on around them is a kind of prevention they could do to prevent rape occurrence, 58.2% would do more to intervene and help others in order to prevent rape occurrence, 78.7% supported that avoid walking alone in the dark, 77.6% would avoid drinking alcohol at party, 76.9% would say no to unwanted touches from boys or men to prevent rape occurrence, 77.6% would avoid multiple boyfriends while 47.0% would use self-defense skills (yelling or fighting back) to prevent rape occurrence (Table 4.5.1a).

However, few of the respondent (31.5%) had participated in some sexual prevention programme before where facilitated discussion was ranked the highest of what happened there followed by self-efficacy, boundaries and assertive communication, extensive physical and verbal techniques and role play as followed respectively (61.3%, 37.6%) as depicted in (Table 4.5.1b).

Some of the respondents (41.9%) received information about sexual violence from the progrmme, 43.0% received information on prevalence of sexual violence including own community, 31.2% received information on ways of helping others, 23.7% received information on increased confidence, 22.6% received information on having a plan of action, 17.2% received information on making a difference. Majority of the respondent (63.4%) learnt new things form the programme to be more aware of what is going on around me, 43.0% learnt to do more to intervene and help others while 34.4% learnt to have increased concern about sexual violence (Table 4.5.1c).

Few of the respondents (7.4%) believed that it is a shameful thing to stop rape from occurring, 18.5% believed that fighting back can lead to laying of ambush for rape to occur, 22.2% believed that they are too young to stop rape occurrence, 22.2% did not know what to do to stop rape while, 29.6% did not have the power to prevent rape from occurring (Table 4.5.2).

Although, many of the respondents (62.0%) had moderate level of preparedness towards rape prevention, 28.8 had poor level of preparedness towards rape while 9.2 had good knowledge on how to prevent rape occurrence (Table 4.5.3).

Majority of the respondents (91.9%) of the respondents thinks that rape prevention programmes should be conducted in secondary schools for girls. Many of the participants (93.7%) thinks pre

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

assault self-defense should be conducted in secondary schools for girls while 89.7% are willing to participate, 95.6% thinks rape awareness programmes should be conducted in secondary schools for girls while 93.0% are willing to participate, 91.9% thinks assertiveness training should be conducted for girls in secondary schools while 91.1% of the girls are willing to participate, 96.3% thinks public enlightenment should be conducted for girls in secondary school while 95.6% are willing to participate, 94.1% thinks bystander intervention should be conducted for girls in secondary while 92.6% are willing to participate, 97.0% thinks that media awareness programme should be conducted for girls in secondary school while 95.2% are willing to participate (Table 4.5.4).

Half the respondents (50.0%) feel that reason for not wanting to participate in rape prevention programmes is that it is risky, 37.5% are not interested while 12.5% feels they are too young to participate in rape prevention programme (Table 4.5.5).

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.1a: Respondents' ways of preventing rape (n=268)

Ways of preventing rape	Frequency	Percent
Be more aware of what is going on around me	170	63.4
Do more to intervene and help others	156	58.2
Avoid walking alone in the dark	211	78.7
Avoid drinking alcohol at party	208	77.6
Saying no to unwanted touches from boys/men	206	76.9
Avoid multiple boyfriends	208	77.6
Use of self-defense skills(yelling/fighting back)	126	47.0

**Multiple responses*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.1b: Activity that happened in the rape prevention programme(n=93)

Activity that happened in the programme	Frequency	Percent
Role play	22	23.7
Facilitated discussion	57	61.3
Self-efficacy, boundaries and assertive communication	35	37.6
Extensive physical and verbal techniques	25	26.9

**Multiple responses*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.1c: Kind of information received from the programme (n=93)

Kind of information received from the programme	Frequency	Percent
Statistics, law, definition of sexual violence	39	41.9
Prevalence of sexual violence including own community	40	43.0
Ways of helping others	29	31.2
Increased confidence	22	23.7
Having a plan of action	21	22.6
Making a difference	16	17.2
New things learnt from the programme		
Be more aware of what is going around me	59	63.4
Do more to intervene and help others	40	43.0
Have increased concern about sexual violence	32	34.4

**Multiple responses*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.2: Respondents' reasons for not being prepared for rape prevention (n=27)

Reasons for not being prepared for rape prevention	Frequency	Percent
Too young to stop rape occurrence	6	22.2
Fighting back can lead to laying of ambush for rape to occur	5	18.5
I do not have the power to prevent rape occurrence	8	29.6
It is a shameful thing to prevent rape occurrence	2	7.4
I don't know	6	22.2
Total	27	100.0

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.3: Respondents' level of preparedness to rape prevention (N=295)

Level of preparedness to rape prevention	Frequency	Percent
Low level of preparedness (0-3)	85	28.8
Moderate level of preparedness (>3-7)	183	62.0
High level of preparedness (>7)	27	9.2
Total	295	100.0

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.4: Respondents response to rape prevention programme to be conducted for girls in secondary schools and willingness to participate. (n=271)

Rape prevention programme to be conducted	Yes	%
Pre assault self-defense skills	254	93.7
Rape awareness programmes	259	95.6
Assertiveness training	249	91.9
Public enlightenment	261	96.3
Bystander intervention	255	94.1
Media awareness campaign	263	97.0
Willingness to participate		
Pre assault self-defense skills	243	89.7
Rape awareness programmes	252	93.0
Assertiveness training	247	91.1
Public enlightenment	259	95.6
Bystander intervention	251	92.6
Media awareness campaign	258	95.2

**multiple response*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.5.5: Reason for not wanting to participate in rape prevention programmes (n=24)

Reason for not wanting to participate in rape prevention programmes	Frequency	Percent
It is a risky prevention programme	12	50.0
I don't have interest	9	37.5
Too young to participate	3	12.5
Total	24	100.0

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4.6 Test of hypothesis

Hypothesis 1 stated that there is no significant association between participant's age and Level of Preparedness to rape prevention. Table 4.6.1 revealed that age of the recruited in-school female adolescents was not statistically significantly associated with their level of preparedness to rape prevention (p-value=0.845). This indicated that participants' age does not determine level of preparedness to rape prevention.

The second hypothesis postulated that there is no significant association between participant's level of knowledge and Level of Preparedness to rape prevention. Table 4.6.2 established that level of knowledge of the recruited in-school female adolescents was statistically significantly associated with their level of preparedness to rape prevention (p-value=0.000). This indicated that participants' level of knowledge determine level of preparedness to rape prevention.

Hypothesis 3 stated there is no significant association between predisposing factors to rape and Level of Preparedness to rape prevention. Table 4.6.3 shows the association between predisposing factors to rape and Level of Preparedness to rape prevention as thus;

Having more than one boyfriend (p-value=0.165), girls who demand material thing from boys/men (p-value=0.075), girls who are not firm to say no to unwanted touches from boys/men (p-value=0.225), girls who hawk to meet parent financial needs (p-value=0.28), Television and radio programmes can increase awareness of rape (p-value=0.737), punishing offenders can reduce rape occurrence (p-value=0.716), watching of sex movies on TV/online (p-value=1.000), girls who had much to drink at party (p-value=0.001), girls who drink/use drugs (p-value=0.055), parental care and advice can reduce rape (p-value = 0.318), watching of home video (p-value= 0.473), walking a male friend home from a party who had had too much to drink(p-value= 0.468)

This depicts that for this study only girls who had much to drink at party was significantly associated with level of preparedness (p-value=0.000) while all other factors are not statistically significantly associated with level of preparedness to rape prevention.

The fourth hypothesis postulated that there is no significant association between predisposing factors to rape and rape. Table 4.6.3 shows the association between predisposing factors to rape and rape as thus;

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Having more than one boyfriend (p-value=0.506), girls who demand material thing from boys/men (p-value=0.302), girls who are not firm to say no to unwanted touches from boys/men (p-value=1.000), girls who hawk to meet parent financial needs (p-value=1.000), Television and radio programmes can increase awareness of rape (p-value = 1.0000), punishing offenders can reduce rape occurrence (p-value=0.720), watching of sex movies on TV/online (p-value=0.506), girls who had much to drink at party (p-value=0.567), girls who drink/use drugs (p-value=1.000), parental care and advice can reduce rape (p-value = 1.000), watching of home video (p-value= 0.329), walking a male friend home from a party who had had too much to drink (p-value = 0.250).

It can be noted from Table 4.6.4 that none of the predisposing factors to rape was significantly associated with rape.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.6.1: Association between Respondents' Age and Level of Preparedness to Rape Prevention

Age	Level of preparedness				X^2	P-value
	Low(0-3) N (%)	Moderate(>3-7) N (%)	High(>7) N (%)	Total N (%)		
10-14 years	46(54.1)	105(57.4)	16(59.3)	167(56.6)	0.336	0.845
15-19 years	39(45.9)	78(42.6)	11(40.7)	128(43.4)		
Total	85(100.0)	183(100.0)	27(100.0)	295(100.0)		

**Not significant*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.6.2: Association between Respondents' Level of Knowledge and Level of Preparedness to Rape Prevention

Knowledge level	Level of preparedness			Total	X^2	P-value
	Low(0-3) N (%)	Moderate(>3-7) N (%)	High(>7) N (%)			
Poor(<10)	13(15.3)	1(0.5)	16(59.3)	14(4.7)	35.659	0.000*
Fair(10-15)	36(42.4)	75(41.0)	6(22.2)	117(39.7)		
Good(>15)	36(42.4)	107(58.5)	21(77.8)	164(55.6)		
Total	85(100.0)	183(100.0)	27(100.0)	295(100.0)		

**Significant*

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.6.3: Association between Predisposing Factors and Level of Preparedness to Rape Prevention

Predisposing factors to rape variables	Level of preparedness				X^2	P-value
	Low N (%)	Moderate N (%)	High N (%)	Total N (%)		
Having more than one boyfriend						
Yes	79(27.8)	178(62.7)	27(9.5)	284(100.0)	3.247	0.165#
No	6(54.5)	5(45.4)	0(0.0)	11(100.0)		
Girls who demand material things from boys/men						
Yes	76(27.4)	174(62.8)	27(9.7)	277(100.0)	5.188	0.075
No	9(50.0)	9(50.0)	0(0.0)	18(100.0)		
Girls who are not firm to say no to unwanted touches from boys						
Yes	74(27.5)	169(62.8)	26(9.7)	269(100.0)	2.987	0.225
No	11(42.3)	14(53.8)	1(3.8)	26(100.0)		
Girls who hawk to meet parental financial need						
Yes	76(27.1)	177(63.2)	27(9.6)	280(100.0)	6.535	0.28#
No	9(60.0)	6(40.0)	0(0.0)	15(100.0)		
Television and radio programme can increase awareness of rape						
Yes	65(27.8)	147(62.8)	22(9.4)	234(100.0)	0.611	0.737
No	20(32.8)	36(59.0)	5(8.2)	61(100.0)		
Punishing offender can reduce rape occurrence						
Yes	70(27.5)	159(62.4)	26(10.2)	255(100.0)	0.206	1.000#
No	15(37.5)	24(60.0)	1(2.5)	40(100.0)		
Watching of sex movies on TV/ONLINE)						
Yes	82(28.9)	176(62.0)	26(10.2)	284(100.0)	12.434	0.001#
No	3(27.2)	7(63.6)	1(9.1)	11(100.0)		
Girls who had too much to drink at party						
Yes	75(26.6)	180(63.8)	27(9.6)	282(100.0)	15.496	0.000*
No	10(76.9)	3(23.0)	0(0.0)	13(100.0)		
Friends who drink/use drugs can rape						
Yes	75(27.2)	173(62.9)	27(9.8)	275(100.0)	5.807	0.055
No	10(50.0)	10(50.0)	0(0.0)	20(100.0)		
Parental care and advice can reduce rape						
Yes	66(27.2)	153(63.0)	24(9.9)	243(100.0)	2.289	0.318
No	19(36.5)	30(58.0)	3(5.7)	52(100.0)		
Watching of video can a make a boy rape a girl						
Yes	48(29.2)	104(63.4)	12(7.3)	164(100.0)	1.499	0.473
No	37(28.2)	79(60.3)	15(11.5)	131(100.0)		
Walking a male friend home from a party who has had too much to drink						
Yes	63(27.5)	143(62.4)	23(10.0)	229(100.0)	1.519	0.468
No	22(33.3)	40(60.6)	4(6.0)	66(100.0)		

