

IVORY TOWER AS A SITE OF EMPOWERMENT AND ENVIRONMENT OF RISK  
FOR FEMALE STUDENTS AT BAHIR DAR UNIVERSITY, ETHIOPIA.

by

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A Dissertation Submitted to the Faculty of the  
MEL AND ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH

In Partial Fulfillment of the Requirements  
For the Degree of

DOCTOR OF PUBLIC HEALTH  
WITH A MAJOR IN MATERNAL AND CHILD HEALTH

In the Graduate College

The UNIVERSITY OF ARIZONA

2012

THE UNIVERSITY OF ARIZONA  
GRADUATE COLLEGE

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## ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to all the members of my committee for their continual support and guidance throughout this journey. You allowed me the freedom to do the research I wanted to, while also encouraging me to push myself analytically and theoretically. Thank you for taking the time to read numerous drafts and for providing continual feedback on all my work. Thank you for looking out for me as your student, but also for pushing me to achieve excellence in my academics and prepare me to be a professional. I am truly grateful for everything each and every one of you did for me.

I would also like to thank my family and friends for their continual support throughout my graduate school career. My parents have been a part of countless phone calls where I just wanted to give up. Their continual support allowed me to push forward and finish. My friends have been there to listen, provide feedback, and get me away from my work when needed.

I would also like to extend a special thank you to the Vossler family (Kendra, Ryan, Andrew, Katelyn, Pam, and Todd) for not only seeing me through my foot surgery resulting from a field work injury, but also to making sure I stayed fed and had a place to go when I needed a break. Thank you all for being such good friends!

I would like to thank Chris Tisch for being an amazing student advocate and support for all students at MEZCOPH. Her work at times is thankless, but I could not have done it without her support over the years!

I would like to thank the Department of Residence Life for providing me with guidance, support, and the opportunities to work in this department. I have learned a lot as a professional, and have grown as a person, through my work in this department. I would especially like to thank my supervisors and resident assistants who have been an amazing support system throughout my educational process.

I would like to thank the BDU/UA project team for providing me with the opportunity to live and work in Ethiopia that eventually led to the creation of this project. A big thank you to my research assistants, who made this research possible. Thank you for your support within the field and while finishing this project.

Last, but not least, I would like to thank Jerry Poplin and Nisara Grandao for assisting me in my statistical analysis endeavors. Not only did they both save me from complete STATA meltdown, but they also taught me valuable coding I will undoubtedly need and use in the future!

## **DEDICATION**

This dissertation is dedicated to all the women in my life that have served as an inspiration to where I am today. In particular, I would like to dedicate this to Anne Garrone; someone I consider a friend, grandmother, and most of all, an exceptional role model. Anne is one of the strongest women I know, and her important work with war veterans and selfless dedication to her family is honorable. I only hope that one day I can repay her for all she has done for me, and I aspire to follow in her footsteps and serve as a positive role model for others.

Lastly, I would like to dedicate this dissertation to all the women in Ethiopia who made this work possible. May your voices serve as a springboard in the journey of creating better lives for women all over Ethiopia and throughout the world.

## TABLE OF CONTENTS

LIST OF TABLES .....	10
LIST OF TABLES- <i>Continued</i> .....	11
LIST OF FIGURES .....	12
ABSTRACT .....	13
CHAPTER 1: INTRODUCTION .....	14
STATEMENT OF PROBLEM .....	15
RESEARCH GOALS .....	18
SPECIFIC AIMS .....	19
SIGNIFICANCE OF PROPOSED RESEARCH .....	20
STUDY FRAMEWORK .....	22
CHAPTER 2: REVIEW OF THE LITERATURE .....	26
BACKGROUND .....	26
The College Setting .....	26
Studies on College Students .....	27
Sexual and Reproductive Health .....	27
Women in Ethiopia .....	29
Higher Education in Ethiopia .....	31
Women in Higher Education .....	32
Why Ethiopia? .....	32
LOCATION OF PROPOSED RESEARCH .....	33
Ethiopia Profile: .....	33
Amhara Region .....	34
Bahir Dar Town .....	34
Bahir Dar University .....	35
CHAPTER 3: METHODOLOGY .....	37
RESEARCH PLAN .....	37
STUDY DESIGN .....	38
SAMPLING .....	39
RECRUITMENT .....	40
STUDY CONFIDENTIALITY .....	41
LOCATION FOR STUDY METHODS ADMINISTRATION .....	42
PARTICIPANT RENUMERATION .....	43
SURVEY DATA COLLECTED .....	44
SURVEY TRANSLATION .....	46
SURVEY INSTRUMENT DEVELOPMENT .....	48
Quantitative Survey Development .....	48
Survey Instrument Development: Qualitative Measures .....	52
In-Depth Interviews .....	52
Female Focus Group Discussions .....	54
Male Focus Group Discussions .....	54
Key Informant Interviews .....	55
Self-Administered Survey Piloting .....	56

Survey Administration Timing .....	57
SURVEY ADMINISTRATION: QUANTITATIVE MEASURES .....	58
Self-Administered Survey .....	58
SURVEY ADMINISTRATION: QUALITATIVE MEASURES .....	60
Female Focus Group Discussions .....	60
Male Focus Group Discussions .....	60
Follow-up Data Collection: Male Substance Use Survey .....	61
Key Informant Interviews .....	62
In-Depth Interviews .....	63
DATA ENTRY AND ANALYSIS .....	64
Data Entry and Coding .....	64
Statistical Analysis .....	64
Key Informant, In-Depth Interviews, and Focus Group Discussion Analysis .....	65
CONSIDERATIONS FOR HUMAN SUBJECT USE .....	65
CHAPTER 4: SELF-ADMINISTERED SURVEY PARTICIPANT CHARACTERISTICS .....	67
CHAPTER 5: GENDER ROLES AND EXPECTATIONS OF BDU .....	73
WHAT IT MEANS TO BE AN ETHIOPIAN WOMEN .....	73
EXPECTATIONS AND PERCEPTIONS OF BDU .....	77
Why Women Came to BDU .....	77
Why Men Came to BDU .....	78
What Women Heard About BDU Prior to Coming .....	79
Women’s Current Experiences .....	80
What Men Heard about BDU Prior to Coming .....	81
Men’s Current Experiences .....	81
How Things Are Different For Women After Coming to BDU .....	82
How Things Are Different For Men After Coming to BDU .....	83
CHAPTER 6: INTITUTION AND ENVIRONMENTAL CONTEXT .....	86
THE INSTITUTION OF BDU .....	86
Clubs and Organizations .....	88
Key Stakeholder Interviews- Administrator Perspectives .....	91
PERCEPTIONS OF SAFETY ON CAMPUS .....	93
Harassment on Campus .....	94
Safe and Unsafe Places .....	97
Structure and Space as a Contributor to Women’s Risk .....	100
Strategies to Remain Safe .....	102
CHAPTER 7: WOMEN’S KNOWLEDGE AND BEHAVIOR .....	105
HEALTH KNOWLEDGE, BEHAVIOR AND COMMUNICATION .....	105
HIV/AIDS Knowledge .....	106
PARTICIPANT HEALTH HISTORIES .....	109
Sexual Activity: Self-Reported Questionnaire Responses .....	110
Sexual Activity on Campus: Focus Group Discussion Responses .....	111
Age at Sex Initiation .....	112
Contraceptive Use: Self-Reported Responses .....	114

Contraceptive Methods: Focus Group Discussion Responses.....	116
Test History: Self-Reported Responses .....	116
Experience with Pregnancy, STDs, and Abortion: Self-Reported Responses.....	118
Experience with Pregnancy and Abortion: Focus Group Discussion Responses ..	119
Where to Get an Abortion: Self-Reported Responses .....	120
Communicating with Partners.....	120
Summary of Mixed Methods Responses of Sexual Activity, Condom and Birth Control Use, and Pregnancy and Abortion .....	122
MULTIVARIABLE ANALYSIS .....	123
The Model Tested .....	124
Univariate Analysis.....	125
Multivariable Analysis (testing the model).....	126
Outcome Variables.....	126
Independent Variables .....	126
CHAPTER 8: WOMEN’S STRATEGIES ON-CAMPUS.....	130
PERCEPTIONS OF DATING RELATIONSHIPS.....	130
Defining Relationships Among University Men and Women.....	130
Development of Dating.....	131
Why Women “Take” A Boyfriend .....	132
Why Men “Take” A Girlfriend.....	135
The Meaning of These Relationships .....	137
Sexual Activity in Dating Relationships.....	139
When a “Known” Partner Becomes a “Safe” Partner.....	141
PERCEPTIONS OF CONDOMS AND BIRTH CONTROL .....	143
Condom Use Acceptability.....	143
Condom Pros and Cons.....	145
Birth Control Acceptability.....	147
Birth Control Pros and Cons .....	148
What Can Be Done to Promote Condom and Birth Control Use .....	151
CHAPTER 9: DISCUSSION AND CONCLUSIONS .....	154
OVERVIEW .....	154
Gender Roles and Expectations (Specific Aim 1) .....	155
The Institutional Space and Safety on Campus (Specific Aim 2) .....	156
Knowledge and Risk Taking Behaviors (Specific Aim 3).....	157
Dating Relationships and Perceptions of Birth Control and Condoms (Specific Aim 4).....	158
LIMITATIONS.....	160
STRENGTHS .....	161
DISCUSSION .....	163
STEPS FORWARD.....	167
APPENDIX A: SELF ADMINISTERED SURVEY .....	172
APPENDIX B: IN-DEPTH INTERVIEW GUIDE FOR FEMALE STUDENTS.....	182
APPENDIX C: FEMALE FOCUS GROUP DISCUSSION .....	190
APPENDIX D: MALE FOCUS GROUP DISCUSSION GUIDE.....	199

APPENDIX E: KEY INFORMANT INTERVIEW GUIDES ..... 206  
APPENDIX F: MALE SUBSTANCE USE SURVEY, IN-DEPTH INTERVIEW, AND  
FOCUS GROUP DISCUSSION..... 213  
WORKS CITED ..... 220

## LIST OF TABLES

<b>Table 1.</b>	Timeline of Research.....	37
<b>Table 2.</b>	Quantitative Data Collected.....	44
<b>Table 3.</b>	Qualitative Data Collected.....	45
<b>Table 4.</b>	Self-Survey Details.....	58
<b>Table 5.</b>	Female Focus Group Discussion Details.....	60
<b>Table 6.</b>	Male Focus Group Discussion.....	61
<b>Table 7.</b>	Male Substance Use Survey.....	62
<b>Table 8.</b>	Key Informant Interview Details.....	63
<b>Table 9.</b>	In-Depth Interview Details.....	63
<b>Table 10.</b>	Self-Survey Sample Characteristics.....	70
<b>Table 11.</b>	Overall Safety on Campus: Themes and Subthemes from Interviews with N=28 Female Students.....	94
<b>Table 12.</b>	Female Survey Respondents' HIV/AIDS Knowledge (N=997).....	107
<b>Table 13.</b>	Female Survey Respondents' STD Knowledge (N=997).....	108
<b>Table 14.</b>	Birth Control Methods Used for Women Reporting Sexual Activity.....	115
<b>Table 15.</b>	General Condom Use for Women Reporting Sexual Activity... ..	115
<b>Table 16.</b>	Female Survey Respondents' Reported Test History (N=997).....	117
<b>Table 17.</b>	Female Survey Respondents' Reported Pregnancy, STD, Sexual Assault and Abortion History.....	118
<b>Table 18.</b>	Female Survey Respondents' Reported Sexual Assertiveness (N=997).....	121

**LIST OF TABLES - *Continued***

<b>Table 19.</b>	Comparison of Self-Reported Data and Focus Group Discussion Data for Select Questions.....	120
<b>Table 20.</b>	Unadjusted Characteristics of Perceived HIV/AIDS Knowledge.....	127
<b>Table 21.</b>	Adjusted Odds of Perceived Knowledge of Sexually Transmitted Diseases of Participants.....	128
<b>Table 22.</b>	Women’s and Men’s Responses to Condom Use Pros and Cons....	146
<b>Table 23.</b>	Women’s and Men’s Reported Pros and Cons of Birth Control....	149

**LIST OF FIGURES**

<b>Figure 1.</b>	Map of Amhara Region, Ethiopia.....	34
<b>Figure 2.</b>	Location of Bahir Dar, Ethiopia.....	35
<b>Figure 3.</b>	Procedures for Self-Survey Piloting.....	57
<b>Figure 4.</b>	BDU Organizational Structure after BPR.....	87
<b>Figure 5.</b>	Sexual Activity of Participants (N=997).....	110
<b>Figure 6.</b>	Response for Age at First Sexual Encounter (N=997).....	112
<b>Figure 7.</b>	Reported Age at First Sexual Encounter (N=167).....	113
<b>Figure 8.</b>	Number of Reported Sexual Partners (N=997).....	114
<b>Figure 9.</b>	Where Women Who Report an Abortion go for this Procedure.....	120

## ABSTRACT

**Background:** The poor health status of people globally is a reminder of the social gradient of health that exists within countries and between countries. Together, the structural determinants and conditions of daily life constitute the social determinants of health (SDH), and result in much of the health inequity between and within countries. In an attempt to address the SDH, and challenge the world to tackle poverty and gender inequalities in the world's poorest countries, the Millennium Development Goals (MDGs) were created. Goal three of the global Millennium Development Goals (MDGs) aims at empowering women through policies and programs that builds women's capabilities, improves their access to economic and political opportunity, and guarantees their safety. Yet, further research is needed to understand how exactly education empowers women and translates into "better lives" for women. **Purpose:** The overall goal is to examine how women navigate, negotiate, and mediate their sexual and reproductive health in the complex university environment. **Methods:** The study was cross-sectional in design and employed mixed methodology. It consisted of key informant interviews, in-depth interviews, focus group discussions, and self-administered questionnaires. **Results:** The case study of Ethiopia provides important lessons learned and an understanding of how to effectively implement strategies to address MDG3. Results of this study suggest that interventions should enhance women's power to make decisions and their ability to access resources. The power dynamics that continue to keep women down must be addressed to allow them the opportunity to rise to the level of their male peers.

## CHAPTER 1: INTRODUCTION

The poor health status of people globally is a reminder of the social gradient of health that exists within countries and between countries, caused by unequal distribution of power, income, goods, and services (Marmot et al., 2008). The consequent and immediate visible circumstances of people's lives, which includes access to health care and education, work conditions, home environment, and the community they live within all impacts their lives in disproportionate ways. This unequal distribution of health-damaging experiences is the consequence of a combination of poor social policies and programs, unfair economic arrangements, and bad policies (Marmot et al., 2008). Together, the structural determinants and conditions of daily life constitute the social determinants of health (SDH), and result in much of the health inequity between and within countries (Marmot et al., 2008: 1661).

While great improvements in health have been observed worldwide and within countries over the past 30 years, much that still needs to be addressed to close the health gap. Without action on SDH the countries in the greatest need will continue to suffer the most (Marmot et al., 2008). Poverty is bad for people's health, but how to address the link between health and poverty in an effective way is less clear. An important component of addressing the SDH involves tackling gender inequities, which are pervasive in all societies (Marmot et al., 2008). Biases in power, resources, entitlements, norms and values, government, organizations and the structures of program damage the health of millions of girls and women worldwide (Marmot et al., 2008). In an attempt to address the SDH, and challenge the world to tackle poverty and gender inequalities in the

world's poorest countries, the Millennium Development Goals (MDGs) were created (Marmot, 2005). Although not all MDGs will be achieved by 2015, the MDGs are an important step in the right direction towards addressing health and poverty by taking action on the SDH. Addressing the MDGs does not only include relieving poverty, but it also includes improving the circumstances in which people live and work by addressing the underlying social fabric and structures at play influencing the health and welfare of people, such as gender inequality (Marmot, 2005).

## **STATEMENT OF PROBLEM**

While over the past few decades advancements have been made in improving the health status of women, such as increased life expectancy and decreased fertility rates, many women in developing countries continue to die each year in pregnancy and childbirth as a result of limited access to health resources (Grown et al., 2005; Cleland et al., 2006; Doyal, 2001). MDG3 aims to empower women through policies and programs that builds women's capabilities, improves their access to economic and political opportunity, and guarantees their safety (Grown et al., 2005).

The precise meaning of "gender empowerment" and how this plays out in the reality of women's health outcomes is not clear and relatively absent from the literature (Grown et al., 2005; Doyal, 2000; Vlassoff, 2002). Historically, the term "empowerment" has been overused, misused, and co-opted (Stromquist, 2002; Stacki and Monkam, 2003; Murphy-Graham, 2010). Empowerment is commonly employed as a synonym for enabling, participating, and speaking out. This idea of empowerment is often linked with increasing educational opportunities for women around the world and

used as a tool to make women's "lives better" (Murphy-Graham, 2010). Resources, in the form of education are thought by many to confer greater economic mobility, personal autonomy, and social status, thereby making women's lives healthier (Murphy-Graham, 2010). This notion has been challenged by questioning whether or not educational attainment can make the necessary contributions to change women's status in society if access to the needed resources are controlled and prohibited by the societal structure (Sperandio, 2010). Nonetheless, the view that education leads to women's empowerment, and indirectly to gender "equality," has gained in popularity, although there is still much to learn about how exactly education empowers women and translates into "better lives" for women (Stein, 1997; Murphy-Graham, 2010). In the past decade, serious attention has been given to promoting women's empowerment vis-à-vis increased educational opportunities in the way of funding from donors and international agencies (Morely, 2007; Murphy-Graham, 2010; Sperandio, 2010). This global push for educating women can be observed in many developing countries such as Ethiopia.

Ethiopia is currently addressing MDG3 and engaging in gender empowerment efforts by actively recruiting and enrolling women into the university setting all over the country. Ethiopia is engaged in a massification of higher education country-wide, and has gone from two federal universities to twenty three over the past ten years (Key Informant Interviews, 2010). Along with the rapid expansion of higher education, new opportunities for students to obtain this education have been created. In 2003, the Ethiopian Government implemented a cost sharing system for higher education that is modeled off the Australian deferred loan scheme (Key Informant Interviews, 2010).

With this cost sharing system, students have the opportunity to be sponsored (tuition, room, and board) by the Ethiopian Government to obtain their degree at one of the federal government universities. Students compete for these sponsored spots by taking a placement exam in their tenth grade of high school. The students who score well enough on this exam are then sponsored by the government and will attend one of the twenty three federal universities. Students who are sponsored will be assigned by the government to both the university and their major. After graduating from the university and obtaining a job, students are expected to pay back 10-15% of their educational costs to the government as part of the deferred loan scheme of this sponsorship.

Because only a select number of students will obtain this sponsorship, a fiercely competitive environment is cultivated beginning as early as high school (male and female focus group discussions, 2010). In an effort to recruit and enroll more women into the university setting, and address MDG3, women have lower entrance and test requirements compared to their male peers, which adds to this competitive environment among men and women. This competitive environment continues throughout a student's university experience, but instead of competition for university sponsorship, the competition now is for grades. Most instructors adhere to a curved grading scheme with only a few students receiving an "A;" therefore students are willing to do anything to receive top marks as they believe this will ensure job placement at graduation (male and female focus group discussions, 2010). Since women are often admitted into university with lower grades and test scores, they often find themselves less academically prepared compared to their male peers, yet they are evaluated and expected to perform at the same academic level as

men. This inequity in the admission process often results in women engaging in sexual relations with male peers and/or instructors in order to pass classes and avoid academic dismissal from university.

Given the hyper-competitive environment that exists, women are often placed at risk in terms of their social status, health, and safety. University women must often contend with traditional masculinities, as well as compete to survive in a tough academic environment. Informal conversations with female students have revealed that the university setting is a site of empowerment, and seen as a “vehicle of change” for them. However, at the same time, this environment is also a place in which women must contend with the long-standing cultural traditions and power relations at play in their everyday lives that may expose them to risks (personal communication, February 2009-April 2010). As a result, the ability of women to navigate, negotiate, and mediate their health experiences in this complex environment is key to understanding how gender empowerment efforts can be better situated and implemented in higher education settings around the world and how to achieve MDG3. This research was undertaken to explore the health experiences, risks on-campus, and coping strategies of undergraduate women attending Bahir Dar University (BDU) during the Fall 2010-Spring 2011 semester.

## **RESEARCH GOALS**

As a means for understanding the role of education in the process of empowerment for women and achievement of MDG3, the overall goal of this research was understand how women who attend BDU navigate, negotiate, and mediate their sexual and reproductive health experiences in the university setting. As an additional

goal for better understanding young, college age women's health, a systematic analysis of the factors influencing the sexual and reproductive health of female students at BDU was examined in this study.

### **SPECIFIC AIMS**

Given the above research goals, the specific aims were as follows:

**Specific Aim 1:** Identify normative gendered behavior for females students before they come to the university and then when they are within the university setting;

**Specific Aim 2:** Document gender-based policies, procedures, and resources at BDU and how women's perceptions and strategies fit within this system;

**Specific Aim 3:** Describe factors influencing women's health by exploring sexual and reproductive health knowledge and attitudes, sexual communication and self-confidence, safety on campus, and personal health practices;

**Specific Aim 4:** Identify individual strategies of students to promote health, safety, and academic success on campus.

## **SIGNIFICANCE OF PROPOSED RESEARCH**

The multidisciplinary nature of this research is designed to link wide audiences and engage various stakeholders interested in women's health in general, and higher education in particular. This research has far-reaching implications for gender advocacy efforts in both developing and developed countries, and can inform policy decisions at the university, country, and global level. The present-day conditions that women face in the university setting must be taken into account to create an environment where women can not only achieve optimal health, but also that their experiences can contribute to larger issues of women's health through "empowerment," and "equity" strategies at the global level. This study will make a significant and needed contribution to the limited body of literature on women's health experiences at university campuses throughout the world. The results of this research will be used at the local and global level to guide future intervention strategies and policy-level action to promote gender equality in university settings.

A key anthropological contribution to this health research is using higher education as a lens in which to examine the health and welfare of female students as a socially embedded and dynamic process. Utilizing an anthropological approach to the study of women's empowerment in higher education, and associated health outcomes, will provide substantive knowledge, offer relevant conceptual frameworks, and methodological insights to the field of gender and development. An anthropological perspective will enhance public health approaches by moving beyond "selective incorporation of specific methods to encompass research conceptualization and

theoretical synthesis” (Lambert and McKevitt, 2002: 212). It is not enough to recognize women’s health issues in university settings as isolated events and create specific public health responses to target them; instead these approaches must be grounded in theoretical approaches that guide appropriate responses. This more explorative approach provides the necessary theoretical framework for this research, and will produce an ethnographic context to women’s health in higher education settings grounded in historical processes and present day circumstances. This research will take a new look at gender empowerment efforts by delving deeper into the mechanisms that limit progress and highlight potential changes required to propel gender and development efforts forward.

Research on women’s gendered health experiences in the university setting in developing country contexts are absent in the current literature, necessitating action and novel approaches to studying this phenomenon. Over the past several decades colleges and universities in the U.S. have focused efforts on making campuses more equitable for men and women, yet the college experience remains impacted by gender inequities (Rowan, 2002; Kelly and Torres, 2006; Smith et al., 1994). While more women are graduating from universities today than ever before, issues of safety and increasing reports of sexual assault hamper women’s experiences (Kelly and Torres, 2006). Top-down gender empowerment efforts are not devoid of the contexts in which they are implemented. However, the local realities are often not considered and understood in a way to engage and assist the very women they are intended to reach with these empowerment and policy actions. By situating this research within a gender health

framework global gender equality and empowerment efforts can be better situated and implemented within the context of higher education.

## **STUDY FRAMEWORK**

This study applied a systematic, comprehensive and integrated public health and anthropological approach to the evaluation of female students' health issues at BDU. The multidisciplinary nature of this research was designed to promote the use of a broader suite of research strategies, as well as future interventions and policies to reduce women's health risks. This research was hypothesis-generating, which allowed for the experiences and knowledge of female students to be studied directly. Many factors influencing the health and welfare of female students were examined in this study, rather than attempting to explain possible associations and relationships in the absence of baseline data.

Through a variety of methods, data collection was designed to assess the local social, cultural, economic, and environmental conditions of female students at BDU. The prevalence and distribution of risky or protective behaviors were identified and variable associations with possible determinants were examined. In addition, the various strategies women take to mediate their health outcomes were examined, as well as strategies they feel BDU can take to assist female students on campus. These approaches have led to the identification of factors that most strongly influence the health and welfare of female students. These approaches not only inform and clarify patterns and predictors of current behavior, but also suggest promising routes to induce behavior change and ways to implement policy. This process was dynamic and iterative, and was used to inform

intervention and policy priorities by verifying where there is sufficient knowledge to move forward and by identifying critical information gaps.

Several theories and approaches guide, inform, and frame this data collection process and discussion of results. Guided by feminist scholarship, the study examined gender as a normative cultural construct, influenced by both space and time in a given society (Butler, 1990). Gender “shapes patterns of expectations, processes of everyday life, ideas of self and identity, and interactions among friends, kin, and strangers” (Lorber, 1994; Thurston and Vissandjee, 2005:232). Gender also orders, and is ordered, by other social institutions such as economy, ideologies, family, politics, religion, and the media (Lorber, 1994: 232). Elgstrom (2000) argues that “new gender norms have to fight their way into institutional thinking.” Therefore, the process of gender equality and empowerment is contested and can involve “negotiation” rather than a simple adoption of new gender policies. This research examined the ways in which women resist or conform to gender ideologies in the university, and how gender is expressed in terms of health decisions and health outcomes.

Feminist theory reminds us that “gender equality” is not synonymous with “sameness.” Gender equality means accepting and valuing equally the differences between women and men and the diverse roles they play in society (Walby, 2005: 327). Thus, this research examined ways to make higher education a transformative process for both women and men, and not just a process of assimilating women into male dominated domains.

Drawing on Inhorn (2006), this research contributes to several ethnographic themes within women's health. First, by examining the cultural construction of women's bodies this research will focus on the ways in which female students perceive themselves as Ethiopian women and how their gendered experiences are embodied, contested, and socially and historically situated. Second, examining the health-demoting effects of patriarchy will contribute to the understanding of the ways in which male dominance in the university contributes to specific examples of gender oppression such as violence against women and women's inability to negotiate safe sex (Inhorn, 2006). Important to the examination of patriarchy, is to understand the power women have to make decisions regarding their health, and how at times this power is impeded. Third, by examining the politics of women's health within the university context we can begin to understand the ways in which women's health becomes a site of overt and covert political struggles (Inhorn, 2006). Lastly, Dudgeon and Inhorn (2004) argue the importance of including men in developing frameworks for women's health paradigms. Therefore, this research included men in study participation (stakeholders and students) as a way to fully understand women's social content and to support strategies that engage them as agents of change in women's health initiatives (Dudgeon and Inhorn, 2004).

Given the challenges and constraints of women, the university can be viewed as both an environment of opportunity and an environment of risk. As a result, this research examined the harm risk reduction strategies women engage in to reduce harmful health outcomes and how this fits into their perceived hierarchies of health risk (Nichter, 2008). The topic of harm reduction can be situated within a larger thematic area of anthropology

and health including: vulnerability, risk, and responsibility (Nichter, 2003:14). Harm reduction practices are an expression of agency and are undertaken to reduce a sense of vulnerability and enhance a sense of self control (Nichter, 2003:14). Harm reduction practices are fostered at the site of the individual body by those who wish to divert various risk factors affecting health (Nichter, 2003:14).

Harm reduction involves a range of behaviors and factors, and this study investigated what steps women (and men) take to reduce harmful health outcomes, particularly with regard to sexual practices. To fully understand the harm risk reduction strategies of women and men at BDU, an understanding of the social relations of risk and vulnerability are needed. It is important to understand not only physical risk, but how social and cultural risk may also be present in a given environment. Understanding the physical, cultural, and social risk at play in students' everyday lives has implications and may provide valuable insights into health prevention measures. Utilizing a harm risk reduction approach invites us to consider the myriad of ways in which people experience and respond to risk individually, as well as part of social groups (Nichter, 2003). By fully recognizing the power harm risk reduction and risk perceptions play in the decision making process of students on campus we can examine ways to mobilize both personal and collective efficacy among women on campus to make positive health changes.

## CHAPTER 2: REVIEW OF THE LITERATURE

### BACKGROUND

#### *The College Setting*

College is a turbulent time for many students and is a well-established developmental phase that students go through (Karam et al., 2007; Trepka et al., 2008; Scott-Sheldon et al., 2008). The college years offer an environment for new experiences, personal freedom, and identity development (Scott-Sheldon et al., 2008). Going to college is a time of great change; students move away from home, family, and long-standing relationships. Throughout their college experience, students pass through a phase of vulnerability, including intellectual, emotional, and social vulnerability (Karam et al., 2007). This time of vulnerability and development is influenced by their new environment, peers, and other factors. This period is noted by the emergence of risky health behaviors that may place college students at risk for health problems (i.e. alcohol use and risky sex) (Scott-Sheldon et al., 2007). College students tend to delay marriage and live and socialize with large numbers of other young adults, which can encourage sexual activity that is not safe and/or monogamous (Trepka et al., 2008). College campuses are unique environments and many young future leaders of the world will have passed through a college campus at some point in their life. Because college campuses are unique environments, the populations of students who inhabit them also have specific health concerns that are not uniformly shared with the general population. This young,

risky, and in many ways heterogeneous and diverse population poses different challenges to already precarious public health infrastructure, particularly in developing countries. Understanding the positive and negative influences in this setting is important for developing health interventions relevant to this specific population of young adults.

### ***Studies on College Students***

Most of the literature published on college students and health related outcomes have primarily been conducted in developed countries (Bearinger et al., 2007; Hasse et al., 2004; Karam et al., 2007; Kirby et al., 2007). Additionally, most studies published in North America largely focus on the problem of alcohol consumption among college students, with little attention focused on other health issues (Johnston et al., 1992; Wechsler et al., 1995; Wechsler et al., 1994; Dantzer et al., 2006; Karam et al., 2007). A collection of published studies do focus on sexual behavior among college students, but usually in relation to alcohol use (Kirby et al., 2007; Ross et al., 2006;). More recently, studies on mental health issues among college students have emerged as an important health concern (Youngman et al., 2009; Kitzrow, 2003; Patel et al., 2007; Karam et al., 2007). More studies on the variety of health issues relevant to college students are needed in general, and in developing nations in particular.

### ***Sexual and Reproductive Health***

Despite global calls for all women to have universal access to reproductive and sexual health services, this area persistently remains neglected in women's health (Cleland et al., 2006). Unsafe sex is the second most important risk factor for disability

and death in the world's poorest communities, and the ninth most important in developed countries (Cleland et al., 2006; Doyal, 2001). Inexpensive and effective interventions are available to prevent unintended pregnancy, provide safe abortions, help women safely through pregnancy and child birth, and prevent and treat sexually transmitted infections. Yet, every year, more than 80 million women globally, have unintended pregnancies, and more than half a million women die from complications associated with pregnancy, childbirth, and the post-partum period, and over 340 million acquire new gonorrhea, syphilis, chlamydia, or trichomonas infections (Cleland et al., 2006; Doyal, 2001). These negative sexual and reproductive health outcomes primarily impact the world's young poor women, appealing to the need for an international and global commitment to addressing gender inequality and reproductive rights (Cleland et al., 2006).

Gender inequalities in income and wealth make women especially vulnerable to poverty (Doyal, 2001). Improving the global health outcomes of women is linked to the need to address sexual and reproductive health as a strategy to decrease poverty. The link between sexual and reproductive health and poverty reduction has been questioned, yet studies conducted in the last two decades provide evidence for an association between poor women and negative reproductive health outcomes and that early and unintended childbearing does lead to poverty (Green and Merrick, 2005). Where sexual and reproductive health services are absent, or of poor quality and underused in many countries, this is often a result of deeply entrenched cultural, religious, and the political nature of issues such as sexual intercourse and sexuality (Cleland et al., 2006; Doyal, 2001). The increasing influence of these forces around the world threatens to undermine

progress in women's health outcomes and prohibit future advancement. The apparent disconnect between the potential for sexual and reproductive health services, and the local realities in which women live, demands the attention of public health.

### ***Women in Ethiopia***

Like many other developing countries, women in Ethiopia still have relatively little power, limited rights, and inadequate access to resources (Prime Minister Office, 2004; DHS, 2005). Women represent 49.8% of the population and significantly contribute to food production; however their participation in the agricultural sector and economics of the country has not translated into better access to resources or decision-making powers (Prime Minister Office Ethiopia, 2004; DHS, 2005). Today, women still hold limited political positions and represent only 7.6% of the Parliament and 12.9% of State (regional) Council (Prime Minister Office, 2004). Violence and discrimination against women is still widespread in the country, and remains relatively accepted. As HIV/AIDS rates continue to rise, women are disproportionately affected compared to men (Prime Minister Office, 2004). The Ethiopia Demographic and Health Survey in 2005 revealed that for women aged 15-49 years the prevalence is 2 %, while for men in the same age range HIV prevalence is under 1 % (DHS, 2005). This same DHS survey revealed that young women are particularly vulnerable to HIV infection and the prevalence of HIV for women aged 20-24 years is over three times that of men in the same age group (DHS, 2005).