* = *Significant*

\# = *Fisher's Exact Test*

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Table 4.6.4: Association between Predisposing Factors and Rape

Predisposing factors to rape variables	Rape			X^2	P-value
	Yes N (%)	No N (%)	Total N (%)		
Having more than one boyfriend					
Yes	17(6.0)	267(94.0)	284(100.0)	0.178	0.506#
No	1(9.1)	10(90.9)	11(100.0)		
Girls who demand material things from boys/men					
Yes	16(5.8)	261(94.2)	277(100.0)	0.840	0.302#
No	2(11.1)	16(88.8)	18(100.0)		
Girls who are not firm to say no to unwanted touches from boys					
Yes	17(6.3)	252(93.7)	269(100.0)	0.253	1.000#
No	1(3.8)	25(96.1)	26(100.0)		
Girls who hawk to meet parental financial need					
Yes	17(6.1)	263(93.9)	280(100.0)	0.009	1.000#
No	1(6.7)	14(93.3)	15(100.0)		
Television and radio programme can increase awareness of rape					
Yes	15(6.4)	219(93.6)	234(100.0)	0.188	1.000#
No	3(4.9)	58(95.1)	61(100.0)		
Punishing offenders can reduce rape occurrence					
Yes	15(5.9)	240(94.1)	255(100.0)	0.158	0.720#
No	3(7.5)	37(92.5)	40(100.0)		
Watching of sex movies on TV/ONLINE					
Yes	17(6.0)	267(94.0)	284(100.0)	0.178	0.506#
No	1(9.1)	10(90.9)	11(100.0)		
Girls who had too much to drink at party					
Yes	17(6.0)	265(94.0)	282(100.0)	0.060	0.567#
No	1(7.7)	12(92.3)	13(100.0)		
Friends who drink/use drugs can rape					
Yes	17(6.2)	258(93.8)	275(100.0)	0.045	1.000#
No	1(5.0)	19(95.0)	20(100.0)		
Parental care and advice can reduce rape					
Yes	15(6.2)	228(93.8)	243(100.0)	0.012	1.000#
No	3(5.8)	49(94.2)	52(100.0)		
Watching of home video can a make a boy rape a girl					
Yes	12(7.3)	152(92.7)	164(100.0)	0.952	0.329
No	6(4.6)	125(95.4)	131(44.4)		
Walking a male friend home from a party who has had too much to drink					
Yes	12(5.2)	217(94.8)	229(100.0)	1.326	0.250#
No	6(9.1)	60(90.9)	66(100.0)		

**Not significant*

 # = Fisher's Exact Test

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

4.7 Result of the In-depth interview conducted among in school female that have experienced forced sex in Ose LGA.

The In-depth interview queried participant that had experienced forced sex and their level of preparedness to rape prevention.

Table 4.6 shows that 13(4.4%) of the participant had experienced forced sex and participated in the in-depth interview. Few of the respondents (7.7%) were in JSS1 and SSS3 while 23.1% were in JSS2, 30.8% in JSS3 and 30.8% in SSS2. Majority of the participant (77.7%) revealed that they were raped at 11-15years while few were raped before the age of 10years. Victims unanimously agreed that perpetrators were people they knew. Some of the respondents' perpetrators (30.8%) were boyfriend, 15.4% were area brothers, 23.1% while7.7% were uncle, brother's friend, neighbour and driver respectively. Some of the participants (30.8%) also revealed that rape happened at their house and boyfriend's house, 15.4% occurred at the area brother house while 7.7% happened at neighbour's house and in the bus.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

Table 4.7: Characteristics of victims of rape from In-depth interview (n=13)

Characteristics of victims of rape from In-depth interview	Frequency	Percent
Class:JSS1	1	7.7
JSS2	3	23.1
JSS3	4	30.8
SSS2	4	30.8
SSS3	1	7.7
Age when raped		
≤ 10years	3	23.1
11– 15years	10	77.0
Perpetrator		
Boyfriend	4	30.8
Brother	3	23.1
Area brother	2	15.4
Neighbor	1	7.7
Driver	1	7.7
Brother's friend	1	7.7
Uncle	1	7.7
Places raped		
My house	4	30.8
Boyfriend's house	4	30.8
Area brother's house	2	15.4
Neighbor's house	1	7.7
Classroom	1	7.7
In the bus	1	7.7

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

All respondents unanimous agreed that the incidence occurred unaware while running errands for parents, neighbours and relatives as narrated by the participants below;

> *"…When my mummy send me message our driver now call me I now say I'm not coming he now push me on the floor …he push me inside the motor and sleep with me…he say I should not shout that he will kill me if I tell anybody or my mummy…"***(Participant B; raped at 10years)**

> *"…My brother told me not to shout when he wanted to have sex with him….I couldn't shout….because he said he would kill me if I shout…that was what scared me…"***(Participant E; raped at 14years)**

However, some respondents were deceived by their boyfriends; pretending they were sick and took advantage of them during their visits.

> *"…Eem….I'm always at home…I am not allowed to go out I'm always indoor…I went to his house as I was going to shop that day when he called me in because I'm an apprentice....then he was even sick that day, he told me he was sick. so I believed him….then before I knew what was happening he was holding my hands and he start to kiss me…I told him no and he said that he was not going to do anything, he even promised me nothing was going to happen…so I believed….when I believed him before I know what was going on he has already disvirgined me….I did not tell anyone about it because he promised me it won't happen again and because of what my friends will say about him…"***(Participant C; raped at 13years)**

Majority of the victims were helpless and did not know whether to shout for help or not because they were threatened to be killed if they shouted for help or called people's attention as at the time it happened as narrated by participant below;

Only one of the victims shouted for help and nobody was around to help her. The victims thought that they could have helped themselves if only they had shouted very loudly or banged something on the perpetrators' heads for escape as narrated by participants below:

> *"…I shouted but nobody came in…maybe I was supposed to shout very well for someone to come in…or hit something on his head…"***(Participant D; raped at 11years)**

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Majority of the respondents were not knowledgeable on how to prevent rape because only one of the respondents indicated that she had participated in rape prevention programme but could not remember what was thought as narrated below:

> *"…Yes, I have participated in a sexual prevention programme before…haa..I can't remember what I was taught... "***(Participant A; raped at 9years)**

It was deduced that few of them were informed about rape and its preventive measures in school and not from an organized programme of rape prevention.

> *"….No, I haven't participated in any…it was in our school they told us that we should shout on anybody that wants to forcefully have sexual intercourse with us…..or do anything….we should shout anytime it wants to happen"***(Participant B; raped at 11years).**

Majority of the participant unanimously agreed that the role of the government as regards control and prevention of rape is to punish offenders by sending them to jail and teach them how to fight back perpetrators as narrated below;

> *"….It is good if we can be taught how to prevent rape…they should teach us how to fight back…"* **(Participant K; raped at 13years)**

> *"… I don't know what the government should do but they should punish people that rape and teach us about prevention…"***(Participant I; raped at 12years)**

Majority of the participants had good level of preparedness to rape prevention programmes. They consented that if rape prevention programmes such as pre assault self-defense, rape awareness campaign, assertiveness training, public enlightenment, bystander intervention and media awareness campaign were organised in schools, churches, mosques and cultural clubs they were willing to participate as narrated below;

> *"….I am willing to participate in all the programmes except rape campaign….because I don't like it…"* **(Participant I; raped at 12years)**

> *"…. Yes, I am ready to do whatever they bring…the government should look into it in order to stop forced sexual intercourse…"* **(Participant A; raped at 9years)**

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Discussion

5.1.1 Socio-demographic characteristics

Majority of the respondents (56.6%) were within ages 10-14 years which is an age of high predisposition to rape according to Heise *et al.,* (1994). This may be due to the fact many children are in school at a level that is inappropraite for their age as the secondary school age in Nigeria national policy is from 12 to 17 years. The fact that majority (75.9%) were Yoruba could be attributed to the location of study area as it is located in the Southwestern part of Nigeria where the predominant ethnic group is Yoruba (Arowojolu *et al*., 2002).

Majority of the parents especially mothers (50.8%) have high percentage of secondary school attainment which could be due to poverty, school dropout, pregnancy or preference in male education than female. Such parents are less likely to be involved in the sexual behaviour of their children. Similarly, study conducted in south western Nigeria, found variables like family history, low or no parental education and type of parental care could affect sexual behaviour of adolescents and are more likely to have early sexual exposure and become pregnant (Abu and Akerele, 2006).

In the course of constructing and implementing educational programmes and life skills strategies, socio-demographic factors such as age, class, level of education of parents revealed in this study are very imperative guides for the selection of educational methods, strategies and educational aids towards prevention of rape among female adolescent at large.

5.1.2 Knowledge of rape

The knowledge of Rape in this study featured various aspect such as definitions, victims, perpetrators, consequences and experiences.

Half the respondents (54.2%) of respondents defined rape as a forceful sexual intercourse without consent of one partner and lowest fraction (1.4%) of respondent defined rape as a sexual intercourse between an adult female and a male below 16years. This is probably because it seems to be more

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

common in our environment than actually reported. This in consonance with report from Morrel and Dunkle (2011) that rape is a problem of considerable proportion in the community where up to one-third of adolescent girls report their first sexual experience as being forced. Rape is a sexual assault which poses a great threat to the norms of societal behavior and hence, knowledge on its predisposition, consequences as well as prevention is germane to societal development.

More than half of the respondent (80.0%) of respondents knew that rape can take place anywhere apart from home. This is in consonance with a Nigeria self-reported study by Eke, Opara and Tabansi, (2011) conducted among estimated 1050 secondary students indicated that 58.9% knew that rape could take place anywhere.

Majority of the respondent (61.7%) knew perpetrator could be anybody and lowest fraction (16.6%) knew that perpetrators could be boyfriends or male strangers which does not corroborate with findings from Jewkes *et al*., (2002) and Anderson and Ho-Foster, (2008) that most common perpetrator can be parents, caregivers, acquaintances and strangers, as well as intimate partners.

The overall knowledge revealed that a good number of respondents (55.6%) had a good knowledge of rape and the various negative consequences of rape. This result is in agreement with a report by Shittu *et al*., (2007); Ogunyemi, (2000) and Eke, Opara and Tabansi, (2011) where adolescents were reported to have a broad knowledge of rape, its definition and health consequences. Likewise in another study conducted in KwaZulu-Natal in South Africa, 91.0% of in-school female adolescents acknowledged the negative impact of rape to be contracting HIV/STI (De Vries *et al*., 2014).

Sexual experiences of rape

Less than half of the respondents (12.5%) reported that they had boyfriend, 89.2% had one boyfriend and 10.8% had more than one boyfriend. According to Bramsen *et al.,* (2012) suggested that, the number of sexual partners and displaying sexual risk behaviours predispose a person to first time peer on peer rape. In correlation with this study report by Pilgrim *et al.*, (2012) that sexual coercion among girls was high in girls who reported multiple partners.

Almost half (43%) of adolescent females in Nigeria are reported to be sexually active, with 20.3% having engaged in sexual intercourse by the age of 15years (Federal Ministry of Health (FMOH),

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

2009). Similarly, in this study, 10.2% reported they have had sexual intercourse. Majority of the respondent who has had sexual intercourse first had intercourse between the ages of 9 to 13years (50.0%). A brother was the first sexual partner of majority of the respondents (27.8%) followed by a boyfriend (22.2%). Therefore these adolescents needs to be fully informed to make right choices about their sexual behaviour and increase their level of preparedness through rape prevention programmes to help them prevent rape occurrence.