Ethiopian researchers and women's rights activists have documented many of the gender-based practices of Ethiopia that lead to negative health outcomes for women

including female genital mutilation (Berhane et al., 2001), early childhood marriage, marriage by abduction (Getahun, 2001), child prostitution, and trafficking of women (Sullivan et al., 2005). The health consequences of the above practices may lead to high maternal mortality, obstetric fistulas, injuries from domestic abuse and rape, psychological trauma, and infection (Sullivan et al., 2005). Although in recent years the Ethiopian constitution has been changed to afford “some” legal protection to prevent these practices, protection and enforcement is not widely and uniformly enforced (Sullivan et al., 2005). As a result, educating women is seen as a means not only to reduce poverty, but also to provide increased economical power thereby decreasing the incidence of the above named negative health outcomes (DHS, 2005; Global Health Council, 2009; OECD, 2003).

The Ethiopian education and training policy declared in 1994 addressed the importance of girls education and stated that the government will give financial support to raise the participation of women in education (Prime Minister Office Ethiopia, 2004). This same policy gives special attention to the participation, recruitment, training, and assignment of female teachers. Although many policies and laws are in place to encourage women’s rights and gender equality throughout the country (Prime Minister Office of Ethiopia, 2004), it is not clear how well these government actions are actually working in everyday practice. Examining the conditions of women who are in the process of attaining a higher education degree offers one lens in which to explore the status of women in Ethiopian society, and presents opportunities to promote gender equality and women’s rights.

### ***Higher Education in Ethiopia***

The traditional Western notion of higher education in Ethiopia can still be considered a relatively recent phenomenon. The initiation of higher education began in 1950 with the creation of the University College of Addis Ababa (Wanna, 2004). The expansion of higher education in Ethiopia experienced growth until the mid-1980s, when what is referred to as the “lost decade” of African Higher Education occurred (Mama, 2003). Higher education in Ethiopia reached considerable success during the later part of the 20<sup>th</sup> century (World Bank, 2003), but did not escape criticism. Specifically, doubts were raised in the 21<sup>st</sup> century about the inability to ensure access, quality, relevance, efficiency, and responsiveness to societal demands in the face of increasing globalization (Semela, 2006). As a result, educational reform was needed to initiate the needed change at the country level (World Bank, 2003; Wanna, 2004).

Higher Education Reform began in Ethiopia in 1994 following the adoption of the Education and Training Policy (TGE, 1994). The objectives of the reform were to: ensure equity, access, accountability, relevance, and responsiveness to the demands of the Ethiopian people (Ashcroft, 2004). In particular, the reform process aimed to keep in perspective poverty reduction and sustainable development (Ashcroft, 2004). In line with the above objectives, gender equality and bridging the development gap between various regional states, nationalities, and other social groups via increasing access to Higher Education has been a major emphasis of this reform (Habtamu, 2004).

### ***Women in Higher Education***

After the fall of the military regime in Ethiopia, the government considered the need to comprehensively address gender inequality in socio-economic and political arenas (Semela, 2006). Addressing gender issues received considerable attention and was viewed as playing a crucial role in poverty reduction, ensuring good governance, and democracy. As a result, major policy documents articulated and emphasized gender equality (FDRE, 1995). Within the constitutional framework, the New Education and Training Policy further articulated the need to address the long history of inequity and discrimination suffered by Ethiopian women. According to this document, special attention is given to women and to those students who did not get educational opportunities in the preparation, distribution, and use of educational support (TGE, 1994). Additionally, the Ethiopian Higher Education Proclamation (FDRE, 2004) has further articulated the need to implement affirmative action for women, students with disabilities, and native students of disadvantaged regions. But, with these policies in place, little focus has been given to keeping women in higher education safe, healthy, and ultimately graduated within this system.

### ***Why Ethiopia?***

Ethiopia offers a unique place to examine how top-down gender empowerment strategies play out at the local level. Although many policies and laws are in place to encourage women's rights and gender equality throughout the country, many question how well these government actions are actually working in everyday practice (Prime Minister Office of Ethiopia, 2004). Little attention has been focused on how best to both

educate and empower women, while also keeping women safe and healthy throughout the process. Examining the conditions of women who are in the process of attaining a higher education degree offers one lens in which to explore the status of women in Ethiopian society, and presents opportunities to promote gender equality and women's rights. As a result, BDU will serve as a site to study how the juxtaposition of higher education and gender equality efforts can be systematically examined, unpacked, and promoted at the country and global level.

## **LOCATION OF PROPOSED RESEARCH**

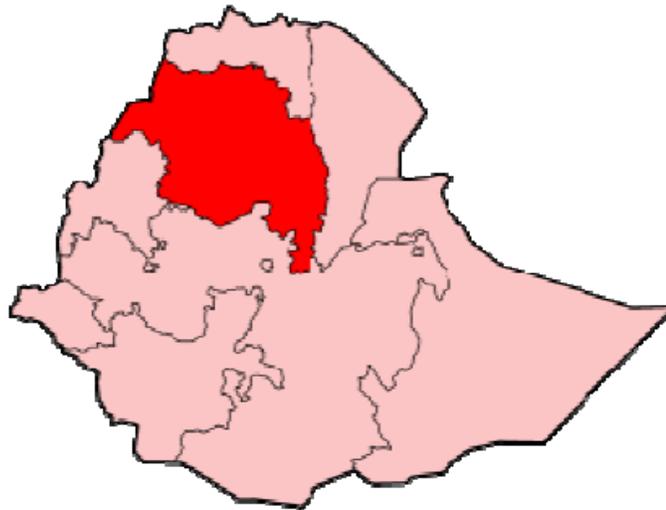
### ***Ethiopia Profile:***

Ethiopia is a landlocked country situated in the Horn of Africa bordered by Eritrea to the north, Sudan to the west, Kenya to the south, Somalia to the east and Djibouti to the north-east (USAID, 2008; CIA World Factbook, 2008; DHS, 2005). Ethiopia is one of the oldest countries in the world and is Africa's second-most populous nation with an estimated 83 million people (DHS, 2005; UN Human Development Report, 2007; CSA, 2008). It is also one of the least developed countries in the world, ranking 168<sup>th</sup> out of 173 countries in the UNDP Human Developmental Index (UNDP, 2002). Despite this, Ethiopia is considered to be the political capital of Africa, holding an important place in the continent's political economy and in the world's view of progress in Africa (Hobson, 2008).

### ***Amhara Region***

The proposed research was carried out in Bahir Dar, which is located in the Amhara region of northwest Ethiopia and occupies a total area of 170,152 km<sup>2</sup> (Figure 1). The Amhara region is one of the nine ethnic divisions of Ethiopia, which contains the homeland of the Amhara (or Amharic) people. The current estimated population of the Amhara region is 17 million, with approximately 91 percent of the population living in rural areas and approximately 9 percent living in urban areas (CSA, 2008).

**Figure 1: Amhara Region, Ethiopia**



### ***Bahir Dar Town***

Bahir Dar is the capital of the Amhara Region, located approximately 578 km northwest of Addis Ababa, the capital of Ethiopia (Figure 2). Bahir Dar is situated on the southern shore of Lake Tana, which is the source of the Blue Nile at an elevation of 1,840 km above sea level. Bahir Dar is one of the leading tourist destinations in Ethiopia with

attractions such as Lake Tana and the Blue Nile Falls. The 2007 Ethiopia census reported a population of 182,672 for Bahir Dar town (CSA, 2008). The largest three ethnic groups reported in Bahir Dar are the Amhara (93.2%), the Tigrayan (3.98%), and the Oromo (0.7%). The primary language of Bahir Dar is Amharic (95.2%) and the primary religion practiced is Ethiopian Orthodox Christianity (87.53%) followed by Muslim (11.47%) (CSA, 2008).

**Figure 2: Location of Bahir Dar, Ethiopia**



### ***Bahir Dar University***

Bahir Dar University is located in Bahir Dar town and was established by the merging of two former smaller institutes; the Polytechnic Institute established in 1963 and the Teachers College established in 1973 (Plan and Program Office, 2009). In 2000,

the university was inaugurated and the Polytechnic Institute and the Teachers College became the Faculty of Engineering and Faculty of Education respectively. In addition, the university added two more faculties, that of Business and Economics and the faculty of Law, which were established in 2001 and 2003 respectively. As of March 2009, Bahir Dar University had reached a size of 38,616 students, of which, 15,639 were regular full-time day students, 6,585 were evening students, 6,955 were summer students, and 9,437 were classified as distance students (Plan and Program Office, 2009).

## CHAPTER 3: METHODOLOGY

This chapter will highlight and provide all details related to the mixed methods approach used in this study. It will begin by highlighting the research plan, study design, sampling framework, recruitment strategy, study confidentiality, location of study administration, and participant remuneration. It will then describe survey translation, survey instrument development, survey piloting, and survey administration.

### RESEARCH PLAN

The research took place over three phases and included approximately 8 months of fieldwork, although the researcher spent approximately 16 months in-country over a 2 ½ year time-period. During the first phase, the researcher selected the study population, piloted the self-administered questionnaire, and trained three female and three male research assistants to assist with data collection and recruitment activities. It was during the second phase, where the researcher conducted the majority of the study activities. During the third phase, the researcher performed follow-up data collection by administering additional female and male focus group discussions, as well as a male self-administered survey and in-depth interviews. The specifics of each can be found below:

**Table 1: Timeline of Research**

<b>Phase 1: Study Set-Up</b>	<b>Dates:</b>
Translated self-administered questionnaire from English into Amharic	August 2010
Hired and train research assistants on the self-administered surveys, in-depth interviews, and focus group discussions	August-September 2010
Secured study site	August-September 2010

<b>Phase 2: Primary Data Collection</b>	<b>Dates:</b>
Recruited students with the assistance of research assistants and piloted self-administered questionnaire during two focus group discussion sessions	September-October 2010
Advertised study and held information sessions	End of September- Early October 2010
Recruited and enrolled students for self-administered survey	October-December 2010
Recruit and enroll students for in-depth interviews	October-December 2010
Conducted focus group discussions	November 2010-January 2011
Conducted key informant interviews with BDU administration and male and female students	December 2010- January 2011
Enter quantitative interview data into Excel Translated qualitative survey from Amharic to English	Ongoing: October 2010- January 2011
<b>Phase 3: Follow-up Data Collection</b>	<b>Dates:</b>
Conduct follow-up female focus group discussions and conduct male substance use sub-study.	May 2011-July 2011

## **STUDY DESIGN**

The conducted study was cross-sectional in design and employed mixed methodology to capture information on female students' sociodemographic characteristics, health behavior, health knowledge, health services access, safety on campus, mental health, and personal health histories at Bahir Dar University. Methods consisted of key informant interviews, in-depth interviews, focus group discussions, and self-administered questionnaires.

## **SAMPLING**

Based on data from the 2009-2010 academic year, approximately 5,804 female and 9,425 male undergraduate students were enrolled as regular day-time students at Bahir Dar University. Because the record keeping at Bahir Dar University is paper-based, and not all students have complete demographic information collected in their records, estimates of the average age of undergraduate students is between 18-22 years. These estimated age ranges are derived from conversations with university officials (President, Vice President, and Registrar, March 2010) and experience working with full time day students for over one year. The total undergraduate students stated above served as the sampling frame for this study. Both female and male students volunteered for study participation. Male students were only asked to take part in key-informant and in-depth interviews, while female students were included in all study components. All full-time female and male undergraduate students who wanted to participate and met the following inclusionary conditions criterion were allowed to participate:

1. Male or female undergraduate student;
2. Enrolled as a regular full-time day student at Bahir Dar University;
3. Willing and able to participate in one or a combination of the following methods:  
key informant interview, in-depth interview, focus group discussion or self-administered questionnaire.

The minimum and maximum number of students originally sought for questionnaire administration was 400 and 600 respectively. The minimum number of 400 was sought to obtain at least 100 students per year (1<sup>st</sup> year through 4<sup>th</sup> year

students), as well as to meet statistical power requirements. Time and budget restrictions limited the number of students surveyed to be 600 students maximum. A study of this nature had never been conducted on this campus before; therefore the a priori selected number was an estimate since the number of students who would actually volunteer for study participation was not known. As with the self-administered surveys, time and budget constraints restricted the number of focus groups that could be conducted for this study to an anticipated 4 for women and 2 for men. Lastly, it was anticipated that 10-15 in-depth surveys would be administered to women who were in their second year and above.

## **RECRUITMENT**

The study was advertised through poster announcements on campus. The announcements included general information about the overall study goals, methods used, and details of remuneration. The posters also included information on where and when study information sessions would be held for students to ask questions and obtain more study information. Additionally, the research team walked around on campus handing out small flyers, that contained the same information as the large posters. Special attention was paid to the recruitment of women from the engineering campus where significantly fewer women are enrolled in classes. The over recruitment efforts were performed to gather information from women who may be less likely to hear about this study through word of mouth due to the more male-dominated nature of the Engineering campus.

## **STUDY CONFIDENTIALITY**

Ensuring participant confidentiality was of utmost importance. All aspects of the study were explained to participants during the informed consent process. During this process, students were notified that their answers and identity would be kept confidential and that they have the right to withdraw from the study at any point in time without penalty. Data collected during this study was kept by the principal investigator in a locked and secure location. Identifying information was collected only when participants initially volunteered for either the self-administered survey or the focus group discussion. One master list for the self-administered survey and focus group discussions was generated per class grade and kept by the principal investigator to verify: 1) the class year of each the student, 2) the campus at which they are registered, and 3) the name of the student. After initial registration and documenting the above information, each student was assigned a survey number for the self-administered survey and a unique identifying number for the focus group. The only identification recorded on the self-administered survey was the assigned survey number. Students were asked not to record their name or any other identifying information on their self-administered survey. The same process of name collection during registration was performed for the focus group discussions, but students were not assigned a survey number since they did not take an individual survey. Instead, they were assigned a unique identifying number on their consent form to ensure that a student only participated once and could be tracked throughout the study if they participate in both the self-administered survey and focus group discussion components.

Given remuneration was provided for study participation, it was predicted students may try to take the survey more than once. The university was unable to provide a master list of all female students enrolled as full-time day students separated by class or as an aggregate group, therefore the above identifying information was collected to reduce the possibility of students taking the survey more than one time, thus limiting potential bias of results. After study completion, the master list of students and all other data collected for the study was stored in accordance with The University of Arizona's Human Subjects established protocol (<http://orcr.vpr.arizona.edu>). The collected information (surveys, focus group discussions, and translations) were stored in a locked file cabinet at the University of Arizona in the College of Public Health and only accessed by the PI. Computer files were protected with a password. At the close of this research, surveys and notes are analyzed they will be aggregated and destroyed in Ethiopia by burning (no shredder was available) (<http://orcr.vpr.arizona.edu>).

#### **LOCATION FOR STUDY METHODS ADMINISTRATION**

Given the sensitive nature of some of the study topics, lack of previous campus-wide research efforts, and fear of being identified by their peers or instructors on campus, the principal investigator thought study participants may chose not to participate in this study. To reduce the possibility that study participants could be identified as taking part in this study, an off-campus location was secured to administer the self-administered survey and conduct focus group discussions. A secure site was located between the two campuses, and within walking distance of both campuses. In order to provide all students with the ability to participate in the study, money for roundtrip transportation was

provided to all participants. The cost of this roundtrip transportation, was minimal (2 birr= \$.15 USD), and was considered to be an important aspect of participant safety and participation.

## **PARTICIPANT RENUMERATION**

To compensate students for their time and participation, each student who participated in an in-depth interview, or self-administered survey received a health information packet, notebook, pen, and a coffee/tea voucher valid for use on campus, and 2 birr for round-trip transportation to and from study site (total worth is approximately 10 birr, which is less than 1 USD). Each student who participated in a focus group interview received a health information packet, 2 birr for round-trip transportation to and from study site, and a coffee ceremony was performed with light snack foods provided during the focus group discussion (total worth approximately 10 birr, which is less than 1 USD). The total monetary amount of 10 birr for all items was chosen based on conversations with other researchers, non-government organizations (NGOs) and government organizations about appropriate levels of compensation for study participation. Most people in the country make less than 1 USD (17 birr) a day, therefore the level of compensation given for study participation is considered appropriate, yet not too exorbitant. Ethiopian society has a definite and well-established “culture of per diem,” where people expect to be paid for their time and participation. This expectation is particularly true for the NGOs that operate within Ethiopia, who are known for paying participants an amount of money that is considered too high and not context-appropriate.

While this “culture of per diem” is still relatively absent on-campus, it was still felt some form of remuneration was appropriate to provide to participants.

## **SURVEY DATA COLLECTED**

In order to have a complete understanding of all surveys administered and information collected, the tables below were created to highlight both the breadth and depth of data collected. Tables 2 and 3 illustrate the range of qualitative and quantitative data collected, the questions asked with these instruments, and the number of students who participated in these surveys. The details of the below tables will be discussed in-depth throughout this chapter with regard to survey translation (when needed), survey development, survey pilot testing, and survey administration.

**Table 2: Quantitative Data Collected**

Method Used	Type of Data Collected	Sample Size
Self-administered Survey	<ul style="list-style-type: none"> <li>• Demographics</li> <li>• Health Knowledge/Health Access</li> <li>• Personal Sexual History</li> <li>• Sexual Assertiveness</li> <li>• Birth control/condom acceptability</li> </ul>	N= 997 participants (252 Variables)
SRQ-F (mental health screening tool)	<ul style="list-style-type: none"> <li>• 29 “yes” or “no” questions regarding if they have experienced symptoms in the last 30 days.</li> </ul>	N= 485 women and N= 493 men
Reproductive Health Survey	<ul style="list-style-type: none"> <li>• Visited pharmacies, clinics, and hospitals to document the types of reproductive health services available and the associated costs.</li> </ul>	N= 32 sites surveyed

**Table 3: Qualitative Data Collected**

Method Used	Type of Data Collected	Sample Size
In-depth (one-on-one) interviews	<ul style="list-style-type: none"> <li>• General info: experience as female student, why decided to come to BDU, what has been different before and after coming, what it takes to be successful.</li> <li>• Scenario questions: “what would you do if you thought you were pregnant?”, “thought you had an STD”.</li> <li>• What can be done to help women on campus? (By BDU, other women, men).</li> </ul>	N= 28 interviews
Female Focus Groups	<ul style="list-style-type: none"> <li>• Verified selected one-on-one survey information (i.e. sexual activity)</li> <li>• Data collected on female gender roles, pregnancy, birth control, condom use, boyfriends, abortions, health issues on campus.</li> </ul>	N= 9 female focus groups (7-12 students each) for a total of 93 students.
Male focus groups	<ul style="list-style-type: none"> <li>• Collected in-depth information on relationships, frequency of sexual encounters, pregnancy, abortions, birth control, using prostitutes, and picture books.</li> <li>• Asking what they think are challenges that women face and what they think they can do to help.</li> </ul>	N= 4 male focus groups (6-12 students each) for a total of 38 students.
Key informant - Administrator Interviews	<ul style="list-style-type: none"> <li>• Asked administrators what they thought about the challenges women face, the policies in place, policies in practice, and what they thought needed to be improved.</li> </ul>	N= 5
Key Informant-Group/Club Staff Interviews	<ul style="list-style-type: none"> <li>• Interviewed Gender clubs, HIV/AIDS clubs, reproductive clinic, health clinics.</li> <li>• Asked about services available, cost, issues they thought women faced on campus, what they thought needed to be done to help women, etc.</li> </ul>	N=10

## **SURVEY TRANSLATION**

Self-administered surveys were translated from English into the national language of Amharic. All study subjects who attended primary and secondary school in the Amhara Region are taught all of their course subjects in the national language of Amharic until high school. Once students reach high school, all subjects are taught in English and then Amharic is taken as an additional subject. Study subjects who attended primary and secondary school in regions outside of the Amhara region in Ethiopia may not have been exclusively taught in Amharic until they reach high school, but are still required to take Amharic until they finished high school since it is the national language. Throughout all of Ethiopia, students in high school are taught all subjects in English, but also required to take an Amharic course, and potentially another language (depending on the region they live in). The language of instruction at the university level is English, however many students come to the university with limited English abilities based on where they received their high school education. English proficiency is limited particularly among first year students, which constitute the largest population of students on campus. Therefore, the survey was administered in Amharic to ensure all students were able to understand the survey and feel comfortable responding in their native language.

Amharic translation used for the self-administered survey was performed by an individual employed at a professional translation agency in Addis Ababa. After translated in Addis Ababa, the survey was then tested in Bahir Dar. First, four research assistants examined the survey for readability and the cultural appropriateness of questions asked. Slight revisions were made for language that was considered too

sensitive. For example, the phrase “anal sex” or “oral sex” was considered offensive in written in Amharic. However, changing these Amharic phrases to be English phrases instead fixed this problem. These were the only instances in which English words were inserted instead of Amharic words. After changes were made, the survey was tested with 20 female students who met the inclusionary criteria. Based on their feedback, a few more slight revisions were made to the readability of questions.

Focus group discussions were conducted in Amharic with the assistance of trained research assistants. Even though the language of instruction at the university is English, students preferred to converse in Amharic when discussing sensitive topics. The research assistants assisted during the focus group discussions by facilitating the discussion questions and documenting the discussions in written Amharic. Focus group discussions were not voice recorded in order to protect the identity of the students and prevent potential fears of being identified by their voice. After focus group discussion completion, the trained research assistants back-translated the focus group discussion notes they took from written Amharic to English with the principle investigator following standard protocol (Sperber, 2004; Harkness and Schoua-Glusberg, 1998; Rahman et al., 2003).

Key informant interviews were originally planned to be conducted in English; however, preliminary observations revealed that not all women had the same English ability, and they were more comfortable having the discussion in Amharic. Therefore, a trained research assistant conducted the interview in Amharic with the presence of the principal investigator. The research assistants documented all responses to the questions

during the interview in written Amharic. After completion of the in-depth interview, the interview was back-translated into English.

## **SURVEY INSTRUMENT DEVELOPMENT**

### *Quantitative Survey Development*

To better understand the health issues female students' face on campus at BDU, a combination of quantitative and qualitative measures were utilized.

The quantitative survey was compiled by using examples of questions adapted for Ethiopia from both the U.S. National Survey of Adolescents and Young Adults (Kaiser Foundation, 2003) and the Africa National Survey of Adolescents (Inter-University Consortium, 2004). These comprehensive surveys examined factors that shape and inform the knowledge and decision making of young people both in the U.S. and in developing countries. These surveys addressed peer pressures faced and coping skills of young people, issues of sexual activity, and how they handle peer and sexual pressure. The surveys examined a range of behavior that could lead to increased health risks (i.e. risky sex and alcohol use), and documents young people's knowledge about specific health concerns, such as HIV/AIDS, STDs, contraception, (Kaiser Foundation, 2003; Inter-University Consortium, 2004). Both of these surveys are large, approximately 60-80 pages, which was too long for the current study setting. For this study, only a select number of questions were chosen and adapted, when necessary, for use within the Ethiopian context.

Although the National survey is administered in the U.S., currently no validated questionnaires with similar survey domains have been administered and applied to the same age ranges of college students available in developing countries. The Africa National Survey has been administered in four sub-Saharan African countries, Burkina Faso, Ghana, Malawi, and Uganda, but the ages targeted for this survey are 12-19 years. In the absence of a single validated questionnaires available for use in developing countries for college students aged 18-22 years, questions from both the U.S. and Africa National survey were selected and adapted (when necessary) to use in the current study context. These surveys were “adapted” in the sense that neither survey is taken in its entirety to use for this study because each survey is too long. These surveys were also “adapted” by selecting a number of questions that are thought to be relevant to the target participant age-ranges (18-21 years and 22-24 years), and have been “adapted” by changing the wording to reflect acceptable and understandable language used in Ethiopia. This latter decision was based on conversations with Ethiopian university women who are part of the targeted study age-ranges and is what they identified as “relevant” and “acceptable” in terms of questions and subsequent language. Compared to other national or global surveys (i.e. Demographic Health Survey), the U.S. based National survey has refined questions and age categories that may be more applicable to a college age population. The Africa National Survey does not differ significantly in content from the U.S. National Survey; however, it was developed and implemented within the context of several African countries. The demographic and health survey for Ethiopia presents data in terms of broad age ranges, i.e. 15-24 year olds, whereas the National Survey of

Adolescents and Young Adults define “young adults” as 18-24 year olds. This more narrow age range is more appropriate to a college age population. The Demographic and Health Survey also asks a breadth of questions that do not fall within the scope of this study. Each survey domain is described below and the full self-administered survey can be found in Appendix A.

The quantitative self-survey administered to female students was divided into five domains with the following themes: demographic characteristics, health knowledge and attitudes, personal sexual history, and sexual assertiveness and communication in sexual relationships. The rationale for examining these five domains is briefly explained below.

#### Demographic Information

Demographic information was collected on participants to understand the background and experience of participants and how that might relate to other variables and data collected in this study.

#### Health Knowledge and Attitudes

An important foundation of prevention efforts is to understand knowledge gaps and local perceptions and attitudes about particular health issues. This information can guide behavioral change strategies. As a result, data were collected on students’ knowledge of HIV/AIDS transmission, general STD transmission, and pregnancy prevention.

### Personal Sexual Health History and Behavior

Many lifestyle and behavioral factors impact health outcomes (Howard and Wang, 2004; Dilorio et al., 2000; Williamson et al., 2009; Widdice et al., 2006; Gomez et al., 2008). Delayed initiation of sex, or sexual debut, is linked to less engagement in high-risk sexual behavior and less risk for unintended pregnancy and STDs (Gomez et al., 2008). Engaging in greater frequency of sex and having a greater number of sexual partners is linked to greater risk for infection of HIV/AIDS and other STDs, as well as risk of pregnancy and negative reproductive health outcomes for women if STDs are left untreated (Howard and Wang, 2004). Increased use of condoms have been associated with a decrease in unintended pregnancies and decreased risk of STDs (Widdice et al., 2006; Dilorio et al., 2000). Greater access and use of modern birth control methods have been successfully promoted in many countries as ways to decrease unintended pregnancies, encourage child spacing, and limit family size (Williamson et al., 2009).

### Attitudes and Self-Efficacy of Condom and Birth Control Use

People may know how a virus is transmitted or how an STD is contracted; however, this knowledge does not always translate into protective behavior (Bandura, 1990). According to Bandura, failure to act occurs because there is not a direct link between knowledge and behavior (Bandura, 1990). Instead, people practice safer-sex only to the degree in which they perceive they can protect themselves (Wulfert and Wan, 1993). Therefore, respondents' perceptions of their self-efficacy with regard to condom and birth control experience and use was examined.

### Sexual Communication and Confidence

According to Weinstein et al. (2008), one of the potential benefits of sexual health knowledge is an improvement in an individual's sexual negotiations by increasing their confidence to enact and communicate preferences for safe-sex behaviors. Communication between partners is critical in negotiating safe-sex behaviors such as condom use (Weinstein et al., 2008; Catania et al., 1992; McQuiston and Gordon, 2000), and lack of assertiveness is associated with inconsistent contraceptive use (Rickert et al., 2002). Therefore, understanding female students' ability to assert themselves and communicate in sexual relationship is important to understand and was examined.

### ***Survey Instrument Development: Qualitative Measures***

The qualitative measures collected included key informant interviews, in-depth interviews, and focus group discussions. The key informant interviews, in-depth interviews, and focus groups discussions allowed for detailed one-on-one discussions with stakeholders, including administrators, staff, and students about the policies, procedure, and resources on campus for women. Additionally, in-depth interviews provided information about specific health experiences and gender role ideologies of female students on campus.

### ***In-Depth Interviews***

The in-depth interviews consisted of a series of open-ended question that follow a general script (Bernard, 2002). Informal conversations with faculty and staff revealed that the most critical year for women is their first year, and if they complete this year,

they have a higher likelihood of graduating. Therefore, in-depth interviews were conducted with female students in their 2<sup>nd</sup> year and above, to understand the coping strategies they employ, and what they have done to succeed through their freshman year. The in-depth interviews were broken into two parts, and only female students who were in their 2<sup>nd</sup> year and above were asked to participate in both parts of this survey. Given the intent was to identify coping strategies, first years students were not included since they had only been campus for three weeks when these interviews were conducted. The first part of the in-depth interview consisted of questions about their experiences as female students at BDU, gender role ideologies, and factors linked to success at BDU. During the second part of the in-depth interviews, female students who were 2<sup>nd</sup> year or above were presented with a variety of “scenarios” and asked how they would respond. Examples of the “scenarios” asked to women include:

- “If you thought you had an STD what would you do?”
- “If you had a problem with a male instructor what would you do?”
- “If you had a question about pregnancy who would you talk to?”
- “If you had access to free or cheap condoms would you use them?” “Why or why not?”
- “Why do you think it’s difficult for women your age to use oral birth control?”
- “What are some of the safety issues on campus?”

The breadth and depth of these scenarios were intended to elicit information about women’s access to health resources, safety on campus, and cultural acceptability of various health resources such as condom and birth control use. Details of the in-depth interviews can be found in Appendix B.

### ***Female Focus Group Discussions***

Each focus group discussion had a specific discussion guide based on information gathered in the in-depth interviews and the self-administered survey. The created questions were intended to illicit more breadth and depth of information of the sexual behavior of students on-campus. The guide was used by the focus group facilitator to lead the discussion, but clarifying questions were asked when necessary (Bender and Ewbank, 1994; Floch-Lyon and Trost, 1981; Colucci, 2007). Female focus group discussions served three purposes: 1) To test/validate the self-administered survey, 2) Discuss various health “scenarios” elicited from the in-depth interviews, and 3) Discuss prevention, intervention, and promotion strategies that women think are necessary for them as individuals, as a collective group of women, and what they think BDU can do to assist them. Details of the female focus group discussion guide can be found in Appendix C.

### ***Male Focus Group Discussions***

Male focus group discussions were conducted to collect in-depth information on relationships, frequency of sexual encounters, pregnancy, abortions, birth control, using prostitutes, and elicit knowledge of female student “picture books.” In addition, men were asked about the challenges they think women face at the university and what they, as men, can do to help. Details of the male focus group discussion guide can be found in Appendix D.

### ***Key Informant Interviews***

The key-informant interviews were guided by a structured set of questions administered by a research assistant. Key informants are people who know a lot about the rules of a culture, are highly articulate, and are, for whatever reasons willing and able to “walk you through” their culture and “show you the ropes” (Bernard, 2002: 187). Good key informants are people you can talk easily with, who understand the information you need, and who are glad to provide you information, or are willing to help you find it (Bernard, 2002). Key informants in this study included: administrators, faculty, staff, and students. Key informant responses from administrators, faculty, and staff will be discussed below, while key informant responses from students are provided with results of in-depth interviews with female students.

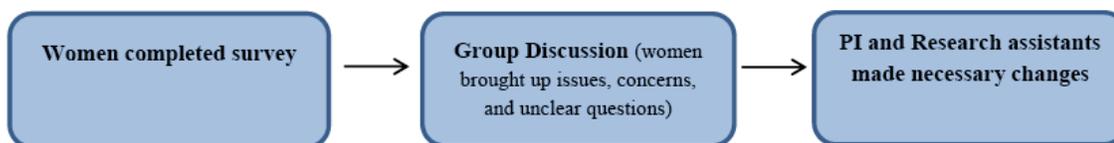
The key informant interviews from BDU administration served to gather information on the various rules, procedures, attrition rates, and policies pertinent to women at BDU. Key informant interviews were conducted by the principal investigator without the assistance of any research assistants. The key informants chosen were proficient in English. The principal investigator had communicated effectively with these individuals over the past two years and was familiar with both their language skills, and willingness to participate in the study. The principal investigator asked general questions about what they thought were issues that women faced on campus and how they thought BDU could assist female students. The specific key informant questions can be found in Appendix E.

### ***Self-Administered Survey Piloting***

Testing was also performed to assess the average time needed for self-administered survey completion. The average time for survey completion was 30-45 minutes, and women unanimously agreed that the survey was not too long and that all the information was important to ask. The self-administered survey was piloted prior to study initiation and changes were made prior to study launch. In particular, piloting was undertaken to identify questions or sections that were: 1) too sensitive to ask, 2) unclear to participants, and 3) when once translated into Amharic from the original written English, no longer made sense in Amharic.

Recruitment for women to test the survey was done by the principal investigator with the assistance of research assistants. The self-administered survey was tested in the setting of a focus-group discussion. First, women were asked to take the survey and then participate in a group discussion with the research assistants and principal investigator immediately following survey completion. During this small group discussion, women were asked about issues, concerns, or unclear questions raised when they took the survey or participated in the focus group discussion. The self-administered surveys and notes collected during the focus groups were incorporated to change the survey (when deemed necessary) and then destroyed after completion of testing and before self-administration survey initiation. Remuneration in the form of traditional coffee, and pastries, round-trip transportation, and a notebook and pen were provided to the women for agreeing to participate in this testing phase. Figure 3 outlines the procedures of pilot testing:

**Figure 3: Procedures for Self-Survey Piloting**



Self-identifying information was not collected during this pilot phase, however, only students who meet the study inclusionary criterion were invited to participate (this was verified, but not recorded). The group discussions that preceded the administration of the self-administered surveys were held to understand issues raised while taking the self-administered survey. After two pilot testing sessions, 20 women participated in completion of the self-administered survey and group discussion about this survey (11 one session and 9 another session). Piloting was not conducted for the qualitative measures collected from female and male students. However, slight changes in questions were made from focus group to focus group if feedback from participants prompted such changes.