In this study, respondents were asked to indicate whether their first experience of sexual intercourse was forced, or by willingness. Few (6.1%) of them said they had forced sexual intercourse. Similarly a WHO Multi-country study on women's health and domestic violence against women, found out that 3–24% of the respondents investigated had their first sexual experience forced, and that for a majority of respondents this occurred during adolescence. Likewise in 10 of the 15 settings studied, over 5% of women reported that their first sexual experience was forced and likewise more than 14% reported forced first sex in Bangladesh, Ethiopia, Peru province and Tanzania (Garcia-Moreno, 2005).

Less than half of the respondents (44.4%) said they had forced sex at their house, 22.2% took place at their boyfriend's house and 16.7% occurred at Area brother's house. This study corresponds with studies that suggest environments such as schools, colleges, homes, and bars to mention a few are favorable environments for sexual abuse and rape and that rape can occur to anyone and anywhere (Krivoshey *et al.*, 2013 and Lawyer *et al* 2010).

Therefore female adolescents should be well informed and trained on how to prevent rape occurrence.

5.1.3 Perception of rape

More than half (67%) of the participants in this study have good perception about rape. This is in agreement with study done by Eke, Opara and Tabanasi (2011) among secondary school students in Port-Harcourt where majority of participants had good perception about rape. This consistence could be as a result that both studies used in-school adolescents. This finding was inconsistent with the study done by the same authors among mothers where 39% had good perception about rape

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

(Eke, Opara and Tabansi, 2011). This difference may be probably because adolescents are more aware of what is happening to them either from interactions with their peers or from their own experiences, while mothers perceived otherwise. This may also be a reflection of a communication gap between mothers and their adolescents

5.1.4 Predisposing factors to rape

In this study respondents were asked what could be the predisposing factors to rape among adolescent girls in secondary schools. Majority of the respondents (96.3%) said having multiple boyfriends can make a girl vulnerable to rape. There is a strong association between women's perceived multiple sexual partner and sexual violence (Chan, 2009; Dalal, Rahman and Jansson, 2009; Johnson and Das, 2009; Tang and Lai, 2008 and Vung and Krantz, 2009). Majority of the respondents (91.2%) said girls who are not firm to say no to unwanted touches from boys could be predisposed to rape.

Likewise, Assertiveness interventions such as saying affirmative 'NO' on verbal consent practices may be useful for addressing this form of assault (Jozkowski and Peterson, 2013;Jozkowski *et al.*, 2014). More than half of the respondents (94.9%) said that girls who hawk to meet parental financial need can be vulnerable victims to rape. Similarly, high prevalence of rape have been linked to high level of poverty especially in Sub-Saharan African countries where parents encourage children in to labour in order to improve the standard of living of the household (UNDP, 2009). However, the scale of prevailing poverty renders children vulnerable to working on the streets and exposed to sexual abuse from many individuals, including from passers-by and in some cases from those who offer them shelter (Mandalazi, Banda and Umar, 2013).

This study revealed that girls who drink alcohol too much at party are more likely to experience rape than those who do not drink alcohol. This is in consonance with wealth of studies by Pilgrim *et al*, (2012), Lawyer *et a*l and Esere *et al* (2009), that there was a relationship between excessive alcohol use and sexual victimization and re-victimization of an individual . Studies revealed that, alcohol has different effect on girl victims by making them submissive first, weak and less able to resist sex.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Majority of the respondents (86.4%) said that punishing offenders can reduce rape occurrence. Unlike the societal level, where there are policies in place to prosecute sexual assault perpetrators, yet the crime remains under reported and under prosecuted, largely because of the blame and stigma assigned to victims (Alemika, 2013;WHO, 2002; Grubb and Turner, 2012). Therefore efforts should be made in Nigeria and other countries with much weaker legal sanctions to encourage girls to speak out and break silence about sexual violence including rape where an alleged perpetrator is brought to court being punished for his offence.

5.1.5 Preparedness to rape prevention

As much as there is less discussion on the level of preparedness to rape prevention in developing countries like Nigeria, 90.8% of the respondents agreed that rape could actually be prevented. Most of the community programmes are often targeted towards community and societal strategies to prevent rape but prevention strategies that addresses individual and relationship factors should be given more attention. According to WHO (2010), It is important to identify the preparedness level of adolescents to rape prevention in rural setting in order to develop or adapt, test and evaluate many more prevention programmes in developing countries, and to discover what does and does not work in a much wider range of settings or environment.

In the same vein, 68.5% of in-school adolescents have not attended any sexual/rape prevention programme and this utterly means that they are mostly predisposed and vulnerable with less defense and prevention against rape and/or sexual assault. In the same vein, 91.9% of the respondents think that rape prevention programmes should be conducted in secondary school for girls and are willing to participate in rape prevention programmes such as pre-assault self defense, rape awareness campaign, assertiveness training, bystander intervention and awareness through public enlightenment and media awareness. Breitenbecher and Scarce, (2001) posited that educating women on effective self-defense strategies with teaching them actual self-defense skills has been found to be effective among in-school female adolescent in Nairobi upon enrollment prevalence of sexual assault is 22.9%. Self-defense strategies and empowerment reduced from a prevalence of 17.9% to 11.1% at follow up (Sarnquist *et al.*, 2014).

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

5.1.6 Implication of the study findings for health promotion and education

Findings from this study has laid a platform for developing appropriate and effective preventive interventions to address rape among in-school female adolescent in Ose LGA and young people inclusive as it was observed that rape is a problem of considerable proportion among female adolescents and high proportion of adolescents have been suffering due to the resulting physical, psychological and social consequences that may affect the reproductive health of individuals including; HIV/STI, depression, unwanted pregnancy, suicidal attempt, school dropout and which may result to risky sexual and unhealthy behaviour in coping with rape experience such as transactional sex, alcohol intake and substance use.

The findings from the study suggest primary prevention interventions that will be targeted on further occurrence and creating positive ways in managing occurrences through employing health promotion and education strategies targeted to the individual, family, community, social and cultural clubs, schools and government such as; public enlightenment which involves educating young people, parents and leaders on sexuality, sexual harassment including rape highlighting the causes of rape, strategies employed, the perpetrators, resulting consequences and ways of prevention through specifying their roles in the prevention; advocacy i.e. liaising with the school authority, community government on behalf of young people and tendering the possible challenges they face within to enable a safe environment through creation of friendly policies and providing punitive consequences for perpetrators that will prevent occurrence of sexual assault; capacity building i.e. equipping young people with life-building skills that will prevent them from being vulnerable like teaching them pre-assault self defense skills, bystander intervention; teaching students/young people how to support a friend or loved one who discloses sexual assault and instructs students how to confront friends who express sexist attitudes and how they can potentially intervene with friends in risky situations, communication, assertiveness and limit setting training, creating awareness using Behavioural Change Communication (BCC) materials like bill boards, school magazines, radio station and television station.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

5.2 Conclusion

From the study, rape is prevalent amongin-school female adolescents in Ose Local Government, Ondo State. Knowledge, perception and predisposing factors influences sexual experience of female adolescent and determines their level of preparedness to rape prevention i.e. those that have poor knowledge and perception tend to experience rape and have low level of preparedness to rape prevention hence it is important to identify the preparedness level of adolescents to rape prevention in rural setting in order to develop or adapt, test and evaluate many more prevention programmes in developing countries, and to discover what does and does not work in a much wider range of settings or environment.

5.3 Recommendations

1. Young people should be more aware of what is happening around them and should report any sign of sexual harassment to a trusted adult or authority that will be able handle the situation without causing harm to both party.

2. Teachers should teach students how to help friends who discloses sexual assault and instructs students how to confront friends who express sexist attitudes and how they can potentially intervene with friends in risky situations.

3. Parents should establish a good relationship with their children and always educate them on sexual abuse from younger age to be able to identify exploitative relationship and speak out if things are going wrong.

4. The religious leaders and school authority should take up more roles in grooming and educating young people about sexual abuse and how to prevent it.

5. The society should reduce stigmatization on young people to enable them open up on issues affecting them.

6. The government should conduct rape prevention programmes in schools to reduce the prevalence of rape in the society and ensure punitive sanctions are imposed on perpetrators.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

REFERENCES

Abiodun, O., Olu-abiodun, O., Ani, F., &Sotunsa, O. 2016. AIDS & Clinical Research Sexual and Reproductive Health Knowledge and Service Utilization among In- school Rural Adolescents in Nigeria, *7*(6). https://doi.org/10.4172/2155-6113.1000576

Abrahams, N., & Jewkes, R. 2005. African men's having witenessed abuse of their mothers during childhood on their levels of violence in adulthood. *American Journal of Public Health,95*(10), 1–6.

Abu, P. B., & Akerele, E. O. 2006. Parental influence adolescents sexual behaviour in Ibadan North Local Government Area of Oyo State Nigeria. *International Journal of African and African-American Studies*, *5*(1), 41–56.

Adudans, M. K., Montandon, M., Kwena, Z., Bukasi, E., & Cohen, C. R. 2011. Prevalence of forced sex and associated factors among women and men in Kisumu, Kenya. *African Journal on Reproductive Health*, *15*(4), 87–97.

Ahonsi, B. A. 2013. Targeting Youth for HIV Prevention and Care in Nigeria:What Role for Governments? *African Journal of Reproductive Health*, *17*(4).

Ajuwon, A. J., McFarland, W., Hudes, S., Adedapo, S., Okikiolu, T., & Lurie, P. 2006. Risk-related behaviour, sexual coercion and implications for prevention strategies among female apprentice tailors in Ibadan, Nigeria. *AIDS & Behaviour*, *6*, 233–241.

Ajuwon, A. J., Olaleye, A., Faromoju, B., & Ladipo, O. 2006. Sexual behaviour and experience of sexual coercion among secondary school studenta in three states in North Eastern Nigeria. *BioMed Central Public Health*, 6: 310.

Alemika, E. O. 2013. Criminal victimization, policing and governance in Nigeria (Monograph Series No. 18). Ikeja, Lagos, Nigeria: CLEEN Foundation.

Anderson, L. A., & Whiston, S. C. 2005. Sexual assault education programs: a meta-analytic examination of their effectiveness. *Psychology of Women Quartely*, (29), 374–388.

Anderson, N.,& Ho-Foster, A. 2008. 13,915 reasons for equity in sexual offences legislation: a national school-based survey in South Africa. *International Jouranal Equity Health*, (17), 20.

Anderson, N., Ho-Foster, A. A., Matthis, J., Marokoane, N., Mashiane, V., Mhatre, S., & Salcedo, M. P. 2004. National cross sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils. *BioMed Journal*, *329*(7472), 952.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Anteghini, M., Fonseca, H., Ireland, M. and Blum, R. W. 2001. Health risk behaviors and associated risk and protective factors among Brazilian adolescents in Santos, Brazil. *Journal of Adolescent*, 28(4*)*, 295–302.

Arowojolu, A.O,. Ilesanmi, A.O., Roberts, O.A. and Okunola, M.A. (2002). Sexuality, contraceptive choice and AIDS awareness among Nigerian undergraduates. *African Journal of Reproductive Health*, 6(2): 60-70.

Borwankar, R., Diallo, R., & Sommerfelt, A. E. 2008. Gender-based violence in sub-Saharan Africa: A review of Demographic and Health Survey findings and their use in National Planning. Washington D.C.

Boy, A., & Kulczycki, A. 2008. What we know about intimate partner violence in the Middle East and North Africa. *Violence Against Women*, *14*(1), 53–70.