### ***Survey Administration Timing***

The self-administered survey was conducted first, due to the presumed longer time needed to collect hundreds of surveys compared to other study components. Next, the in-depth interviews were conducted followed by the focus group discussions. The in-depth interviews and self-administered surveys helped guide the focus group discussions and were used to verify information gained from the in-depth interviews. Lastly, the key informant interviews, male focus group discussions, SRQ-F survey, and reproductive health services surveys were conducted.

## SURVEY ADMINISTRATION: QUANTITATIVE MEASURES

### *Self-Administered Survey*

As stated in the beginning of this chapter, there were several instruments administered in this study. The quantitative self-administered survey details are discussed below, and as a reminder, the specifics of the data collected in this survey are found in Appendix A and below:

**Table 4: Self-Survey Details**

Method Used	Type of Data Collected
Self-administered Survey	<ul style="list-style-type: none"> <li>• Demographics</li> <li>• Health Knowledge/Health Access</li> <li>• Personal Sexual History</li> <li>• Sexual Assertiveness</li> <li>• Birth control/condom acceptability</li> </ul>

### Demographic Information

Demographic information was collected from each student including: campus (poly or peda), current age, year in school, faculty/college/institute they belong to on campus, marital status, religion, home region, size and setting (rural vs. urban) of home town, family size, number and relation of male and female family members who have attended a university.

### Health Knowledge and Attitudes

Data were collected on the pressures students face to engage in alcohol use, smoking cigarettes, and in sexual relations. Data were collected on students': 1) sources of health information, and 2) perceptions about various health concerns applicable to

their age group such as physical violence, sexual violence, alcohol use, smoking cigarettes, chewing Khat, and mental illness.

#### Personal Sexual Health History and Behavior

The behaviors examined in this study include: initiation of sex, frequency of sex, number of sexual partners, condom use, contraceptive use in general, pregnancy, abortion, and measures of sexual risk taking (i.e. frequency of sex without a condom).

#### Attitudes and Self-Efficacy of Condom and Birth Control Use

Female students were asked questions regarding their perceived ability (self-efficacy) to utilize condoms and birth control, and their attitudes towards these methods. Attitudes towards using condoms were assessed by utilizing the ‘Attitude Towards Condoms Scale’ (Brown, 1984) and self-efficacy of condom use and oral birth control was assessed by using the “Sexual Risk Behavior Beliefs and Self-Efficacy Scale” (Basen-Enquist et al., 1998).

#### Sexual Communication and Confidence

Participants who identified as sexually active were asked to answer questions about their sexual communication and confidence in relationships. Determining a participant’s ability to assert themselves in sexual relationships was assessed by using the Hurlbert Index of Sexual Assertiveness (Hurlbert, 1991; Davis et al., 1998). Participants were asked to indicate how accurately various statements described their experience.

## **SURVEY ADMINISTRATION: QUALITATIVE MEASURES**

### ***Female Focus Group Discussions***

Each focus group discussion included a set of questions used by the focus group facilitator to lead the discussion. Discussions were conducted in Amharic with the assistance of three research assistants along with the principal investigator. One research assistant served as the facilitator and the other two research assistants served as scribes to document the discussion. The principal investigator was also present to observe body language and follow-up on any issues that may arise during the discussion that the research assistants may not be able address. Additionally, since the principal investigator had basic proficiency in Amharic she was able to follow the flow of the conversation and ask the research assistants to ask follow-up questions when necessary. Each focus group discussion lasted for approximately one hour. The focus group discussion guide that was used for each of these focus groups can be found in Appendix C and the details of data collected in this survey are found below:

**Table 5: Female Focus Group Discussion Details**

Method Used	Type of Data Collected
Female Focus Groups	<ul style="list-style-type: none"> <li>• Verified selected one-on-one survey information.</li> <li>• Collected in-depth data on female gender roles, pregnancy, birth control, condom use, boyfriends, abortions, health issues on campus.</li> </ul>

### ***Male Focus Group Discussions***

As with female focus groups, each male focus group discussion was lead by a facilitator using a set of questions. Focus group discussions were conducted and

documented using hand written notes in Amharic with the assistance of two or three male research assistants along with the principal investigator. Notes were later and back-translated into English. One male research assistant served as the facilitator and the other one or two (depending on the focus group) served as scribes. Again, the principal investigator was present to take note of body language during the discussion and to answer any questions and/or concerns should they arise. However, the principal investigator stepped out of the room for questions pertaining to sexual activity in hopes of eliciting more truthful responses. Although it is not standard procedure for a female principal investigator to be present during a male focus group discussion, this was done for two reasons. One, to ensure the male participants would attend the group discussion, and two, to protect the Ethiopian woman who was conducting the traditional coffee ceremony from harassment. Each focus group discussion lasted for approximately one hour. The focus group discussion guide that was used for each of these male focus groups can be found in Appendix E and the details of data collected are found below:

**Table 6: Male Focus Group Discussion Details**

Method Used	Type of Data Collected
Male focus groups	<ul style="list-style-type: none"> <li>• Collected in-depth information on relationships, frequency of sexual encounters, pregnancy, abortions, birth control, using prostitutes, and picture books.</li> <li>• Asking what they think are challenges that women face and what they think they can do to help.</li> </ul>

***Follow-up Data Collection: Male Substance Use Survey***

A second wave of male focus group discussions were conducted as an additional sub-study examining the substance use (alcohol, tobacco, and Khat) among

undergraduate men on-campus. However, the information collected as part of this sub-study will not be included in the data analysis, results, and discussion in this study. The details of the data collected for the sub study can be found below in Table 7 and the specific questions asked can be found in Appendix F.

**Table 7: Male Substance Use Data\***

Method Used	Type of Data Collected
Self-administered Survey	<ul style="list-style-type: none"> <li>• Demographics</li> <li>• Substance use history (alcohol, tobacco, and Khat)</li> </ul>
Key informant interviews	<ul style="list-style-type: none"> <li>• General info: experience with Khat, why people chew Khat, when in life people begin to chew, frequency and duration of Khat sessions, where Khat is chewed, Khat use in relation to other substances.</li> </ul>
Focus Group Discussions	<ul style="list-style-type: none"> <li>• Collected in-depth information on Khat use among students, why students chew Khat, gender norms and chewing, frequency and duration of Khat use, emotions and feelings of using Khat.</li> </ul>

\*This was collected as part of a sub-study and follow-up data collection from May-July 2011

### ***Key Informant Interviews***

Key informants were interviewed to assess issues female students face from the administrative, staff, and student perspective. Interviews were conducted with administrators, staff, and students. Administrators interviewed included one female and four males. Additionally, staff members who worked in the Gender Office (three women), HIV/AIDS club (one man), and women's reproductive health club (two women) were interviewed. Lastly, two female and two male students who were well-known and knowledgeable about campus participated in interviews. Key informant discussion guide can be found in Appendix E and the details of data collected are found below:

**Table 8: Key Informant Interview Details**

Method Used	Type of Data Collected
Key informant - Administrator Interviews and students	<ul style="list-style-type: none"> <li>• Asked administrators what they thought about the challenges women face, the policies in place, policies in practice, and what they thought needed to be improved.</li> </ul>
Key Informant-Group/Club Staff Interviews	<ul style="list-style-type: none"> <li>• Interviewed Gender clubs, HIV/AIDS clubs, reproductive clinic, health clinics.</li> <li>• Asked about services available, cost, issues they thought women faced on campus, what they thought needed to be done to help women, etc.</li> </ul>

***In-Depth Interviews***

The in-depth interviews with female students were conducted by the research assistants in Amharic with the principal investigator present. The plan was to conduct these interviews in English; however piloting demonstrated most women lacked confidence and ability with English skills, and they were ultimately more comfortable conversing in Amharic with the trained research assistants. As a result, the interviews were conducted in Amharic with the research assistant then back-translating into English. The in-depth discussion guide can be found in Appendix B and the details of data collected are found below:

**Table 9: In-depth Interview Details**

Method Used	Type of Data Collected
In-depth (one-on-one) interviews	<ul style="list-style-type: none"> <li>• General info: experience as female student, why decided to come to BDU, what has been different before and after coming, what it takes to be successful.</li> <li>• Scenario questions: “what would you do if you thought you were pregnant?”, “thought you had an STD”.</li> <li>• What can be done to help women on campus? (By BDU, other women, men).</li> </ul>

## **DATA ENTRY AND ANALYSIS**

### ***Data Entry and Coding***

Questions from the quantitative surveys were entered into a Microsoft Excel spreadsheet by two research assistants. One research assistant entered survey numbers 1-500 and another research assistant entered surveys 501-997. After initial entry of all 997 surveys, each research assistant checked 150 surveys entered by the other research assistant selected by the principle investigator at random. This method was used instead of double data-entry because twice as much data was collected than originally intended, and time and budget constraints prohibited double data entry from occurring. Data from the qualitative focus groups were collected by taking detailed notes and pictures of the group writing activities were taken during the focus group discussion. The sessions were not digitally voice recorded as this would not have been an acceptable method in this context. The notes were then back-translated from Amharic to English within one day of focus group completion in order to be systematically analyzed.

### ***Statistical Analysis***

Descriptive analyses were conducted to assess health knowledge, personal health histories, and mental health. Additionally, multivariate logistic regression was used to determine the association between particular variables (HIV/AIDS knowledge and other STD knowledge). Statistical analyses were performed using STATA (Intercooled 9), College Station, TX. The specific details of the statistical analyses conducted and associated results can be found in Chapter 7.

### ***Key Informant, In-Depth Interviews, and Focus Group Discussion Analysis***

The approach used to analyze the qualitative data in this study was content analysis. Content analysis allows the researcher to sift through large volumes of data in a systematic way, and is a powerful data reduction technique (Stemler, 2001; Hsieh and Shannon, 2005). Content analysis was useful in this study to examine patterns and themes that emerged from the discussions provided by female students. Emergent coding will was used during the analysis to categorize data. Emergent coding is a strategy in which categories are established following preliminary examination of the data (Mayring, 2000). Focus-group data was tested for reliability by comparing the responses of focus groups as well as to in-depth interviews (Bender and Ewbank, 1994). An ethnographic summary was also developed using direct quotes with narrative explanation. Taken together, the quantitative data analysis, content analysis and the ethnographic summary provide a nuanced picture of the health and welfare of female students. The results of this analysis are presented in Chapters 5- 8.

### **CONSIDERATIONS FOR HUMAN SUBJECT USE**

The Proposed Research met the definition of Human Subjects Research and fell under “Social and Behavioral Research” division at the University of Arizona. Approval for this study by the Institutional Review Board (IRB) at the University of Arizona (UA) was initially granted on July 8, 2010 and was valid until July 7, 2011. Permission to conduct this research was also granted by Bahir Dar University’s Ethical Review Committee in March 2010. Revisions made to study instruments were amended and

approved through the IRB office at the University of Arizona as revisions became necessary. Renewal of the project for an additional year was sought in May 2011 and approved in June 2012.

## **CHAPTER 4: SELF-ADMINISTERED SURVEY PARTICIPANT CHARACTERISTICS**

Table 01 illustrates the demographic characteristics of the 997 female students who took the self-administered surveys. This survey was administered to female students in all class years who voluntarily came forward to take the survey. Of the women who took the survey, 66.8% were students who attended the Peda campus, while 33.2% were students who attended the Poly campus. This distribution is fairly representative of each campus make-up, where approximately 60% of the students at Peda are female and approximately 20% of the students at Poly are female (personal communication with Administration, 2010). Most of the students (86.1%) were between the ages of 19-22 years old, which is in-line of the age range for full-time day students at BDU (personal communication with Administration, 2010). However, smaller percentages of women were below 19 years old (6.8%), and older than 22 years old (6.5%).

With regard to academic year, 27% were first-year students, 33.7% were second year students, 36.7% were third year students, and 1.8% were 4<sup>th</sup> and 5<sup>th</sup> year students. More 2<sup>nd</sup> and 3<sup>rd</sup> year female students participated in this study compared to first year students, which may be a result of 2<sup>nd</sup> and 3<sup>rd</sup> year students expressing more desire to participate in the study and wanting to share their thoughts and ideas. Additionally, first year students had only been on campus for approximately three weeks when the study began; therefore they may have not felt the need to be involved or fully understood the study objectives compared to 2<sup>nd</sup> and 3<sup>rd</sup> year female students. Campus life itself was so new to first year students, that participating in a survey administered off-campus may not

have been of interest to them. Also, fewer 4<sup>th</sup> and 5<sup>th</sup> year students are on campus because most academic programs at both Poly and Peda are only 3 years in length (except for Law and Engineering, which are 4 and 5 years respectively). These programs (Engineering and Law) are discussed by administrators, faculty, and students as difficult and few women are assigned to these programs by the Ministry of Education (although this trend is slowly changing). As a result, few female students graduate in these subjects because they do not have as many opportunities in these subjects compared to their male peers (personal communication with Administration, 2010; and Male and Female Focus Group Discussions, October-December 2010). Lastly, in the interest of time and money, the research team stopped data collection for the self-survey in order to administer other survey instruments; otherwise, it is presumed more women in each class would have come forward to take the survey over time.

Notably, 11.1% of the females interviewed were married, 86% had never been married, 0.7% were divorced, and 0.1% were widowed. Based on informal conversation and 16 months of living in country, it was hypothesized that the majority of the women who were married would be from rural areas where marriage at an earlier age is common, however this discrepancy will be explored in further analysis.

Not surprising, 86.1% of the sample population identified their religion as Orthodox Christian, 7.9% Muslim, 8.6% Protestant, and 0.6% Catholic. Orthodox Christianity is the primary religion of Ethiopia, and in particular in the Amhara region where the study took place. More than 60% of the students in this study are from the Amhara region; the expectation was most would state they practice Orthodox

Christianity. Practicing Protestants are less common in the Amhara region, than in the south of Ethiopia where Protestant missionaries have been more active over the past 20 years.

The majority of the study population identified as being from the Amhara region (66.7%), while 11.3% come from the Tigray region, 11.4 from the Southern Nations and Nationalities People, 8.4% from the Oromia region, 0.9% from the Harari region, 0.1% from Addis Ababa, and 0.2% from Dire Dawa. While the government assigns students from all regions to attend universities all over the country, it does not always equally assign students from each region to attend the 23 public universities situated throughout the country. The regions are not represented equally because students in each region may not have scored well enough to be sponsored by the government, and some students may have chosen not to travel to the Amhara region because of the far distance from their home, and not wanting to attend this university. In fact, during the qualitative data collection most students stated they came to BDU because, 1) they were sponsored and therefore got the “chance” to go, and 2) it was close to home and travel was not expensive. Students did not actually decide to come to BDU because they wanted to attend BDU, in fact, many did not want to come to BDU because of rumors they heard about Bahir Dar Town and BDU (discussed in Chapter 5). However because this was their only “choice,” most decided to ultimately attend.

In terms of household size (from their hometown), 6.3% had 1-3 household members, 28.3% had 4-5 members, 34.0 % had 6-7 household members, 21.7% had 8-9

household members, 6.6% had 10-11 household members, 1.1% had 12-15 household members, and 0.3% had 16-20 household members.

With regard to the number of women in the household who have attended college, 73.9% of the sample women are among the first women in the household to attend university. More than 18.3% of the sample had one other woman in the household who have attended university, 4.5% have two other women in the household who have attended university in addition to themselves, and 1.3% have 4-5 women in addition to themselves who have attended a university.

**Table 10: Self-Survey Sample Characteristics**

<b>Variable</b>	<b>Number of Participants</b>	<b>Percent of Sample (%)</b>
<b>Campus Attended</b>		
Peda	666	66.8
Poly	331	33.2
<b>Age</b>		
17	2	0.2
18	66	6.6
19	166	16.7
20	374	37.5
21	223	22.4
22	101	10.1
23	41	4.1
24-28	17	1.7
Missing	7	0.7
<b>Academic Year</b>		
1 <sup>st</sup> year	269	27.0
2 <sup>nd</sup> year	336	33.7
3 <sup>rd</sup> year	366	36.7
4 <sup>th</sup> year	12	1.2
5 <sup>th</sup> year	6	0.6
Missing	8	0.8

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Marital Status	111	11.1
Married	857	86.0
Never Been Married	7	0.7
Divorced	1	0.1
Widowed	10	1.0
Refuse	11	1.1
Missing		
Religion	819	82.1
Orthodox	79	7.9
Muslim	84	8.4
Protestant	0	0.0
Jehovah-Witness	6	0.60
Catholic	1	0.1
No Religion	3	0.3
Other	2	0.2
Refuse	3	0.3
Missing		
Administrative Region	665	66.7
Amhara	113	11.3
Tigray	84	8.4
Oromia	1	0.1
Benishangul-Gumuz	0	0.0
Afar	1	0.1
Somali	115	11.5
SNNP	9	0.9
Harari	1	0.1
Addis Ababa	2	0.2
Dire Dawa	6	0.6
Missing		
Size of Town	175	17.6
Addis Ababa	264	26.5
Region town	360	36.1
Woreda town	194	19.5
Rural town	3	0.30
Missing		
Household Size	63	6.3
1-3	282	28.3
4-5	339	34.0
6-7	216	21.7
8-9	66	6.6

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10-11	11	1.1
12-15	3	0.3
16-20	17	1.7
Missing		
Total brothers & sisters		
attended university	493	49.5
1	245	24.6
2	133	13.3
3	52	5.2
4	23	2.3
5	11	1.1
6	7	0.7
7-11	33	3.1
Missing		
Total women in household		
attended university	737	73.9
1	182	18.3
2	45	4.5
3	10	1.0
4	3	0.3
5	20	2.0
Missing		
<b>Total</b>	<b>N=997</b>	<b>100.0</b>

## CHAPTER 5: GENDER ROLES AND EXPECTATIONS OF BDU

This chapter will discuss women's perceptions of gender roles and what it means to them to be an Ethiopian woman. This information will expand upon their perception of how women's roles have changed prior to and after coming to the university. This chapter also will examine what male and female participants in the study had heard about BDU prior to coming to the university and what their experiences had been after coming to BDU. In particular, this chapter will address specific aim 1:

**Specific Aim 1:** Identify normative gendered behavior for females students before they come to the university and then when they are within the university setting;

### WHAT IT MEANS TO BE AN ETHIOPIAN WOMEN

When female participants were asked about the roles of Ethiopian woman and what it means to be an Ethiopian woman several responses were provided. Generally, women discussed that being an Ethiopian woman meant looking after the household, children, husband, being a good cook, and being tolerant and adaptable to many conditions. The following quotes illustrated these perceptions:

“A good Ethiopian woman must be a good wife, and be a good cook and good with the children”(Female Focus Group Discussion, June 2011).

“She must be tolerable, silent, and slow. She must cope up with others and know how to handle others” (Female Focus Group Discussion, June 2011).

“She must look after herself until marriage [be a virgin], keep quiet, and keep her religion” (Female Focus Group Discussion, June 2011).

“She is loyal to her husband, looks well, and leads her life in a timely manner” (Female Focus Group Discussion, June 2011).

When women were asked about their perception of societal views of woman who get a university education the general responses were mixed. Some women believed society would now see women negatively because they are not taking the path of a traditional Ethiopian woman, by getting married, having children, and taking care of her family. A university education was viewed by some as delaying important expected milestones of a traditional Ethiopian woman. Other women thought they would now be viewed in a positive light because they would be helping to advance society after graduation and getting a job. Since many of the respondents were the first women in their family to go to the university (Chapter 4), they were viewed by their family as the person to make a positive economic impact on the future of the family although some feared negative sentiments. The following illustrates the range of responses:

“We will now be seen as negative and rude, especially if we don’t graduate” (Female Focus Group Discussion, June 2011).

“Our family and village will honor us for our hard work. We will even be viewed positively by God” (Female Focus Group Discussion, June 2011).

“Even though the government wants many females to go to university, still the views in rural places are not positive. Many families do not want their daughters to go to university and education is not seen as a positive thing” (Female Focus Group Discussion, June 2011).

“Getting into the university is seen as very positive because it is difficult to do so. We will be seen as role models” (Female Focus Group Discussion, June 2011).

“Many families do not see what an education will bring. There are no so many people graduating from university and still they do not have jobs, so then they do not want to send their children, especially women to university” (Female Focus Group Discussion, June 2011).

“My family is so positive for me to succeed, that I know I must. I thank God to get this opportunity to come to BDU and I am so positive about my experience” (Female Focus Group Discussion, June 2011).

When women were asked if views on marriage in Ethiopia have changed over time and if they believed an educated woman has a harder time getting married today the responses again were varied. Some women believed that today women could choose who they wanted to marry, whereas before their parents would choose for them. Other women, who came from rural areas, stated that they either had a husband already at home, or that their parents will decide who their husband when they return home after graduation. Most women believed that an educated woman would be seen as a positive for men, and therefore they would be more marriageable after their education. A few women stated that if a man is from a rural area an educated woman may not be preferred because her educational status would make her too different from him. The quotes below describe women’s perceptions on these topics:

“Today, men do not want to be involved in only one relationship only so it [education] is becoming risk for women” (Female Focus Group Discussion, June 2011).

“The youth are not viewing it [education] as they have before. Many people wait to get married and sometimes women have the choice” (Female Focus Group Discussion, June 2011).

“Today men want to marry a woman who is employed” (Female Focus Group Discussion, June 2011).

“It is better for men today to marry an educated woman because of the cost/benefit of finding a woman who can make money” (Female Focus Group Discussion, June 2011).

“Some men do not want to marry an educated woman because once she has these skills she may seem higher than the men and he would not like that” (Female Focus Group Discussion, June 2011).

“If a man is educated then maybe he might want an educated woman, but if he is not educated he may prefer a woman who is not educated” (Female Focus Group Discussion, June 2011).

Women were asked if their personal views of marriage have changed since coming to BDU. Some women stated their views had changed, while others said their views had not changed, and a few stated they had never given marriage much thought before or after coming to BDU. The following illustrates the range of views:

“It is not the same to me. Before I used to think I should marry a wealthy man to help my family but now I know I can marry any kind of man because I can make my own money and help my family by working hard” (Female Focus Group Discussion, June 2011).

“I have never thought about marriage back then or now. This is because the only thing that has ever been on my mind is to get educated and to help my poor family. If I get married then I don’t think I would do this anymore [help them]” (Female Focus Group Discussion, June 2011).

“Before we have seen our mother’s suffer so much to take care of her children, the home, and life. But now, we know we have the power and possibility to have a better life and suffer less” (Female Focus Group Discussion, June 2011).

“Back when I was living with my parents, I used to think I was supposed to live like my mother by getting married to a better man. But after I got here I discovered I can live by my own and even support my family without a man’s help and get married whenever I want and without any person pushing me towards that. (Female Focus Group Discussion, June 2011).

“The more educated we get the more aware we are of our choices in marriage” (Female Focus Group Discussion, June 2011).

“When we get here we think we have responsibility to help our parents before we get into marriage” (Female Focus Group Discussion, June 2011).

“I still thinking getting married is important, but it does not have to happen now. First I must get an education so I can make something of myself. Then I will find a husband and get a baby” (Female Focus Group Discussion, June 2011).

Clearly, there is not one view of marriage among these, but many women’s views of marriage changed in light of the presumed greater economic opportunities their education will one day afford them (if jobs are available). Most women no longer felt dependent on a man to support them and their family as they once had; their education was seen as a vehicle of economic freedom and opportunity that they did not think was possible before working on a university education. This financial freedom allowed women to think about their future in new ways and is what often drove them to work as hard in their studies as they reported. It was not that they had no interest in getting married, rather who they married and when they married could be more controlled by them as a result of their education.

## **EXPECTATIONS AND PERCEPTIONS OF BDU**

Male and female students were asked why they decided to come to BDU and what they heard about BDU prior to coming to BDU. They were also asked to speak generally about their experiences as students at BDU.

### ***Why Women Came to BDU***

When women were asked why they decided to come to BDU, several reasons were given, mostly focusing on their “chance” to get an education and make a better life for themselves and their family. They also stated they came to BDU because their family

supported the move and because the government assigned them to BDU. Examples of responses can be found below:

“I got the chance to go from the government” (Female Focus Group Discussions, November, 2010).

“To change myself and change my family” (Female Focus Group Discussions, November, 2010).

“Because it is my family’s choice for me to come” (Female Focus Group Discussions, November, 2010).

“It is near to my home and I want to learn and gain skills to have a better life and make a better country” (Female Focus Group Discussions, November, 2010).

“I came to BDU for success and to achieve my dreams” (Female Focus Group Discussions, November, 2010).

“To develop our country by different aspects like to solve health care system problems, to manage the country infrastructure, to learn family planning, and to live a modernized way (Female Focus Group Discussions, November, 2010).

### ***Why Men Came to BDU***

When men were asked the same question they provided similar responses to women. Mostly, their responses centered on being assigned by the government to come to BDU, pressure from their family to come to BDU, and the opportunity to get an education. Examples of specific responses are found below:

“It is not our choice for BDU, the government assigns us” (Male Focus Group Discussions, December 2010).

“We came because we got the chance for an education, but we did not get to chose were we go, the Ministry of Education tells us” (Male Focus Group Discussions, December 2010).

“I came to make my family happy, they wanted me to come. There is family pressure to leave the house and be successful” (Male Focus Group Discussions, December 2010).

“I came so that one day I can be successful and enjoy life” (Male Focus Group Discussions, December 2010).

“I came because there is nothing for me at home. If I stay at home then I have no opportunities”(Male Focus Group Discussions, December 2010).

“Even though I do not prefer BDU because it is so far from my home and I have heard negative things about BDU, I came because I have no other opportunity for my education” (Male Focus Group Discussions, December 2010).

“I was assigned to BDU so I had no choice if I wanted an education. I did not prefer BDU, but I came anyway” (Male Focus Group Discussions, December 2010).

Both men and women shared similar reasons for coming to BDU, mainly centered on the chance to get an education and to make a better life for themselves, their family, and even the country. All students did not want to attend BDU, but instead were assigned by the Ministry of Education; therefore, they ultimately decided to attend to not lose out on this government sponsored opportunity. There was a general sentiment among all students on campus that BDU was not their preferred institution, in fact Addis Ababa University was; however, because they got assigned to BDU and did not want to forgo this opportunity they decided to attend.

### ***What Women Heard About BDU Prior to Coming***

When women were asked about what they heard about BDU prior to coming to campus, many women’s responses focused on dismissing students, reputation of Bahir Dar town, issues women face, the quality of education, and the weather in Bahir Dar.

Examples of specific response from women include:

“I heard that it dismisses a lot of students every year, more than any other university in Ethiopia”(Female Focus Group Discussions, November 2010).

“I heard many women get dismissed and because it is too shameful to go home, they become a prostitute in town” (Female Focus Group Discussions, November 2010).

“The town has bad practices, such as evil practices on each other. If a guy decides he needs you, he may use something bad to drive you crazy. We even noticed some girls shouting and getting crazy. You then have to go to a traditional person to cast this spirit away” (Female Focus Group Discussions, November 2010).

“Because BDU is a tourist site, females are exposed to prostitution and so much disease and HIV/AIDs. Also there are so many nightclubs around town and near to campus, but this always leads to bad things” (Female Focus Group Discussions, November 2010).

“I heard the climate is so warm and it makes you so uncomfortable” (Female Focus Group Discussions, November 2010).

“We heard that female students are expected to have sexual relationships with male students and sometimes even instructors or we will get dismissed” (Female Focus Group Discussions, November 2010).

“It has good quality education, but it is so heavy” (Female Focus Group Discussions, November 2010).

“I have only heard negatives, never positives” (Female Focus Group Discussions, November 2010).

### ***Women’s Current Experiences***

When women were asked about their actual experiences at BDU, most stated that some things were better than expected, such as the living conditions. However, they did state that the education is difficult and that there are still many dismissals. They also stated that they believe BDU is better than other universities in terms of quality

regardless of the other hardships they feel they face on campus (such as harassment, poor sanitary conditions, and difficult courses).

### ***What Men Heard about BDU Prior to Coming***

When men were asked what they heard about BDU prior to coming to campus the responses were varied, but centered around the quality of education, the course load/requirements, women's behavior off-campus, the weather, and prevalence of HIV/AIDs in this area. Examples of some responses provided by my males students are found below:

“We heard BDU has quality education and that they dismiss a lot of students” (Male Focus Group Discussions, December 2010).

“We heard that students who go to BDU get jobs because we have good skills” (Male Focus Group Discussions, December 2010).

“The education is said to be difficult” (Male Focus Group Discussions, December 2010).

“The weather conditions is not good and it is hot” (Male Focus Group Discussions, December 2010).

“The females are outgoing and they like to play and want to go outside of campus too much” (Male Focus Group Discussions, December 2010).

“There is a lot of HIV/AIDS in Bahir Dar so everyone is afraid to come here because they don't want to get it [HIV]” (Male Focus Group Discussions, December 2010).

### ***Men's Current Experiences***

Like women, men also expressed that some prior perceptions they had of BDU were different once they came to BDU. Specifically, they did not find the weather

conditions to be as difficult as expected. They did find the coursework to be difficult, but most stated it was manageable because they were hard workers and focused on their studies. Men also shared the sentiment that dismissals were high, but that it mostly happened to women and not as much to men.

### ***How Things Are Different For Women After Coming to BDU***

Women were asked to discuss how their life was different at BDU than before when they lived at home. Most women's discussions revolved around their new found freedom, reduced work load, and lack of social support. Below are responses given by women:

“Before I came my social life was weak but now it is getting better” (Women's Focus Group Discussion, November 2010).

“Before it was harder to communicate with boys and after coming here I can now communicate with the guys” (Women's Focus Group Discussion, November 2010).

“I have so much freedom now to do what I want. I am not responsible to cook, clean, and get water. I also do not have anyone telling me what to do as I did before” (Women's Focus Group Discussion, November 2010).

“I used to be afraid of people and I had a very heavy work load and I could not take school properly. Now I have freedom from home and I can talk to my friends and other people and I can focus on my courses.” (Women's Focus Group Discussion, November 2010).

“The university has helped me to improve my confidence. I can also move more freely and as I want” (Women's Focus Group Discussion, November 2010).

“It can be difficult without family here. I have to do everything on my own and no one is looking out for me.” (Women's Focus Group Discussion, November 2010).

“Before I came, I had everyone to tell me what to do. Now, I have no one and it is up to me. This can be good, but also bad when you need help. Especially when it comes to harassment, no one will help you here” (Women’s Focus Group Discussion, November 2010).

### *How Things Are Different For Men After Coming to BDU*

Men were asked to discuss how life was different after coming to BDU compared to how life was at home. In terms of freedom, they did not express the same new found freedom as women did, because as men, their home life was always very free and they could come and go as they wanted. A lot of men expressed not being satisfied with their life at BDU. They stated that their course load was difficult and that instructors were only there to examine them and not actually teach them the subject matter. They stated how they believed many students were too involved in their social life and not focused enough on their studies. Male respondents perceived that many male students on campus became addicted to Khat and alcohol, and that many female students have a lot of sex with men outside of the university. Lastly, they reported more health issues than they expected such as malaria and gastritis. Below are select responses provided by men:

“The course load is so heavy and they do not provide courses as scheduled. When they give us an exam they ask us about things we do not prepare. They trick us so that some will get dismissed” (Male Focus Group Discussions, December 2010).

“Malaria is a problem here and so many people get sick with gastritis. The campus is dirty and no one cleans it so we are always sick. The clinic does not help and they will not refer us to town so we suffer” (Male Focus Group Discussions, December 2010).

“I do not find much difference here at BDU from my home. The big change is that I spend all my time on my studies and I have no time to be social. Those that are social become addicted and they will not succeed” (Male Focus Group Discussions, December 2010).

“Here I am just as free as I was at home. At home I could always concentrate on my studies, but I also had a social life because the subjects were not as hard. Here [at BDU] all I do is study and I have no time for social life” (Male Focus Group Discussions, December 2010).

“Because the weather is so hot, it leads us men to have more sex. We cannot control our emotions in these weather conditions” (Male Focus Group Discussions, December 2010).

“My life is not much different here at BDU. I am away from my family and I have heavy course load, but nothing else is different” (Male Focus Group Discussions, December 2010).

In summary, women in this study reported their perceived ideas of what a “good” Ethiopian woman should be, which often included an attentive and faithful wife, mother, and tolerant of many conditions. While these ideals may not change after coming to the university, most women expressed their desire to be more independent and make life choices on their own, such as who they marry. While women did not report wanting to forgo marriage altogether, they did discuss having the choice and the ability to delay marriage as a result of having an education, leading to greater economic opportunities. Pursuing a university education translated into a reduced physical workload for women, and their first opportunity to fully concentrate on their course work. While all women may not fully devote all free time to her studies, as will be explored in later chapters, this freedom is an important component to women’s experiences on-campus. This new found freedom and absence of family places them in uncharted territory that may or may not expose them to uncomfortable situations such as harassment and unsafe practices such as participating in risky sexual encounters.