Bramsen, R. H., Lasgaard, M., Koss, M. P., Elklit, A., & J, B. 2012. Adolescent sexual victimization: a prospective study on risk factors for first time sexual assault. *European Child Adolescent Psychiatry*, (21), 521–526.

Brecklin, L. R., & Ullman, S. E. 2005. Self-defense or assertiveness training and women's responses to sexual attacks. *Journal of Interpersonal Violence*, *20*(6), 738–762.

Breitenbecher, K. H., & Scarce, M. 2001. An evaluation of the effectiveness of a sexual assault education program focusing on psychological barriers to resistance. *Journal of Interpersonal Violence*, (16), 387–407.

Brown, D. W., Riley, L., Butchart, A., Meddings, D. R., Kann, L., & Harvey, A. P. 2009. Exposure to physical and sexual violence and adverse health behaviours in African children: results from the Global School-Based Student Health Survey. *Bull World Health Organization.*, *87*(6), 447–455.

Central Intelligence Agency 2016. *The World Factbook*. Retrieved from www.cia.gov/library/ publication/the-world-factbook/geos/ni.html

Chan, K. L. 2009. Sexual violence against women and children in Chinese societies. *Trauma Violence & Abuse,10*(1), 69–85.

Chandra, A., Martino, S. C., Collins, R. L., Elliott, M. N., Berry, S. H., Kanouse, D. E., & Miu, A. 2008. Does watching sex on television predict teen pregnancy? *Findings from a National Longitudinal Survey of Youth. Pediatrics*, *122*(5), 1047–1054.

Cherry, J., & Hategekimana, C. 2013. Ending gender based violence through grassroots women's

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

empowerment: lessons from post-Rwanda, Agenda empowering women for gender equity. *AGENDA*, *27*(1), 100–113.

Cochran, W. G. 1977. *Sampling techniques Hoboken, NJ: John Wiley* (3rd ed.).

Coker, A., Cook-Craig, P., Williams, C., Fisher, B., Clear, E., & Garcia, L. S. and Hegge, L. M. 2011. Evaluation of Green Dot: An Active Bystander Intervention to Reduce Sexual Violence on College Campuses. *Violence against Women*, 17(6), 777-796.

Cooperative for Assistance and Relief Everywhere Available from www.care.org. 2010. *Bringing an End to Gender Based Violence*.

Criminal Code Act 1990 Chapter 77. Laws of the Federation of Nigeria.

Crittenden, C. A., & Wright, E. M. 2013. Predicting patriarchy: using individual and contextual factors to examine patriarchal endorsement in communities available from: PM:23262819 Dahlberg. *Journal of Interpersonal Violence*, *28*(6), 1267–1288.

Cummings, N. 1992. Self-defense training for college women. *Journal American College Health*, *40*(4), 183–188.

Dalal, K., Rahman, F., & Jansson, B. 2009. Wife abuse in rural Bangladesh. *Journal of Biosocial Science*, *41*(5), 561–573.

De Vries, H., Sander, M. E., Champak, J., Meyer-Weitz, A., Taylor, R., & Sathiparsad, M. 2014. Adolescents' Beliefs About Forced Sex in KwaZulu-Natal, South Africa. *Archives of Sexual Behaviour*, *43*, 1087–1095.

Eke, G. K., Opara, P. I., & Tabansi, P. N. (2011). Perception of rape among Secondary School in PortHarcourt. *The Nigeria Health Journal*, *11*(1), 23–26.

Elwood, L. S., Smith, D. W., Resnick, H S Gudmundsdottir, B Amstadter, A. B., Hanson, R. F., Saunders, R. F., & Kilpatrick, D. G. (2011). Predictors of rape, findings from the national survey of adolescents. *Journal of Traumatic Stress*, *24*(2), 166–173.

Esere, M. O., Idowu, A. I., Durosaro, I. A., & , Omotosho, J. 2009. Causes and consequences of intimate partner violence: experiences of victims in Lagos, Nigeria. *Journal of Aids and HIV Research*, *i*(1), 001–007.

Ezzati, M., Lopez, A. D., Rodgers, A., & Murray, C. J. 2004. Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors. *Open Journal of Mathematical Science*.

Fawole, O. I., Ajuwo, A. J., Osungbade, K. O., & Faweya, O. C. 2002. Prevalence of violence

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

against young female hawkers in three cities in South Western Nigeria. Health Education. *Health Education*, (102), 230–238.

Federal Ministry of Health. 2009. *Assessment Report of the National Response to Young People's Sexual and Reproductive Health in Nigeria.* Abuja.

Foubert, J. D. 2000. The longitudinal effects of a rape-prevention program on fraternity men's attitudes, behavioral intent, and behavior. *Journal of American College Health*, *48*(4), 158–163.

Freudenberg, N., & Ruglis, J. 2007. Framing school dropout as a public health issue. *Preventing Chronic Disease*, (4), A47.

Garcia-Moreno, C. Jansen, H. A., Ellsberg, M., Heise, L. and Watts, C. 2005. WHO Multi-Country study on women's health and domestic violence against women:Initial results on prevalence, health outcomes and women's reponses. World Health Organization.

Gidycz, C. A., Layman, M. J., Rich, C. L., Crothers, M., Gylys, J., Matorin, A., & Jacobs, D. C. 2001. An evaluation of an acquaintance rape prevention program.

Gray, M., Lesser, D., Quinn, E., & Bounds, C. 1990. Effects of rape education on perception of vulnerability and on reducing risk-taking behavior. *Journal of College Student Development*, (31), 217–223.

Grubb, A., & Turner, E. 2012. Attribution of blame in rape cases: A review of the impact of rape myth acceptance, gender role conformity and substance use on victim blaming. Aggression and Violent Behavior, *17*(5), 443–452.

Hanson, K. A., & Gidycz, C. A. 1993. Evaluation of a sexual assault prevention program. *Journal of Consulting & Clinical Psychology*, (61), 1046–1052.

Heise, L., Pitanguy, J., & Germain, A. 1994. Violence against women: Washington, DC. *The Hidden Health Burden*, 225.

Heppner, M. J., Good, G. E., Hillenbrand-Gunn, T. L., Hawkins, A. K., Hacquard, L. L., Nichols, R. K., & DeBord, K. A., & Brock, K. J. 1995. Examining sex differences in altering attitudes about rape: A test of the elaboration likelihood model. *Journal of Counseling and Development*, 640–647.

Hollander, J. 2014. Does self-defense training prevent sexual violence against women? *Violence Against Women*.

Jespersen, A. F., Lalumiere, M. L., & Seto, M. C. 2009. Sexual abuse history among adult sex

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

offenders and non-sex offender: a meta-analysis. *Child Abuse & Neglect*, *33*(3), 179– 192.

Jewkes, R. Vundule, C., Maforah, F., & Jordaan, E. 2001. Relationship dynamics and adolescent pregnancy in South Africa. *Social Science and Medicine*, 52(5), 733–744.

Jewkes, Levin, J., & Mbananga, N. 2002a. Rape of girls in South Africa. *Lancet*, *359*, 319–20.

Jewkes, R., & Morrell, R. 2010. Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention 13:6. *Journal of the International AIDS Society*, (13), 6.

Jewkes, R., Sen, P., & Garcia-Moreno, C. 2002. *Sexual violence. In: Krug EG et al., eds World report on violence and health, Geneva, World Health Organization.*

Jewkes, R., Sikweyiya, Y., Morrel, R., & Dunkle, K. 2011a. Gender inequitable masculinity and sexual entitlement in rape perpetration in South Africa: Findings of a cross sectional study. *Women Studies*, 80–95.

Jewkes, R., Sikweyiya, Y., Morrel, R., & Dunkle, K. 2011b. *Gender inequitable masculinity and sexual entitlement in rape perpetration in South Africa: Findings of a cross sectional study. Women Studies*.

Johnson, K. B., & Das, M. B. (2009). Spousal violence in Bangladesh as reported by men: prevalence and risk factors. *Journal of Interpersonal Violence*, *24*(6), 977–995.

Jozkowski, K. N., & Peterson, Z. D. 2013. College students and sexual consent: Unique insights. *Journal of Sexual Research*, *Jozkowski*(50), 517-523. https://doi.org/10.1080/00224499

Jozkowski, K. N., Peterson, Z. D., Sanders, S. A., Dennis, B., & Reece, M. M. 2014. Gender differences in heterosexual college students' conceptualizations and indicators of sexual consent: Implications for contemporary sexual assault prevention education. *Journal of Sexual Research*, *51*, 904-916. https://doi.org/10.1080/00224499.

Kennedy, S. B., Atwood, K. A., Harris, A. O., Taylor, C. H., Gobeh, M. E., Quaqua, M., … Warlonfa, M. 2012. HIV/STD risk behaviors among in-school adolescents in post-conflict Liberia available from: PM:21924644 Korbin. *Journal of Association of Nurses AIDS Care*, *23*(4), 350–360.

Krivoshey, M. S., Adkins, R., Hayes, R., Nemeth, J. M., & Klein, E. G. 2013. Sexual assault reporting procedures at Ohio colleges. *Journal of American College Health*, *61*(3), 142–147.

Kunnuji, M. O., & Esiet, A. 2015. Prevalence and correlates of sexual abuse among female out of school adolescents in Iwaya Community, Lagos State, Nigeria. *African Journal on*

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Reproductive Health, *19*(10), 82–90.

Lalor, K. 2004. Child sexual abuse in Sub-saharan Africa: A literature review. *Child Abuse and Neglect*, *28*, 439–460.

Lawyer, S., Resnick, H., Bakanic, V., Burkett, T., & Kilpatrick, D. G. 2010. Forcible, drug-facilitated and incapacitated rape and sexual assault among undergraduate women. *Journal of American College Health*, *58*(5), 453–460.

Malow, R., Devieux, J., & Lucenko, B. A. 2006. History of Childhood Sexual Abuse as a Risk Factor for HIV Risk Behavior. *Journal of Trauma Practice*, (5), 13–32.

Mandalazi, P., Banda, C., & Umar, E. 2013. Street children's vulnerability to HIV and sexually transmitted infections in Malawian cities. *Malawi Medical Journal, Matasha*, *23*(1), 1–4.

Mangioloi, R. 2009. The impact of child sexual abuse on health: a systematic review of reviews. *Clinical Psychology Review*, *29*(7), 647–657.

Martin, E. K., Taft, C. T., & Resick, P. A. 2007. A review of marital rape. *Aggression and Violent Behavior*, *12*(3), 329–347.

Mathew, S. Abrahams, N., Jewkes, R., Martin, L. J. and Lombard, C. 2009. Alcohol use and its role in female homicides in the Western Cape, South Africa. *Journal of Studies on Alcohol and Drugs*, *70*(3), 321–327.

Ministry of Economic Planning and Budget. 2010. *Facts & Figures on Ondo state*. Akure, Ondo state: Department of Research and Statistics.

Muehlenhard, C. L., & Linton, M. A. 1987. Date rape and sexual aggression in dating situations. *Incidence and Risk Factors. Journal of Counseling Psychology*, (34), 186–196.

Ogunyemi, B. 2000. Knowledge and perception of child sexual abuse in urban Nigeria: some evidence from a community-based project. *Africa Journal of Reproductive Health*, *4*, 44–52.

Ohia, O., Soronnadi, V., Udemezue, G., & Okonkwo, U. 2002. Child Abuse and Neglect. In: Ezeilo JN, ed. Enugu: Women's Aid Collective (WACOL). *Legal Literacy Series*, 1–6.

Okello-Wengi, S. 2005. *Socio-Economic Factors Contributing to Girl Child Abuse in Botswana*. World University Service of Canada, Gaborone.

Oleribe, E. O. 2002. Themes on Child Abuse. In: Oleribe EO, ed. *The Concept of Child Abuse. Abuja: An Anti- Child Abuse Society of Africa Publication (National War College Abuja Printing Press)*, p. 49–92.

Olle, L. 2004. Medical Responses to Adults who have experienced Sexual Assault. *Royal*

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Australian and New Zealand College of Obstetrics and Gynecology.

Olugbenga- Bello, A. I., Adebimpe, W. O., & Abodunrin, O. L. 2009. Sexual Risk Behaviour Among In-School Adolescents in Public Secondary Schools in a Southwestern City in Nigeria. *International Journal of Health Research*, *2*(3), 241–252.

Omaar, R., & de Waal, A. 1994. Crimes without punishment: sexual harassment and violence against female students in schools and universities in Africa. *African Rights*, 4.

Onah, N. G. 2010. Human Trafficking in Nigeria: A Christian Response. *Nsukka Journal Religion and Cultural Studies*, *3*(1), 141–160.

Oshiname, F. O., Oguwale, A. O., & Ajuwon, A. J. 2013. Knowledge and perceptions of date rape among female undergraduates of a Nigerian University. *African Journal on Reproductive Health*, *17*(8), 137–148.

Owuamanam, D. O., & Bankole, M. O. 2013. Family type and attitude to sexual promiscuity of adolescent students in Ekiti State, Nigeria. *European Scientific Journal*, *17*, 171–177.

Pilgrim, N. A., Ahmed, S., Gray, R. H., Sekasanvu, J., Lutalo, Nalugoda, F. K., Wawer, M. J. 2012. Sexual coercion among adolescent women in Rakai Uganda: does family structure matter? *Journal of Interpersonal Violence*, *20*(6), 1289–1313.

Pinheiro, P. S. 2006. *World report on violence against children, United Nations*. Geneva.

Proto-Campise, L., Belknap, J., & Wooldredge, J. 1998. High school students' adherence to rape myths and the effectiveness of high school rape-awareness programs. *Violence Against Women*, (4), 308–328.

Ricket, V. I., Wiemann, C. M., Vaughan, R. D., & White, J. W. 2004. Rates and Risk factors for sexual violence among an ethically diverse sample of adolescents. *Archives Pediatric Medicine*, *158*(12), 1132–11399.

Sarnquist, C., Omondi, B., Jake, S., Carolinah, G., Lee, P., Munyae, M., Yvonne, M. 2014. Rape Prevention Through Empowerment of Adolescent Girls. Retrieved May 21, 2018, from http://pediatrics.aappublications.org

Schewe, P. A. 2004. Best practices for school-based sexual assault & teen dating violence prevention programs. Paper presented at the 2004 Illinois Prevention First Conference, Rosemont, IL.

Schewe, P. A. 2007. Interventions to prevent sexual violence. In: Doll L *et al*., eds. New York (NY), Springer. *Handbook of Injury and Violence Prevention*, 183–201.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Seto, M. C., Kjellgren, C., Priebe, G., Mossige, S., Svedin, C., & Longstrom, N. 2010. Sexual coercion experience and sexually coercive behaviour: a population study of Swedish and Norwegian male youth. *SAGE*, *15*(3), 219–228.

Shittu, L., Zechariah, M., Ajayi, G., Oguntola, J., Izegbu, M., & Ashiru, V. 2007. The negative impacts of adolescent sexuality problems among secondary school students in Oworonshoki Lagos *Science Research Essays*, (2), 23–28.

Smith, K., Bryant-Davis, T., Tillman, S., & Marks, A. 2010. Stifled voices: barriers to help seeking behaviour for South African childhood sexual assault survivors. *Journal of Childhood Sexual Abuse*, (19), 255–274.

Söchting, I., Fairbrother, N., & Koch, W. J. 2004. Sexual assault of women: Prevention efforts and risk factors. *Violence Against Women*, *10*(1), 73–93.

Tang, C. S., & Lai, B. P. 2008. A review of empirical literature on the prevalence and risk markers of male-on-female intimate partner violence in contemporary China, 1987– 2006. *Aggression and Violent Behavior*, *13*(1), 10–28.

Tolman, D. L., Kim, J. L., Schooler, D., & Sorsoli, C. L. 2007. Rethinking the associations between television viewing and adolescent sexuality development: bringing gender into focus. *Journal of Adolescent Health.*, *40*(1), 84–89.

Ullman, S. E. 1997. Review and critique of empirical studies of rape avoidance. *Criminal Justice and Behavior*, *24*(2), 177–204.

Ullman, S. E., & Knight, R. A. 1993. The efficacy of women's resistance strategies in rape situations. *Psychology of Women Quarterly*, (17), 23–38.

UNDP 2009. *Human Development Report, UNDP, UNODC*. New York.

Van-Decraen, E, Michelelsen, K., Herbots, S., Van-Rossem, R., & Temmerman, M. 2012. Sexual coercion among in-school adolescents in Rwanda: prevalence and correlates of victimization and normative acceptance. *African Journal of Reproductive Health*, *16*(3), 139–153.

Vung, N. D., & Krantz, G. 2009. Childhood experiences of interparental violence as a risk factor for intimate partner violence: a population-based study from northern Vietnam. *Journal of Epidemiology and Community Health*, *63*, 708–714.

West, D. J., & Farrington, D. P. 1977. The delinquent way of life. New York: Crane, Russak & Co.

Whitaker, D. J., Baker, C. K., & Arias, I. 2007. Interventions to prevent intimate partner violence. In: Doll L *et al*., eds. New York (NY), Springer. *Handbook of Injury and Violence Prevention*,

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

203–223.

World Health Organization 2002. *World Report on Violence and Health. Geneva, Switzerland: Author*.

World Health Organization 2005. *WHO Multi-Country Study on Women's Health and Domestic Violence against Women*.

World Health Organization (2010). *Preventing intimate partner and sexual violence against women: taking action. World Health Organization*. Geneva.

Ybarra, M. L., & Mitchell, K. J. 2013. Prevalence Rates of Male and Female Sexual Violence Perpetrators in a National Sample of Adolescents. *Journal of the American Medical Association Pediatrics*, *167*(12), 1125–1134. https://doi.org/10.1001/jamapediatrics.

Young, B. J., Furman, W., & Jones, M. C. 2012. Changes in the adolescents 'risk factors following sexual coercion: evidence for a feedback loop. *Development and Psychopathology*, (24), 559–571.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX 1

Questionnaire

Serial NO: { }

PREDISPOSING FACTORS AND PREPAREDNESS TO RAPE PREVENTION AMONG IN-SCHOOL FEMALE ADOLESCENTS IN OSE LOCAL GOVERNMENT AREA, ONDO STATE

Dear Respondent,

I am a post graduate student at the department of Health Promotion and Education, Faculty of Public Health, University of Ibadan. The purpose of this study is to gather information about the **PREDISPOSING FACTORS AND LEVEL OF PREPAREDNESS AMONG IN-SCHOOL FEMALE ADOLESCENTS OF RAPE PREVENTION IN OSE LOCAL GOVERNMENT, ONDO STATE**

Please note that your participation in this study is entirely voluntary. It is going to be interviewer-administered questionnaire. Each questionnaire has been given a SERIAL NUMBER to conceal your identity. All information that would be collected during this study will be treated with utmost confidentiality.

Your willingness to complete the questionnaire implies you have given consent to participate. Thank you for cooperating. ***Please answer all the questions as honestly and accurately as you can — this is very important***.

SECTION A: **Demographic Characteristics**

1. Class: 1. JSS1 [ ] 2. JSS2 [ ] 3.JSS3 [ ] 4.SSS1 [ ] 5.SSS2 [ ] 6. SSS3 [ ]
2. Age as at last birthday: _____ years old
3. Religion: 1. Christian [ ] 2. Muslim [ ] 3.Traditional [ ] 4. Others (specify) [ ]
4. Ethnic group: 1. Yoruba [ ] 2. Igbo [ ] 3.Hausa [ ] 4. Others (specify) [ ]
5. Marital status of the student 1. Single [ ] 2.Married [ ] 3. In a relationship [ ]

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

4. Others (specify) [ ]

6. With whom are you living now 1. Both parent [ ] 2. Father alone [ ]
3. Mother alone [ ] 4. Relative [ ] 5. Grandparents [ ] 6.Guardian [ ]
7. Boyfriend/Husband [ ] 8.others (specify) [ ]

7. Father's level of education 1. No formal education [ ] 2. Primary education [ ] 3. Secondary education [ ] 4.Vocational [ ] 5.Tertiary education [ ] (1) NCE [ ] (2) OND [ ] (3) HND[ ] 4. University [ ]

8. Mother's level of education 1. No formal education [ ] 2. Primary education [ ] 3. Secondary education [ ] 4.Vocational [ ] 5.Tertiary education[ ] (1) NCE [ ] (2) OND[ ] (3) HND[ ] (4) University [ ]

9. Father's Occupation 1. Civil servant [ ] 2. Trading [ ] 3. Artisan[ ] 4. Farming [ ]
5. House wife [ ] 6. Other (specify) [ ]

10. Father's Occupation 1. Civil servant [ ] 2. Trading [ ] 3. Artisan[ ] 4. Farming [ ]
5. House wife [ ] 6. Other (specify) [ ]

11. How many wives is your father having? 1. Only one [ ] 2. _____wife/wives apart from my mother

12. How many children does your family have? _____

SECTION B: KNOWLEDGE OF RAPE

13. What is rape? 1. Forceful sexual intercourse without consent of one partner [ ]

2. Sexual intercourse between an adult male and a female below 16years [ ]

3. Sexual intercourse between an adult female and a male below 16years [ ]

4. Sexual intercourse under coercion [ ]

5. All of the above [ ]

6. None of the above [ ]

14. Who can be raped? 1. ABaby [ ] 2. A Girl [ ] 3. A Boy [ ] 4.I don't know [ ]

15. At what age can a girl be raped? 1. 0-5years [ ] 2. 6-10years [ ] 3. 11-15years [ ]

4. 16- 19years [ ] 5. I don't know [ ] 6. At any age [ ]

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

16. Where does rape takes place? 1. Home [ ] 2. School [ ] 3.Neighbor's house [ ] 4. Relative's house [ ] 5. Anywhere [ ]

17. Who can rape a girl? 1. Boyfriend [ ] 2. Father [ ] 3. Male stranger [ ]

4. Neighbor[ ] 5. Step-father [ ] 6.Houseboy [ ] 7.Uncle [ ] 8. Anybody [ ]

The following are questions on **Consequences of rape and Sexual Experiences**

18. Which of the following can be consequences of rape? You can tick more than one you considered correct.

S/N	Consequences of rape	True	False
1.	Unwanted pregnancy		
2.	Suicidal attempt		
3.	Vaginal bleeding		
4.	Death		
5.	Marriage		
6.	Mental problem		
7.	Depression		
8.	Shame		

19. Do you have a boyfriend? 1. Yes [ ] 2. No [ ]

20. How many boyfriend(s) do you have? __

21. Have you had any sexual intercourse? 1. Yes [ ] 2. No [ ]

22. At what age did you have your first sexual intercourse? 1. 9-13years [ ] 2. 14- 19years[] 3. Never [ ]

23. Have you had sexual intercourse in the last six months? 1. Yes [ ] 2. No [ ]

24. What was your reason for starting sexual intercourse? (1) Based on willingness (2) Peer pressure (3) Engagement in marriage (4) Forced sex (5) To get money.