Men reported the least change after coming to the university compared to their life at home before BDU. At home, men were privy to freedom and had time to devote to their studies, so unlike women, men experienced a less drastic change with regard to household work obligations. However, men consistently reported that the coursework was very difficult and that the requirements were too much. Many reported spending all their time on their studies and never having free time to have a social life. Not all men fell into the category of devoting all time to his studies, but some thought that these men would later not be as successful as those who concentrated fully on their studies.

Both men and women reported the main reason they decided to attend BDU was because they got assigned and they did not want to lose out on this opportunity. Additionally, they equated BDU's reputation of dismissing a lot of students as meaning they would be getting a "quality" education. The logic that since BDU dismisses a lot of students, graduation was a great achievement. Staff and students shared the sentiment that graduates from BDU would have a competitive advantage of students who graduated from other universities that had a reputation of graduating all accepted students. In reality, graduating from BDU is a great achievement, but this accomplishment may have less to do with the "quality" of education provided, and more to do with the strategies students take to be successful within this highly competitive environment. These ideas will be explored in later chapters; however, student strategies for adapting to the university environment are worth mentioning here to lay the groundwork for the proceeding chapters.

## CHAPTER 6: INTITUTION AND ENVIRONMENTAL CONTEXT

### THE INSTITUTION OF BDU

This chapter will describe the organization and structure of BDU and will discuss the various gender related issues administrators, staff, and students identified as problematic on-campus. First, the size and structure of BDU will be outlined. Next, the various clubs and organizations available on campus for women will be described and the views of key stakeholders (administrators) at BDU will be examined. Lastly, women's views on the safety and security of campus will be explored. Taken together, the information in this chapter will address specific aim 2:

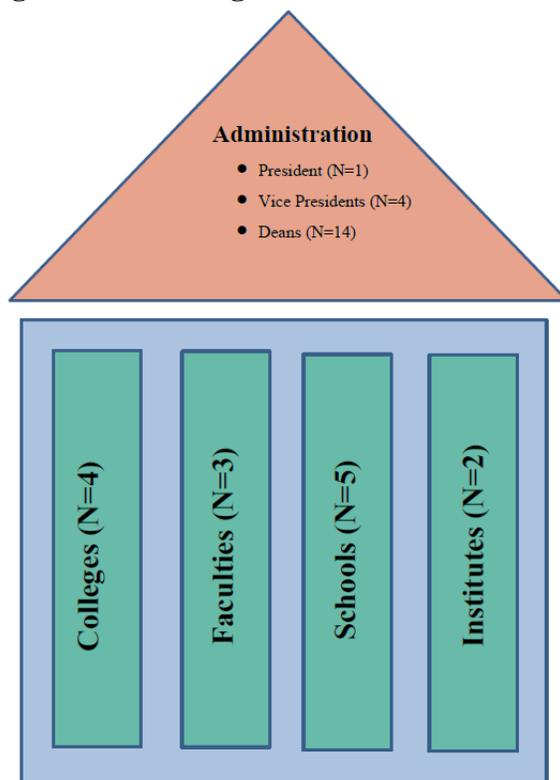
**Specific Aim 2:** Document gender-based policies, procedures, and resources at BDU and how women's perceptions and strategies fit within this system;

As previously described in chapter 3, BDU serves a student population of approximately 38,000. Of the 38,000 students, 16,000 are regular day students, 6,000 are weekend/evening students, 7,000 are summer students, and 9,000 are distance (satellite campuses) students. The number of faculty members is approximately 1,053, of which 908 are male and 145 are female. The majority of faculty who teach at BDU hold a diploma or bachelor's degree (55%), with the remaining holding a Master's degree (40%) or a Doctorate degree (5%).

In 2011, the structure of BDU, as with all Ethiopian public universities, underwent a transformation and re-organization mandated by the government (Mengesha

and Common, 2007; Erhardt and Scholz, 2009). This re-structuring and re-organization was one of the many current government's reforms in the public sectors of Ethiopia, referred to as Business Process Reengineering (BPR). BPR focuses on complete structural change and reform in an attempt to provide more effective services and contribute to development (Mengesha and Common, 2007). Through this reform, BDU was re-organized at every level of the university from the administration down to the individual departments. Under this current organization, the university operates with the administration at the top as the overarching umbrella over the: faculties, institutes, colleges, and schools (See Figure 4). Given this information, the discussion will now turn to examining the environment and space at BDU.

**Figure 4: BDU Organizational Structure after BPR**



### *Clubs and Organizations*

There are approximately 10 student clubs/organizations and student service offices located at Poly and Peda campuses of BDU (information conversations during fieldwork, 2010). For this study, the staff members for five clubs/organizations and offices were interviewed with regard to services they provide for students on-campus, and in particular for women. The clubs and offices interviewed included: Gender office, HIV/AIDS club, Student's Union, Sexual and Reproductive Health Office, and the campus Health Clinics.

The Gender office serves as one of the main offices supporting the needs of women on campus, and is staffed by two women at Peda and one woman at Poly. This office attempts to support women by providing photo copy services (when power is available and the machine works) monthly hygienic needs (body soap, clothes soap and sanitary pads), and general guidance and support with the everyday struggles female students face. The Gender Office has also conducted informal surveys attempting to gather information on various issues on-campus such as women's retention, women's harassment, and women's reported problems with male instructors. Lastly, the Gender Office has been instrumental in assisting with developing university policies addressing harassment on campus. While there is an official policy against harassment on campus, and a mechanism to report such harassment, in practice, this policy has not been fully implemented and upheld according to staff, faculty, and women interviewed (Key informant interviews, 2010). Given the resources the Gender Office provides, the staff

reports that their primary restraint is the little funding they receive severely limits the number of women they can reach and services they can provide.

The HIV/AIDS club is a student-run club advised by a faculty member on campus; there is an office located on both Peda and Poly campus. This club serves as a place where students who have HIV/AIDS can go for support, as well as a space where HIV-negative students can serve as allies. The HIV/AIDS club promotes HIV/AIDS testing and counseling, promotes awareness of HIV/AIDS to reduce stigma, and safer sex practices on-campus. Lastly, the HIV/AIDS club has a computer lab on campus, which serves as a major attraction to students given the resource-limited environment on-campus, and when open, this lab is generally full.

The Student's Union is the student government body on campus. The students are elected to their respective positions by their peers and the major positions include: president, vice president, secretary, and historian. The purpose of the Student's Union is to serve the needs of the student body. If students come to the Student's Union with issues or problems they are having on campus, the Student's Union will work with the student to resolve the issue they may be facing. Sometimes the nature of the problem requires the Student's Union to bring it to higher officials at BDU. The Student's Union also coordinates community service projects such as volunteering at local elementary and high schools.

The Reproductive Health Services office opened in June 2011 and is currently funded by external donors. There is one office located at both Peda and Poly; and Peda has two women who staff the office and Poly has one woman that staffs the office. All

services are available to both male and female students at BDU. Services include access to free and confidential reproductive health services such as male condoms, female condoms, oral birth control, and community referrals for services not provided on campus such as abortions, emergency birth control, and intrauterine devices. Additionally, frequent campus community discussions/workshops are initiated by the Reproductive Health Services office. At these workshops, various topics are discussed such as “how to communicate effectively in sexual relationships,” “staying safe in sexual relationships,” and “how to avoid harassment on campus.” Depending on the topic of the workshop, both men and women may be allowed to attend together, or the workshops may be separated according to gender. Interviews with staff in each office revealed that workshops where both men and women were allowed to attend together were not as beneficial to women as men dominated the conversations and women did not speak up and actively participate. Therefore, staff found it more beneficial to separate men and women during these workshops, but still cover the same topics with men and women.

A general health clinic is located on both Peda and Poly campus and is staffed primarily by nurses. Doctors also work at the clinic, but not on a regular basis, and only when time permits them to leave their teaching responsibilities at the Medical School. Very little information was provided from the Health Clinics during this study. Six staff members agreed to speak to the research team, but when questions were asked, staff members then wanted to see proof that the study was approved by BDU. When proof of BDU support was provided, as well as a one page written general overview and goals of the study, staff members refused to participate. This refusal was identified in many ways

such as setting up appointments and not being present during these predetermined appointments, saying “come back tomorrow,” stating they were “too busy” when research assistants and the PI arrived, and then finally stating they “didn’t trust” what the PI and research assistants were doing. Even after the PI and research assistants stressed their purpose was not to make them “look bad,” but rather to understand the general health issues students face on campus and to document the resources clinic staff needed from BDU to continue their services, refusal to participate continued. Subsequently, this study’s primary data collection does not provide information pertaining to the main health issues students on campus face. One health worker who did not work as a clinician, but rather performed epidemiologist duties such as tracking disease transmission did talk with the PI and a research assistant. This health worker discussed some of the top health concerns of students being: gastroenteritis, typhoid, typhus, HIV/AIDS, and pregnancy. Specific questions asked of clubs/organizations and student services can be found in Appendix F.

### ***Key Stakeholder Interviews- Administrator Perspectives***

Key stakeholder interviews were conducted with five administrators in the highest positions at BDU (one female president, two male vice presidents, one male outreach/communication faculty, and one male ethics/research faculty). The president is the first female president of a university in Ethiopia. She became the interim president in Fall 2009, official president in Spring 2011, and subsequently left BDU in December 2011 to become the ambassador to South Africa. This signified an important step in women’s involvement in higher education in general, and in higher-level administrative

duties in particular. The questions asked of administrators ranged from gender-based admissions policies are for women to what they think are some of the biggest challenges women face at BDU. The exact questions in which the key stakeholders were asked can be found in Appendix E.

With regard to gender-based admissions policies and resources, all administrators reported that women are allowed to enter the university with a lower GPA than men; women can be admitted with a 2.5 GPA, while men need a minimum of a 3.0 GPA to be admitted. Additionally, the administrators stated female freshman students have access to “tutorials” for the courses in which they may not be performing well in, whereas men do not have access to the same tutorials. Administrators stated that some of the issues (in no particular order) that women face on campus include: male harassment, difficulty with coursework, language barriers, unwanted pregnancies, and getting unsafe abortions. Administrators highlighted the need for more resources in women’s reproductive health services and educating both men and women on these available resources and specific health topics. Harassment was a salient topic in all interviews; however the administrators interviewed did not offer possible solutions to this growing problem. All administrators did discuss official university policy on reporting on-campus harassment but, also stated that most women would not come forward for fear of nothing being done and the possible repercussions for doing so (i.e. being dismissed). Lastly, when asking administrators about BDU’s reputation as “dismissing a lot of students” most administrators said that this action was true of the past, but this trend is no longer the case. When asked why there was now a change, most administrators felt that students

were better able to succeed academically and therefore were not being dismissed as frequently as in the past. Additionally, this notion of “dismissals” was tied to providing a “quality” education. Administrators and students interviewed perceived BDU as being one of the most academically rigorous universities, as evidenced by dismissals, and therefore it provided students with a high quality education (Key Information Interviews and Male and Female Focus Group Discussions, October-December, 2010). Examples of statements provided by administrators are as follows:

“It is true we used to dismiss many students, but now things are different. Not as many students leave BDU” (Key Informant Interview, December 2010).

“More people succeed compared to before. There are more resources and students are more serious about their studies. If they are not serious they do not get admitted” (Key Informant Interview, December 2010).

“Because in the past we dismissed students people want to come here to get a quality education. We [BDU] now has a reputation of providing a quality education because it is tough here” (Key Informant Interview, December 2010).

Most conversations around the issue of “dismissals” were in the context of academic dismissals, although behavioral dismissals were discussed on occasion. When asked for retention percentages, no official document was provided to the PI, and the reported numbers of academic dismissals could not be verified.

## **PERCEPTIONS OF SAFETY ON CAMPUS**

The issue of campus safety was a salient theme among male and female students and administrators interviewed. Several themes and subthemes emerged from the qualitative data collected during in-depth interviews and focus group discussions. Table 11 provides a brief overview of the major themes and subthemes that emerged from the

interviews with female students who identified as second year and above as well as focus group discussions. A discussion of each is found in the sections following the general table.

**Table 11: Overall Safety on Campus: Themes and Subthemes from Female Students**

<b>Themes</b>	<b>Subthemes</b>
Safe Places	Dorms
Unsafe Places	Common spaces (libraries, walkways, cafeterias)
Improving Safety	Police Presence Better lighting Strict punishment Men's awareness programs
Situational Safety	Avoid men (harassing situations) Avoid night travel Communicate with men to stop harassing Walk in large groups of women Do not report to higher officials

*Source:* Qualitative in-depth interviews and focus group discussions, 2010

### ***Harassment on Campus***

Harassment is an obstacle women face on a regular basis both on and off campus. Harassment has come to be a social norm in Ethiopia with women all over the country facing this challenge (Emebet, 2004). Harassment on campus is different from off-campus as women on campus no longer have their social support networks (fathers, brothers, relatives, etc.) in place to protect them. Women did discuss this new found

“freedom” and “independence” as a change they face when moving onto campus. When discussing this “independence” relative to their safety they said things such as “we are alone now” and “no one is here to help us.” While most of the women discussed harassment in terms of verbal harassment, they did say that harassment could turn physical in the form of grabbing, pushing, and sometimes forcing sex. The verbal harassment women described was of both sexual and non-sexual nature and was usually, but not always, worse when women walked alone and encountered groups of men.

Many women in the study discussed how they faced harassment almost everywhere on campus, in particular while walking throughout campus, while studying at the libraries, and even while eating in the cafeterias. Women discussed harassment coming from male students, guards, cafeteria attendants, library attendants, and even instructors. Women discussed the harassment they faced on campus as something they came to expect and must endure if they wanted to succeed in the university. Although most of them would agree that the harassment they faced was something that wears on them mentally, they also come to accept the behavior as a social norm and part of being a woman in Ethiopia (although it is likely not this simple). They said things such as “it is our culture” and it is something we (women) have to “deal with.” While harassment has come to be a “norm” for most women, they expressed a desire for the atmosphere to change on campus. They see the harassment as one of many barriers they must overcome to be successful on campus. They described harassment as a stress not endured by their male counterparts.

Although not all women in this study viewed harassment as a problem for them specifically, they unanimously agreed that harassment is a problem on campus. The harassment is gender-specific, not experienced by men, and primarily orchestrated by men. In all focus groups, men recognized their active role in women's harassment on campus, but spoke very little about their motivations and how a harassment-free environment could be created. Some men even conjectured that women "appreciated" this attention and as it was a "compliment," and behaved in ways to seek out this sort of "attention." While this rhetoric is reminiscent of "blaming the victim," the body language and facial expressions (i.e. smirks and laughs) of men during focus group discussions demonstrated they knew that this type of behavior would not be thought of as acceptable. But, in the context of a group of their peers, joking and laughing about such harassment was commonplace. Men's engagement in harassing behavior was expected and thought of as something that they could get away with because it can be chalked up to an environment of "culture" where men are expected to, if not encouraged to engage in such behavior. In a culture where male dominance is pervasive, such behavior has become part of the culture of growing up male in Ethiopia. Administrators, staff, and students interviewed in this study were not surprised by the issue of harassment; in fact, they often justified it by stating that it is something "men do" in Ethiopia.

The reasons female harassment is so pervasive in Ethiopian society is poorly understood and relatively under studied (Emebet, 2004), and even less understood in the university context. Some women believe that harassment is a "strategy" men employ on

campus to make sure women don't succeed in the university. A quote taken from an in-depth interview conducted with a third year female student illustrates this belief:

“The men...they are very strategic, they finish all their school work and then they come to the library and harass us. They take our notebooks, pens, and they say stuff to us. They do this so that we don't do better in classes and so that we don't succeed.” (Peda Student, November 2011)

Both men and women were at a loss for words when asked why harassment occurs and why it continues. However, both male and female students and administrators agreed the behavior was a problem and was prominent in key informant interviews, in-depth interviews, and focus group discussions. When men were asked what they could do to help women on campus they agreed that women on campus should be treated like their “sisters.” However, when asked how to put this “sisterly” treatment into practice across campus, no suggestions were provided. Instead, men provided statements such as, “even if we try it would not work,” and “what can we do, this is our culture?” In this study, female harassment was simply viewed as something that was “par for the course” for women in Ethiopia, and processes for change initiated by men were not elaborated on as viable means to put into practice on campus.

### *Safe and Unsafe Places*

Women in this study were asked during in-depth interviews and focus group discussions to identify places on campus that they perceived as being “safe” or “unsafe.” The one place women unanimously agreed upon and identified as a “safe” place was the dorms. Women repeatedly described dorms as a place in which they felt safe, and a place in which if men entered they would be immediately dismissed from the university.