25. Have you been raped before? 1. Yes [ ] 2. No [ ]. If No, skip to question 32.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

26. Who raped you? 1. Father [ ] 2. Uncle [ ] 3. Brother [ ] 4. Teacher [ ] 5. Guardian [ ] 6.Boyfriend/Husband [ ] 7. House boy [ ] 8.Step-father [ ]

27. What is your relationship? _____

28. Which of the following places and location did you first had forced sexual intercourse?

1. Hotel room [ ] 2. Bush [ ] 3.Classroom [ ] 4. Our house [ ] 5. Church [ ]
6. Boyfriend's House [ ] 7. Mosque [ ] 8. Within the school compound/playground [ ]

29. SECTION C: Perception of rape and preparedness to rape prevention

S/N	Statement for consideration	Agree	Disagree
	Perceived susceptibility of rape		
1.	Wearing of dresses that are revealing can lead to rape		
2.	Collecting money or material things from boys/men cannot cause rape		
	Perceived seriousness of rape		
3.	Rape can lead school drop out		
4.	Rape cannot lead to HIV/STI		
	Perceived barriers considered by individual to taking measures to prevent incidence of rape		
5.	It is risky		
6.	It is time wasting		
7.	It is difficult to learn		
	Perceived ways of controlling and preventing rape in the society(cue to action)		
8.	Government should encourage mass media campaign of rape		
9.	Public enlightenments at schools, social clubs, cultural clubs, churches and mosque of rape should not be allowed		
10.	Pre assault self-defense tutorial should be allowed in schools		

SECTION D: Predisposing Factors to Rape.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

30. Which of the following factors can promote/inhibit rape? You can tick more than one you considered correct.

Predisposing factors to rape	**True**	**False**
Having more than one boyfriend		
Girls who demand material things from boys/men		
Girls who are not firm to say no to unwanted touches from boys		
Girls who hawk to meet parental financial need		
Television and radio programme can increase awareness of rape		
Punishing offenders can reduce rape occurrence		
Watching on sex movie online/ Television		
Girls who drink too much at party		
Friends who drink/use drugs can rape		
Parental care and advice can reduce rape		
Watching of home video can make a boy rape a girl		
Walking a male friend home who had had too much to drink can lead to rape		

SECTION D: Level of preparedness towards rape prevention

31. Is there anything you can do to prevent rape occurrence? 1. Yes [ ] 2. No [ ]

32. If yes, what kinds of prevention can you take? Tick as many as you considered appropriate

1. Be more aware of what is going on around me [ ] 2. Do more to intervene and help others [ ] 3. Avoid walking alone in the dark [ ] 4. Avoid drinking alcohol at party [ ] 5. Saying no to unwanted touches from boys/men [ ] 6. Avoid multiple boyfriends [ ] 7. Use of self defense skills (yelling/fighting back) [ ] 8. Others (specify) _____

33. If No, why_____

34. Have you participated in any sexual prevention program? 1. Yes [ ] 2. No [ ] If No, skip to question 39.

If yes, which of the following happened there?

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

1. Role play [ ] 2. Facilitated discussions [ ] 3. Self-efficacy, boundaries and assertive communication skills [ ] 4. Extensive physical and verbal technique practice [ ] 5. Others (specify) _____

35. What kind of information did the program present to you?

1. Statistics, laws and definition of sexual violence [ ] 2. Prevalence of sexual violence including own community [ ] 3. Ways of helping others [ ] 4. Increased confidence [ ]

5. Having a plan of action [ ] 6. Making a difference [ ] 7. Others (specify) _____

36. Did the program teach you anything new? 1. Yes [ ] 2. No [ ]. If No skip to

37. If yes, tick any one that is appropriate.

1. Be more aware of what is going on around me [ ] 2. Do more to intervene and help others [ ] 3. Have an increased concern about sexual violence [ ] 4. Others (specify) _____

38. Do you think that any of these should be conducted for girls in secondary schools in order to prevent rape occurrence? 1. Yes [ ] 2. No [ ]. If yes,tick as many as appropriate.

Rape prevention programme to be conducted for girls in secondary schools	**Yes**	**No**
Pre assault self-defense skills		
Rape awareness programmes		
Assertiveness training		
Public enlightenment		
Bystander intervention		
Media awareness campaign		
Are you willing to participate?		
Pre assault self-defense skills		
Rape awareness programmes		
Assertiveness training		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Public enlightenment		
Bystander intervention		
Media awareness campaign		

39. If No, why? _____

_____

_____

Thank you for your participation.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

IN-DEPTH INTERVIEW GUIDE FOR THOSE THAT HAVE EXPERIENCED RAPE

PREDISPOSING FACTORS AND LEVEL OF PREPAREDNESS AMONG IN-SCHOOL FEMALE ADOLESCENTS OF RAPE PREVENTION IN OSE LOCAL GOVERNMENT AREA, ONDO STATE

GREETING: - Good day to you

Introduction**:** My name is _____ (first name) and my colleagues are _____ and _____ we are from the Department of Health Promotion and Education, College of Medicine, University of Ibadan, Ibadan. We are here to share in your knowledge on sexual experiences consequences and prevention to rape. In this discussion there are no rights or wrong answers. All, we interested in are your opinions on this issue. So you should be relaxed and open minded in this discussion. We appeal to you to allow us use tape recorder so that we will not forget the important things you will tell us and your opinions will be kept confidential and will not be used against you in any way.

Thank you.

General Discussion

1. How were you raped?
2. What action did you take to stop the perpetrator from raping you?
3. Have you participated in any prevention programme of rape before?
4. What should be the role of society regarding control and prevention of rape?
5. If there are organized programmes to prevent rape among adolescent would you be willing participate? If yes whichone and if no, why?

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX II

AWON OUNFA ATI IPELE IGBARADI LARIN AWON AKEKO ODO BIRINI LATI DENA IFIPA BANI LOPO NI IJOBA AGEGBE TI OSE NI IPINLE ONDO .

IWE IBEERE

Oludahun mi owon,

Mo je akeekoo gboye keji ni eka igbeleke ilera ati eto eko, eka eko ilera ara ilu, koleji ti iwosan ni eko giga ifasiti ti ilu Ibadan ni ipinle Oyo. Idi ise yi ni lati se **awon ounfa ati ipele igbaradi larin awon akekeo odo birinl lati dena ifipa bani lopo ni ijoba agegbe ti Ose ni ipinle Ondo .**

Abajade ise yii yoo ṣe ranwọ lati ṣe eto ati abadofin ti yoo ran awon akekeo odo birini lati dena ifipa bani lo. Iwadii yii ko ni gbaju iṣẹju mẹwaa lọ lati dahun ati wi pe, ẹwẹ, ikopa kii ṣe dandan. ko si ewu ninu kikopa ninu iwadii yii, ti o ba si pinu lati kopa, aridaju wa wi pe a o ṣe aabo fun idanimọ rẹ

E jowo e ba mi pese idahun otito si awon ibeere yi. Mo fe ki e mo wipe ako niba enikeni so ohun ti e ba so fun wa. Lati ma je ki enikeni da yin mo, a ko ni lo oruko yin ninu iwadi yi, nomba ti a o ko sori iwe ibeere ni a o lo..

Nigba ti mo ti mo gbogbo nkan ti iwadi yii ko sinu ti o si ti ye mi yekeyeke, mo se tan lati kopa ninu iwadi yi

_____

Ibowolu/ ika tite Olukopa

Ese pupo.

Abala A: ìbeereabuda eni ajemo awujo

E mu esi ibeere yin pelu amin yi (X)

1. kini kilasi re 1. JSS1 [ ] 2.JSS2 [ ] 3.JSS3 [ ] 4.SSS1 [ ] 5.SSS2 [ ] 6. SSS3 [ ]

2. kini ojo ori re in ojo ibi ti o koja _____ (ni odun)

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3. Esin: 1. Kristiani [ ] 2. Musulumi [ ] 3.Esin abalaye [ ]. 4. Eso omiran ti e mon _____

4. Eya: 1. Yoruba [ ] 2. Hausa [ ] 3. Igbo [ ] 4. Eso omiran ti e mo _____

5. kini ipo igbeyawo akeko 1. Mo dawa [ ] 2.Mo w anile oko [ ] 3. Mo wa ninu ibasepo [ ] 4. Eso omiran ti e mo _____

6. Tani oun ba gbe po lowolowo 1.Obi mejeji [ ] 2. Baba nikan [ ] 3. Iya nikan[ ] 4. ojulumo [ ] 5. Obiobi [ ] 6.Alagbato [ ] 7.Orekunrin/oko [ ] 8. Eso omiran ti e mo _____

7. kini ipele Eko baba: 1. N ko kawe rara [ ], 2 Eko iwe mefa [ ], 3. Eko sekondiri [ ] 4. Eko ile iwe giga [ ]

8. kini ipele Eko iya: 1. N ko kawe rara [ ], 2 Eko iwe mefa [ ], 3. Eko sekondiri [ ] 4. Eko ile iwe giga [ ]

9. Kini ise ti baba re nse: 1. Osise ijoba [ ] 2. Onisowo [ ] 3. Onise owo [ ] 4. Agbe [ ] 5. Ojogbon [ ] 6. Eso miran ti e mo_____

10. Kini ise ti iya re nse: 1. Osise ijoba [ ] 2. Onisowo [ ] 3. Onise owo [ ] 4. Agbe [ ] 5. Iyawo ile [ ] 6. Eso miran ti e mo_____

11. Iyawo melo ni baba re fe? 1. Okan pere [ ] 2. _____o ju okan lo yato si iyami

12. Omo melo ni baba re ni? _____

ABALA B: Imo lori ifipa banilopo, ipa ati iriri ibanilo.

13. kini ifipa ni lo? 1.ifipa banilo laisi ifowosi enikeji ri[ ] 2. ibani lopo larin okunrin ati obirin ti okere ju odun merindinlogun lo[ ] 3. Ibalopo larin obirin ati okunrin ti okere ju odun merindinlogun lo [ ]

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

4. Ibanilopo pelu ipa [ ]

5. Gbogbo e lati oke [ ]

6. kosi iru eyi ti ojo

14. Tani a le fi ipa ba lopo? 1. AOmo kekekre [ ] 2. Omo birin [ ] 3. Omo kunrin [ ]

4.Nko mo [ ]

15. Bi omo dun melo la le fi pa ba omode birin lopo? 1. Omo ojo si omodun marun [ ]

2. Omodun mefa si odun mewa [ ] 3. Omo odun mokanla si odun marundinlogun [ ]

4. Omo dun medogun si okan din logun [ ] 5.Nko mo [ ]

16. Nibo ni ifi pa lopo le ti waye? 1. ile [ ] 2. Ile iwe [ ] 3. Ile alaadugbo [ ]

4. ile ojulumo [ ] 5. Eso miran ti e mo _____

17. Tani o le fi ipa ba omode birin lopo? 1. Ore kunrin [ ] 2. Baba[ ] 3. Ajeji okunrin [ ]
4.Aladuugbo [ ] 5. Akobaratan-baba [ ]6 . Omo-odo okunrin [ ]

7. Egbon arakunrin [ ] 8. Eso miran ti e mo _____

Awon wonyi je ibeere ton toka si ipa ifipa bini lop ati iriri iba lopo.a

18. Ewo ninu awon won yi lo lo je ipa fi fipa bani lopo? Fa ila si okan tabi ju beelo ti o dara.

S/N	Ipa fi fipa bani lopo	**Otito**	**Iro**
1.	Oyun ti akofe		
2.	Igbiyanju ati para eni		
3.	Dida eje loju ara		
4.	Iku		
5.	Igbeyawo		
6.	Arun opolo		
7.	Irewesi okan		
8.	Itiju		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

19. Nje oni ore kunrin? 1. Beeni [ ] 2. Rara [ ]. To ba je rara fo si ibere nomba merin lelogun.

20. Ore kunrin melo loni? _____

21. Nje oti ni ibalopo Kankan ri? 1. Beeni Yes [ ] 2.Rara [ ]. To ba je rara fo si ibere nomba meta din logbon.

22. Oje omo dun melo ni ojo ori nigbati o koko ni ibalopo? 1. Omo odun mesan si odun metala [ ] 2. Omo odun merinla si odunmokandinlogun [ ] 3.koribe [ ]

23. Nje o ti ni ibalopo larin osu mefa seyin? 1. 1. Beeni [ ] 2. Rara [ ]

24. kini idi ti o fi bere ibalopo? (1) Nipa oun ti mo fe si [ ] (2) Agbara elegbe [ ] (3) Igbayawo [ ] (4) Ifipa ba ni lo [ ] (5) Lati ri owo [ ].

25. Nje a ti fi ipa ba o lopo ri? 1. Beeni [ ] 2. Rara [ ].To ba je rara fo si ibere nomba Meji le logbon.

26. Tani o fi ipa ba o lopo ri? 1. Baba [ ] 2. Egbon arakunrin [ ] 3. Arakunrin [ ] 4. Oluko [ ] 5. Alabojuto [ ] 6.Ore kunrin/oko [ ] 7. Omodo Okunrin [] 8. Akobaratan-baba [ ]

27. Kini ibasepo yin? _____

28. Ninu gbogbo wonyi ibo ni ati koko ba oni ifi pa lopo?

1. Yara Hoteeli [ ] 2.Igbo [ ] 3.Iyara ikeko [ ] 4. Inu ile re [ ] 5. Soosi [ ] 6. Ile arakunrin re [ ] 7. Mosalasi [ ] 8. Agbegbe ile iwe [ ]

29. **ABALA D: Ero nipa ifipa banilo ati igbaradi lati dena ifipa bani lopo**

S/N	Awon oro fun ijiroro	Mogba	Miogba
	Ero nipa pe mole je eniti ale fi pa balopo		
1.	Wiwo aso ti on fi ara le le fa ifipa bani lo		
2.	Gigba owo tabi awon nkan amu sara loge lowo odokunrin/agbalagba okunrin le fa ifipa bani lo		
	Ero nipa bi ifipabinilopo se le		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

3.	Ifi pa banilopo le fa ki omo birin ma pari eko re		
4.	Ifipa banilopo le fa HIV/STI		
	Ero nipa ohun ti ole je idiwo fun olukuluku lati gbara di fun diena ifipa bani lo		
5.	Olewu		
6.	O maan gba akoko eni		
7.	O soro lati ko		
	Ero nipa bi ase le dena ifipa bani lopo laarin awujo		
8.	Ki ijoba polongo imoye ifipa ba ni lopo		
9.	Ki ama gba eko italaye ni ile iwe, agbalagba awujo,asa awujo, soosi ati mosalasi		
10.	Ki afi aye gba lilo oun ija (ipariwo/jija pada) ni awon ile iwe wa		

ABALA E: Awon okunfa si ifipa banilopo.

30. Ewo ninu awon okunfa yi ni ole fa igbelaruge/dena ifipa banilopo? Fa ila si okan tabi ju beelo ti o dara.

S/N	Iforowewe ti idaniloju	Beeni	Rara
1.	Nini ju ore kunrin kan lo le fa ifipa banilo		
2.	Awon omode binrin to feran lati ma gba nkan amu sara loge lowo arakunrin lai fe ibalopo le yori si ifipa banilopo		
3.	Awon omode binrin ti ko le duro lori rara si ifowokan okunrin le yori si ifipa ba ni lopo		
4.	Awon omode birin ti o maa n ta oja lati fi ran obi lowo le je njiya fun ifi pa bani lopo		
5.	Eto loriTelifisionu ati Redio le fikun imoye lori ifipa banilopo		
6.	Ijiya fun awon elese le din ifi pa ba ni lo ku		
7.	Wiwo fiimu ibalopo lori telifisionu tabi lori afefe le mu ki odokunrin fipa ba odo binrin lopo		
8.	Odo binrin to ba n muti ni ariya le je njiya fun ifi pa bani lopo		
9.	Ore ti maan muti tabi lo ogun oloro le fipa ba odo birin lo		

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

10	Abojuto ati imoran obi le dena ifi pa bani lopo		
11	Wiwo ere agbele wo le mu ki odo kun fipa ba odo binrin lopo		
12	Sisin ore ti o ti moti yo lo ile lati ariya le fa ifi pa ba ni lopo		

Abala E: Ipele igbaradi lati dena ifipo bani lopo

31. Nje oun ko hun wa ti o le fi dena ifi pa ba ni ifipa ba ni lopo? 1. Beeni [ ] 2. Rara [ ]

32. To ba je beeni, iru idena wo lo lese? Fa ila si okan tabi ju beelo ti o dara

1. Ma se akiyesi oun ti o n sele lagbegbe mi [ ] 2. Ma se iranwo fun elomiran [ ]

3. Si sora lati marin lokun [ ] 4. Si sora lati ma mu oti lile ni ariya [ ]

5. Nipa si so rara si okunrin fun fifo wa kan ni ona ti o to [ ]

6. Si sora lati ma ni ore kunrin pupo [ ] 7. Si sora lati ma gba owo tabi oun amu sara loge lowo okunrin [ ]

8. Nipa lilo oun ija (ipariwo/jija pada) 10. E so oun miran ti e mo_____

33. Ti o ba je iro kini idi _____

34. Nje o ti kopa ninu eto ti n dena ifi pa bani lopo ri? 1. Beeni [ ] 2. Rara [ ] To ba je rara, fo si nomba mokan din logoji.

To ba je beeni, ewo lo sele nibe?

1. Ere idaraya [ ] 2. Iseto ijiroro [ ] 3.Ipa ara eni, ati igboya ibara eni soro [ ] 4. Ogbon nipa lilo oro ati oun ija [ ] 4. Eso oun miran ti e mo_____-_____

35. Iru alaye wo ni eto na gbe fun e?

1. Statistiki,ofin ati itumo nipa ifioa ba ni lopo [ ]

2. Iwopo ifi pa ni lopo ni papaa ni agbegbe wa [ ] 3. Ona miran lati ran eni keji lowo [ ] 4. Ifikun idara eni loju [ ] 5.Eto igbese mi [ ] 6. Sise ayi pada [ ] 7. E so oun miran _____

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

36. Nje eto na kao e ni oun titiun? 1. Beeni [ ] 2. Rara[ ]. To ba rara fo si nomaba mokandinlogbon.

37. To ba je beeni, fa ila si okan tabi ju beelo ti o dara.

1.Ma se akiyesi oun ti o n sele lagbegbe mi [ ] 2. Ma se iranwo fun elomiran [ ]

3. Ma se ifokan si oun ti ba n se ifi pa banilopo [ ] 4. E so oun miran ti e mo _____

38. Se o lero pe ale se eyi keyi eto yi le waye ni ile ekon sekondiri fun awon idi birin lati fi dena ifi pa ba ni lopo?. Fa ila si okan tabi ju beelo ti o dara

Eto idena ifipa ni lopo ni ile eko sekondiri fun awon akeko obirin	**Beeni**	**Beeko**
Saaju sele ijaja jara eni		
Ipolongo imoye ifipa ba ni lopo		
Eko ikeko imudani loju		
Eko italaye		
Iranlowo fun ara		
Ipolongo media fun imoye ifi pa ba ni lopo		
Nje o wun e lati kopa?		
Saaju sele ijaja jara eni		
Ipolongo imoye ifipa ba ni lopo		
Eko ikeko imudani loju		
Eko italaye		
Iranlowo fun ara		
Ipolongo media fun imoye ifi pa ba ni lopo		

39. Ti o ba je beeko kini idi_____

O seun fun iko pa re.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

ITOSONA IJO MITORO FUN AWON TI ATI FI IPA BA LO PO

1. Bawo lase fi ipa ba o lopo?
2. Kini igbi yanju re lati dena isele ifi pa ni lopo yi?
3. Nje o ti ni anfaani lati kopa ri ninu eko idena ifi pa ni lopo ki isele yi to wa ye?
4. Ipa wo ni awujo le ko lati fi moju to ati fi dena ifi pa ba ni lopo?
5. Nje ti awon eto idena ifi pa ba ni lopo ba wa se o se tan lati kopa Ipa wo ni awujo le ko lati fi moju to ati fi dena ifi pa ba ni lopo?

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX III

INFORMED CONSENT FORM

INFORMED CONSENT FORM FOR PREDISPOSING FACTORS AND LEVEL OF PREPAREDNESS AMONG IN-SCHOOL FEMALE ADOLESCENTSOF RAPE PREVENTION IN OSE LOCAL GOVERNMENT AREA, ONDO STATE.

IRB Research Approval Number:

This approval will elapse on:

Title of Research: Predisposing Factors and Level of Preparedness Among In-School Female Adolescent of rape Prevention in Ose Local Government Area, Ondo State.

Name of Researcher: This study is being conducted by Aderanti Oluwaseun Hefsiba a postgraduate student in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine University of Ibadan.

Purpose of Research: The purpose of this study is to investigate the Predisposing Factors and Level of Preparedness Among In-School Female Adolescent of rape Prevention in Ose Local Government Area, Ondo State.

Sample size and procedure for data collection:A total of 301 In-School Female Adolescent attending Public schools in Ose Local Government Area, Ondo State would be recruited for this study using a multi stage sampling procedure to select eligible respondents.

Expected duration of the research and participant(s) involvement: The process of this study will last for one month. You are to provide answers to the questions contained in the questionnaire. The questionnaire is expected to last about 15 minutes to complete.

Risk(s): There is no physical risk in participating in this study. However, there are some questions on knowledge, consequences and sexual experiences which some respondent would find it uncomfortable to answer.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Cost to participating of joining the research: Participation will cost you nothing. It will however take a little of your time.

Benefit: At the end of the research, findings will be useful in the design of interventions or strategies aimed at preventing and controlling rape in adolescence.

Confidentiality: All information collected in this study will be given coded numbers. Names of participants will not be written on the questions. In addition, your name or any other identifiers will not be used in any publication or report emancipating from this study.

Voluntariness: Your participation in this research is entirely voluntary.

Consequences of participants' decision to withdraw from the research and procedure for orderly termination of participant: You can choose to withdraw from the research at any time without any penalty. Please also note that some of the information that has been obtained about you before you choose to withdraw may have been used in reports and publications.

Statement of Person Obtaining Inform Consent

I have fully explained the nature and scope of the research to _____and have provided sufficient information to her which is needed by her to make informed decision

Date _____ **Signature** _____

Name _____

Statement of Person Giving Consent

I have read the description of the research and the research has been explained to me in a language I understand or have been translated into a language I understand. I understand that my participation is voluntary. I know enough about the purpose, methods, risk, and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. Finally, I have received a copy of this consent form and additional information sheet to keep for myself.

Date _____ **Signature** _____

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Name _____

Detailed contact information including contact address, telephone, fax, email and any other contact information of researcher(s), institutional HREC and head of the institution:

This research has been approved by the Ondo State Research Ethics Committee and the chairman of this committee can be contacted at Ministry of Health, Secretariat, Akure. In addition, if you have any question about your participation in this research, you can contact the principal investigator,

Date _____

Phone _____

Name _____

Signature _____

Name: Aderanti Oluwaseun Hefsiba

Department: Health Promotion and Education

Phone: 08037015449

Email: aderantioluwaseun12@gmail.com

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

INFORMED CONSENT FOR PARENTS/GUARDIAN

IRB Research Approval Number:

This approval will elapse on:

Title of Research: Predisposing Factors and Level of Preparedness Among In-School Female Adolescent of rape Prevention in Ose Local Government Area, Ondo State.

This study is being conducted by Aderanti Oluwaseun Hefsiba a postgraduate student in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine University of Ibadan. The purpose of this study is to investigate the Predisposing Factors and Level of Preparedness Among In-School Female Adolescent of rape Prevention in Ose Local Government Area, Ondo State.