Dorms were the one place on campus in which strict punishment was imposed upon men who violated this policy, and men rarely risked violation. However, women stated that this policy did not stop men from hanging out right outside the dorms, and at times, engaging in harassing behaviors that hampered women's ability to enter or leave their dormitory. A quote by one woman illustrates the freedom and safety she felt in her dorm room:

“Yes, I feel safe in the dorms because everyone of us is ladies. We are so free to do everything we want, to play, to chat. That is the only place the girls are free. We even sleep without locking the doors.” (Peda student, October 2011).

There was not unanimous agreement among women in the identification of “unsafe” places, although several places repeatedly came up as being unsafe at times. These places included: walkways on campus, libraries, and cafeterias. A range of responses were provided by women in discussing these common spaces as potential areas of risk to safety. The following quotes regarding whether or not women felt safe using the library demonstrates the range of responses given:

“We don't feel safe at all in the libraries. There is not enough security in the library at all. The only people we get are those people that are supposed to help with books only. They will not watch over our security at all. Even if they saw harassment they will say it is “not our problem” or our “duty” and will just leave it and not do anything about it at all.” (Poly student, October 2011)

“To some extent yes (we feel safe). But, sometimes if my friends are not with me I don't feel comfortable and I am afraid of male students.” (Poly student, November 2011)

“Yes, I feel safe here (the library). In my opinion, for a student to feel safe or not depends on her attitude. As long as we went there to study, nothing bad will happen to us.” (Peda student, October 2011)

“I actually hate the library, but if it is a must to go to the library sometimes I use it. But, I don’t feel safe because there is harassment.” (Peda student, November 2011)

“Half of the time I feel safe. In the libraries you will meet guys. They will come to the library drunk and disturb us on purpose.” (Peda student, November 2011).

With regard to the walking spaces throughout campus, women repeatedly discussed the lack of lighting and limited presence of security as creating more harassment and unsafe situations. They believed that having stricter punishment for breaking rules would make the campus safer. The following quotes highlight this belief:

“Security men should be distributed to each and every place on campus and they should do their work properly.” (Poly student, October 2011)

“The law should be more strict than ever and also there should be heavy punishment to make examples and teach others.” (Peda student, November 2011)

“The police should be stronger and look after us more. And as much as possible there should be lights in campus as the darkness will create more harassment opportunities.” (Peda student, November 2011).

Lastly, many women discussed wanting all-female services available on campus such as all female libraries, recreational areas, and TV rooms. The women stated that having female only services would make activities safer and more free from harassment. Women felt having access to female-only spaces may help them be more successful on campus.

### ***Structure and Space as a Contributor to Women's Risk***

The discussion in the preceding section highlights areas in which women identified as “safe” and “unsafe” on campus. The structure and space in which women reside contributes to their perceptions and experiences of safety on campus. The dorms as a structure are considered to be “safe” by women, however the paths in which they must walk through to go to and from their dorms are not considered safe and free from harassment. This “space” is usually populated with groups of men, and at night, is poorly lit. These environmental features contribute to women’s perception of feeling unsafe, and to negative experiences they may have had in this space. Additionally, the library is often considered unsafe because this space is not monitored by campus security and there are many places within the library that lends more easily to male harassment.

An ambiguous discussion revolves around what is commonly referred to as “the space” on campus. Men, women, and administrators reference “the space” on campus as places in which deviant behavior such as pre-marital sex, drinking, smoking, chewing Khat, and harassment takes place. Nothing good is ever thought to have happened in “the space” and it is never discussed with positive intonation. While at first glance “the space” discussion appears to be abstract, in reality there is an abundance of random “space” on campus in which the aforementioned behaviors can easily take place.

These “spaces” are literally places on campus that are either in between buildings or line the perimeter of each campus in undeveloped areas. Most important to the discussion of safety, is “the space” are places where security rarely goes, are poorly lit, and where students know they can go to be alone. The “space” is a place where sexual

activity occurs due to private and reclusive nature of these places. When sex in the “space” was described by men and women, it was not typically described as forced sex, but it may be considered coerced sex, which is common within boyfriend and girlfriend relationships. Meaning, men help women with schoolwork in exchange for sex, therefore women believe they must “pay” men back by engaging in sexual activity with them. These “boyfriend” and “girlfriend” relationships are described in greater detail in chapter 8. Evidence of sexual activity in “the space” was found by walking through these places early in the morning to see the ground littered with used beer bottles, Khat, cigarettes, used condoms, and emergency birth control packages (discussed in greater detail in chapter 8). The “space” was also described as a place where harassment was at its worst given the reclusive and hidden nature of this environment. However, most women stated they avoided traveling in the “space” alone and usually went there due to pressure or request made by men. Therefore, the “space” may contribute to safety issues for women on-campus, as well as promote a place where risky sexual behaviors occur.

While premarital sex, alcohol consumption, smoking, and chewing Khat is generally considered socially deviant behaviors, and a violation of Ethiopian values and norms, these same activities are not socially deviant when performed in “the space.” These activities, when done in “the space,” serve as a form of situational deviance, and relatively accepted on-campus as a situation that cannot be controlled. Students participate in “concealed” socially deviant behaviors, but because “the space” is considered to be an unregulated and unmanageable place, these activities continue to occur with full knowledge of administrators, faculty, staff and students. Administrators

felt their hands were tied and were absolved of responsibility because this space cannot be regulated.

### *Strategies to Remain Safe*

Although women described many issues and daily concerns, they also expressed their agency and ways they take action to make improvements to their situational safety. Walking in large groups of women and avoiding walking at night, especially alone at night, were actions that women perceived as easy strategies that could improve their safety on campus. With regard to harassment from male peers on campus, most women stated they would confront the men themselves and try to resolve it on their own by communicating with them, or that they would avoid situations where they may come into contact with men. For example, when women were asked what they would do if they had a problem with a male student on campus the following was stated:

“As much as possible I will try to have a conversation with him and solve the problem on my own. When I am about to use the library or study, I will try my best not to be near or seen by male students who cause me problems. When I am in the campus then I would not be walking alone and I will walk with my girlfriends” (Peda student, October 2011)

“First I try to advise him and tell him why I am here and that I will not be with him. After that, if he does not accept it, then there is nothing else I can do.” (Poly student, October 2011)

“I would hide myself and give time to avoid the situation.” (Poly student, November 2011)

“First I will try to have a talk with him if it is possible and if we can try to solve it through talking. But if not, and I thought he might hurt me or something like that then I would go straight to higher officials.” (Peda student, November 2011).

When women were asked what they would do if they had a “problem” with a male instructor (meaning an instructor was asking them to engage in sexual relations for a grade in their course), all but one woman out of the 28 total women interviewed stated that not much that could be done. Most women stated they would discuss with the instructor that they did not want to have sex with him, but that if the instructors were pressuring them to do so, they would only have two choices to: 1) have sex with him, or 2) to leave the university. The following quotes illustrate their thoughts on this issue:

“There will not be anything I could do about it. If there is anything I can do, it would be leaving the campus. Even if we file a complaint, no one will listen to us. The only choice if we want to continue our study, we have to do what they ask us to do, otherwise we will leave the campus.” (Peda student, October 2011)

“If I am not willing to do the things asked by him, the only thing I can do is to leave the campus.” (Peda student, November 2011)

“First, I try to do anything that he is asking me to do except for to have sex with him. If he says no or tries to convince me to have sex I know I can’t complain on him and there will not be anything that will force him from changing my grade. I will just pretend that I am okay with it until I finish my grade. But, I will not do anything he says. If he forces me I will just leave campus.” (Poly student, October 2011)

“I would do nothing. I can’t even think about it because I am afraid of them and I don’t know what I am supposed to do. I have no idea regarding on this, but if it is so much pressure I may advise him not to do it.” (Poly student, November 2011)

“First I will tell him in a language that he can understand me why I am here. Then, there will not be anything more that I can do other than leaving campus.” (Peda, October 2011)

“I will try to talk to him and convince him if I am not interested I will not do it. Otherwise, I won’t go to higher officials to report him because no one will listen or force him to give grades. He has all the power to do what he wants to do. I will try to have peace with him. This has not happened to me, but I have seen so many girls leaving the campus by this.” (Poly student, November 2011).

In summary, this chapter outlined issues of harassment on campus, “safe’ and “unsafe” places on campus, “the space” on campus where deviant behavior occurs, and strategies women take to be safe and succeed on campus. In general, women’s harassment on-campus is viewed as a problem and an on-going and daily issue that women must face. However, there was no agreement as to what could be done to stop this harassment on campus. With regard to safety, women stated that the dormitories are the safest place on-campus, because they are free from male harassment. However, female participants identified the libraries, cafeterias, and walk-ways as places that at time may be unsafe because these places lend themselves easily to harassment. It is “the space” on campus in which the majority of deviant behaviors are thought to occur such as pre-marital sex and substance use. These activities are aided by the very nature of “the space” as an unmanageable and unregulated environment where campus security rarely goes. It is in “the space” where risky behaviors such as unprotected sex and substance use is occurring and nothing is currently being done to prevent this activity from occurring or promoting safer practice in these places.

## CHAPTER 7: WOMEN'S KNOWLEDGE AND BEHAVIOR

### HEALTH KNOWLEDGE, BEHAVIOR AND COMMUNICATION

This chapter will outline participants' self-reported knowledge on HIV/AIDS and other STDs in order to understand where sufficient knowledge exists and where additional education is needed. Based on self-reports, the sexual health histories and recent sexual encounters of participants will be examined to identify female students' sexual risk taking behaviors. Women's self-reported assertiveness and confidence in communicating during sexual relationships will be explored as strategies that may serve to protect or promote risky sexual behaviors. This chapter will provide results of exploratory data analysis with associated descriptive statistics as well as the selected model used for univariate and multivariable analysis. Lastly, this chapter will highlight, when appropriate, information collected during focus group discussions that supplements, and assists in, explaining several inconsistencies revealed in the data collected from the self-administered survey. Taken together, the quantitative and qualitative data collected for this chapter will address specific aim 3:

**Specific Aim 3:** Describe factors influencing women's health by exploring sexual and reproductive health knowledge and attitudes, sexual communication and self-confidence, safety on campus, and personal health practices;

#### *Exploratory Statistical Analysis*

Exploratory analysis was used to gain familiarity with the data set, note any missing values or out of range values, and ensure that the data are meeting the

assumptions of the statistical tests that were conducted. During this exploratory phase, any necessary data modifications were made to prepare for the modeling phase of analysis. Data were coded as “missing” in the system when the variable with the missing value was used. Tables 13-19 and Figures 5-9 provide a summary of the exploratory analysis and descriptive statistics.

### ***HIV/AIDS Knowledge***

With the current HIV/AIDS pandemic, great efforts have been made throughout Ethiopia to educate people on HIV/AIDS prevention. As a result, women in this study were predicted to have a great amount of knowledge on how to contract and prevent the spread of HIV/AIDS, but would be less knowledgeable about prevention of other STDs since they are not as discussed and promoted in Ethiopia. This subject will be modeled and tested further during multivariable analysis, but Table 13 below illustrates the descriptive statistics of the questions asked of women about HIV/AIDS and their responses. Not surprising, >90% knew that a healthy looking person can have HIV/AIDS, or that HIV/AIDS cannot be contracted from sharing food with an HIV-infected individual. In response to the inquiry of a cure or a vaccine for HIV/AIDS, the responses were not as clear. The majority of women (59%) knew that there is currently no cure for HIV/AIDS; however 22% thought there was a cure and 19% were not sure. Also, the majority of women (60%) knew there is currently no vaccine, while 10% believe there is a vaccine and 30% were not sure. In response to questions of risk reducing behaviors such as partner reduction and condom use, most women had knowledge on how to protect themselves. Of the 997 respondents, 87% knew that having

sex with one faithful partner and 83% knew that wearing a condom could reduce their risk of contracting HIV/AIDS. While 97% of women answered that having multiple sexual partners increased risk of contracting HIV/AIDS. Lastly, 67% of women thought they could avoid HIV/AIDS by avoiding sex, while 30% did not believe that abstinence was protective, and 10% were not sure. See Table 12 below for all results.

**Table 12: Female Survey Respondents' HIV/AIDS Knowledge (N=997)**

Question	Response	Percentage (%)
A healthy person can have HIV/AIDS	Yes	93
	No	5
	Don't know	2
There is a cure for HIV/AIDS	Yes	22
	No	59
	Don't know	19
There is a vaccine for HIV/AIDS	Yes	10
	No	60
	Don't know	30
Multiple sex partners increases HIV/AIDS Risk	Yes	91
	No	4
	Don't know	5
Can get HIV/AIDS by sharing food with a person who has HIV/AIDS	Yes	2
	No	94
	Don't Know	4
Can contract HIV/AIDS from mosquito bites	Yes	17
	No	73
	Don't know	10
Having sex with one faithful partner can reduce risk of HIV/AIDS	Yes	87
	No	9
	Don't know	4
Can avoid HIV/AIDS by not having sex	Yes	67
	No	30
	Don't know	3

Using a condom can reduce risk of contracting HIV/AIDS	Yes	83
	No	10
	Don't know	7
There is medicine that people infected with HIV/AIDS can take	Yes	74
	No	10
	Don't know	16

As predicted before study initiation, women were not as knowledgeable about other STDs outside of HIV/AIDS. The majority (70%) of women felt they had “a lot” of knowledge on HIV/AIDS. While examining the same category for other STDs, the percentages of respondents reporting “a lot” was lower: 13% for gonorrhea, 9% for genital warts, 9% for chlamydia, and 14% for syphilis. Respondents reported knowing the least about genital warts and chlamydia, and knowing slightly more about gonorrhea and syphilis. The locally accepted Amharic translations were used when asking questions about specific STDs, however it is thought that for many respondents this may not be common vernacular. See Table 13 below for respondents’ self-perceived knowledge.

**Table 13: Female Survey Respondents’ STD Knowledge (N=997)**

Question	Response	Percentage (%)
Knowledge of HIV/AIDS	A lot	70
	Some	23
	A little	2
	Nothing	5
Knowledge of Gonorrhea	A lot	13
	Some	37
	A little	25
	Nothing	25

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Knowledge of Genital Warts	A lot	9
	Some	23
	A little	23
	Nothing	45
Knowledge of Chlamydia	A lot	9
	Some	22
	A little	23
	Nothing	46
Knowledge of Syphilis	A lot	14
	Some	28
	A little	26
	Nothing	32

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## **PARTICIPANT HEALTH HISTORIES**

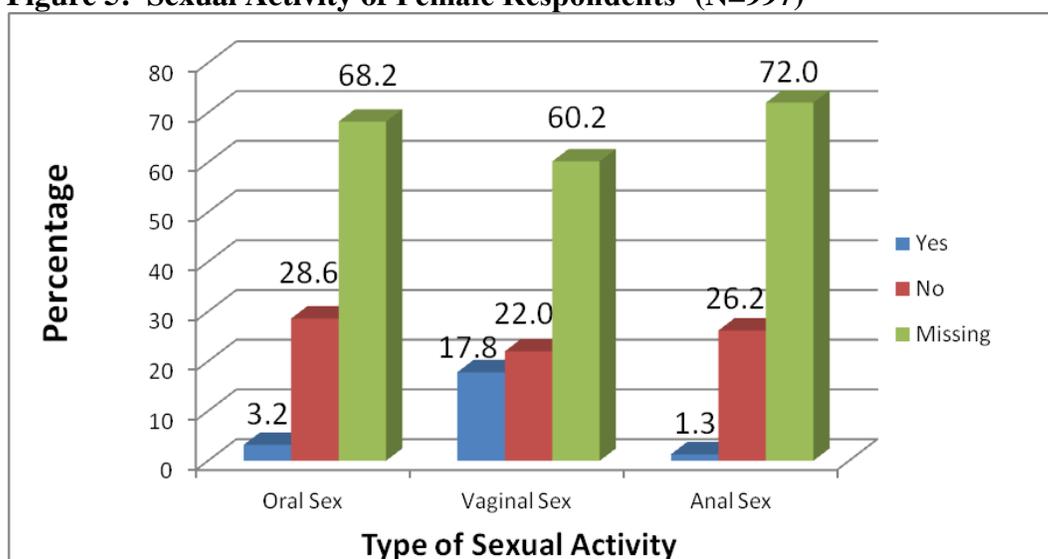
The sexual health histories were gathered to understand both the risky and protective behaviors of those who volunteered for this study. Since these questions were of a sensitive nature, the decision was made to ask them in the self-administered questionnaire in an effort to elicit more honest and thorough responses. However, after conducting descriptive statistics, the inquires related to sexual activity elicited more questions than answers. In particular, responses were inconsistent relative to reports of participation in sexual activities. For example, a participant may answer