I will be recruiting 301participants which they will be randomly selected among female adolescents attending public secondary schools in Ose Local Government Area, Ondo State. A multi-stage sampling procedure will be used to select eligible respondents.An interviewer will administer questionnaire to your child/children in their classrooms and will be collected back after they have been filled. The interviewer and other participant will be present during the interview. Each interview will take about 15minutes. There are no physical risks to participate in the study. However, your child/children maybe uncomfortable with some of the questions she will be asked. But she may decide not to answer the question she may feels uncomfortable about.

Your child's/children participation in this research is absolutely voluntary and will not cost you anything. There are no direct and immediate benefits for participation in this study. Your child's/children participation in this study may provide the basis for the assessment of rape prevention among students and the optimization of existing policy and rape prevention programmes for use.

You are expected to state below whether your child/children should be allowed to participate in this study. All information collected cannot be linked to your child in any way as her name will not be collected. As part of my responsibility only the researcher, members of the researcher's staff and representatives from the Ondo State Health Research Ethics Committee may have access to the

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

study records. They are required to keep your child identity confidential. Results of this study may be used for research publications, or presentations at scientific meetings, but your child result will never be discussed as an individual. No identifying information will be kept on the actual survey form so nobody will be able to connect your child name to the survey.

Statement of Person Giving Consent

Now that the study has been well explained to me and I fully understand the content of the study process. I hereby agree to allow my child/children to be part of the study.

Date _____ **Signature** _____

Name _____

Detailed contact information including contact address, telephone, fax, email and any other contact information of researcher(s), institutional HREC and head of the institution:

This research has been approved by the Ondo State Health Research Ethics Committee and the Chairman of this Committee can be contacted at Ministry of Health, Secretariat, Akure. In addition, if you have any question about your participation in this research, you can contact the principal investigator, Aderanti, Oluwaseun Hefsiba at The Department of Health Promotion and Education, University College Hospital, Ibadan. The phone and Email address are 08037015449 and aderantioluwaseun12@gmail.com.

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX IV

FỌỌMU IFOHUNSI TI ṢALAYE AWON OUNFA ATI IPELE IGBARADI LARIN AWON AKEKEO ODO BIRINl LATI DENA IFIPA BANI LOPO NI IJOBA AGBEGBE TI OSE NI IPINLE ONDO .

IRB iwadi ìtẹwọgbà nọmba:

Itẹwọgbà yii yoo kọja ni:

Akole ti iwadi:Awon ounfa ati ipele igbaradi larin awon akekeo odo birinl lati dena ifipa bani lopo ni ijoba agbegbe ti Ose ni ipinle Ondo**.**

Orukọ ti oluwadi: Iwadi yi ti waye nipasẹ Aderanti Oluwaseun Hefsiba, omo Ile-ẹkọ giga ti Ibadan niẹka Igbelaruge Ilera ati Ẹkọ.

Idi iwadi: Idi iwadi yi da lori awon ounfa ati ipele igbaradi larin awon akekeo odo birin lati dena ifipa bani lopo ni ijoba agbegbe ti Ose ni ipinle Ondo**.**

Iwọn ati ilana fun gbigba data: Lapapọ odunrunlelokan awon odo birin ti won je akeko ti ile iwe sekondiri ti ijoba ni yio kopa ninu iwadi awon ounfa ati ipele igbaradi larin awon akekeo odo birin lati dena ifipa bani lopo ni ijoba agbegbe ti Ose ni ipinle Ondo**.**

Akoko ti a yẹ fun iwadi: Ilana yii yoo ṣiṣe fun osukan. O ni lati pese idahun si ibeere ti o wa ninu iwe ibeere naa laarin iseju meedogun.

Ewu: Kosi awọn ewu ti ara ni ki kikopa ninu iwadi yii. Sibẹ sibẹ, awọn ibeere kan wa lori awọn imo lori ifipa banilopo, ipa ati iriri ibanilopoti yoo le diẹ fun awọn olufisun lati le dahun.

Awọn iye owo lati kopa ninu di dapọ mọ iwadiyii: kikopa ninu idahun ibeere yi ki yoo na o lo ohunkohun, sibẹsibẹ, yo gba diẹ ninu akokorẹ.

Anfaani: Ni opin iwadi naa, awọn awari yoo wulo ni idamo awọn ogbon imo ti yo ṣe alaye ti o to lori ifapa banilopo laarin odo binrin.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Asiri: Gbogbo awọn alaye ti a gbani iwadi yii ni a o fun ni nọmba. Orukọ awon eniyan ti o idahun kii yoo walori awọn ibeere. Ni afikun, orukọ rẹ tabi awọn ami idanimọ miiran kii yoo wa lori iwe tabi iroyin.

Iyọọda: ikopa ninu iwadi yi yoo je ati inuwa.

Awọn abajade ti ipinnu awọn olukopa lati yọ kuro ninu iwadi ati ilana fun létòletò ifopinsi: O le yan lati yọ kuro ninu iwadi ni eyikeyi akoko laisi ijiya kankan. Jọwọ ṣe akiyesi pe diẹ ninu awọn alaye ti a ti gba lati ọdọrẹ ṣaaju ki o to yan lati yọ kuro ni a le lo ninu awọn iroyin ati awọn iwe aṣẹ.

Gbólóhùn ti Èniyàn

Mo ti ṣe alaye ni kikun tii se daa ti darapọ mo iwadi naa fun _____ ati wipe mo ti pese alaye ti o to fun

Ọjọ _____ **Ibuwọlu** _____

Oruko _____

Gbólóhùn ti Èniyànti fi asesiiwadi

Mo ti ka apejuwe ti iwadi naa atipe a tise alaye fun mi ni ede ti o ye mi. Mo mo wipe ikopa mi jẹ ati nuwa. Mo mọ nipa idi, awọnọna, ewu, ati awọn anfani ti iwadiyi lati darapo ati ṣe alabapin ninu rẹ. O ye mi pe mo le ma tẹsiwaju ninu iwadiyi. Níkẹyìn, Mo ti gba fọọmu iwadi ìtẹwọgbà ati iwe ifowosi alayefun ara mi.

Ọjọ _____ **Ibuwọlu** _____

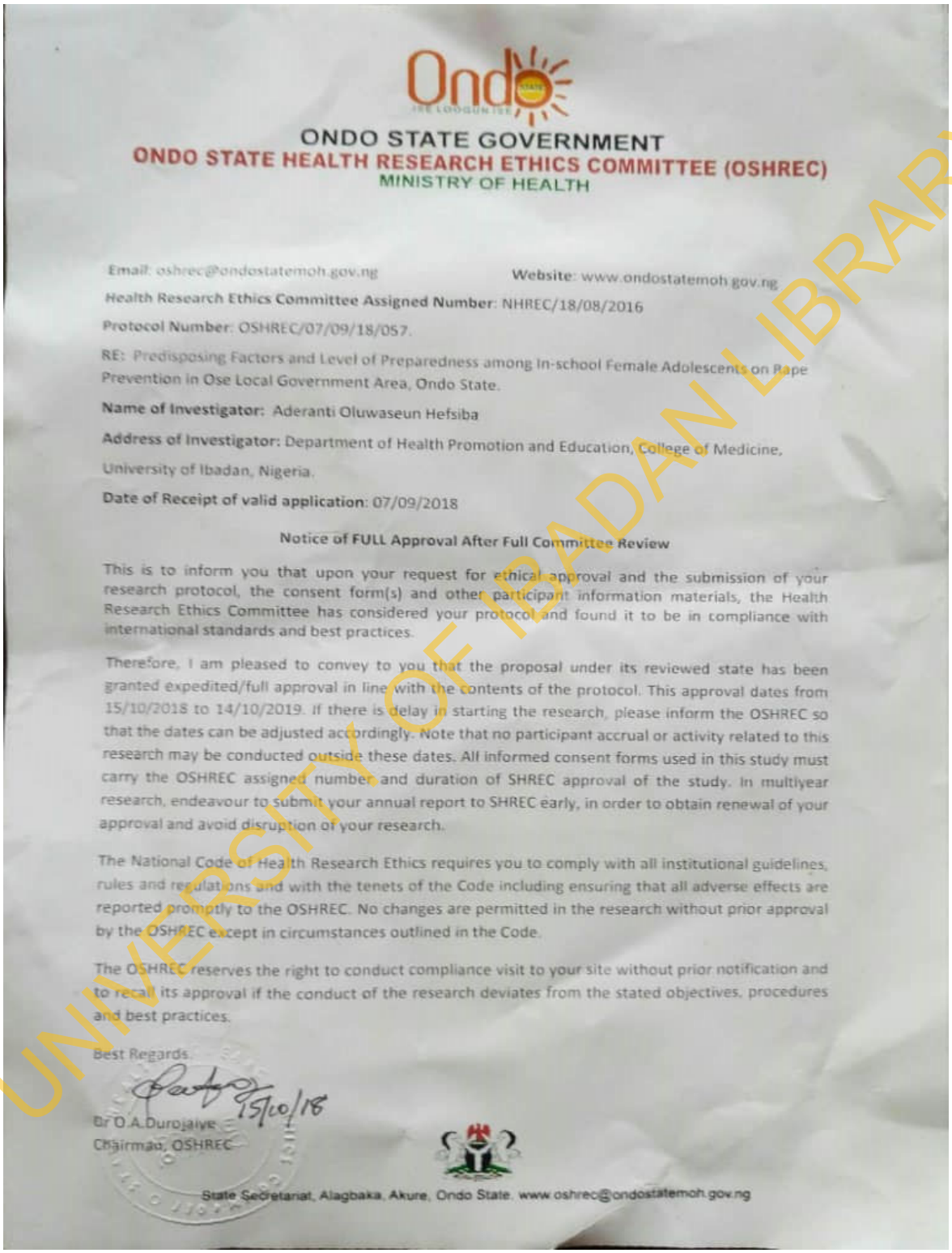
Oruko _____

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX V

Ethical Approval Letter



ONDO STATE GOVERNMENT
ONDO STATE HEALTH RESEARCH ETHICS COMMITTEE (OSHREC)
MINISTRY OF HEALTH

Email: oshrec@ondostatemoh.gov.ng Website: www.ondostatemoh.gov.ng

Health Research Ethics Committee Assigned Number: NHREC/18/08/2016

Protocol Number: OSHREC/07/09/18/057.

RE: Predisposing Factors and Level of Preparedness among In-school Female Adolescents on Rape Prevention in Ose Local Government Area, Ondo State.

Name of Investigator: Aderanti Oluwaseun Hefsiba

Address of Investigator: Department of Health Promotion and Education, College of Medicine, University of Ibadan, Nigeria.

Date of Receipt of valid application: 07/09/2018

Notice of FULL Approval After Full Committee Review

This is to inform you that upon your request for ethical approval and the submission of your research protocol, the consent form(s) and other participant information materials, the Health Research Ethics Committee has considered your protocol and found it to be in compliance with international standards and best practices.

Therefore, I am pleased to convey to you that the proposal under its reviewed state has been granted expedited/full approval in line with the contents of the protocol. This approval dates from 15/10/2018 to 14/10/2019. If there is delay in starting the research, please inform the OSHREC so that the dates can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside these dates. All informed consent forms used in this study must carry the OSHREC assigned number and duration of SHREC approval of the study. In multiyear research, endeavour to submit your annual report to SHREC early, in order to obtain renewal of your approval and avoid disruption of your research.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse effects are reported promptly to the OSHREC. No changes are permitted in the research without prior approval by the OSHREC except in circumstances outlined in the Code.

The OSHREC reserves the right to conduct compliance visit to your site without prior notification and to recall its approval if the conduct of the research deviates from the stated objectives, procedures and best practices.

Best Regards.

15/10/18

Dr O.A.Durojaiye
Chairman, OSHREC

State Secretariat, Alagbaka, Akure, Ondo State. www.oshrec@ondostatemoh.gov.ng

UNIVERSITY OF IBADAN LIBRARY

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT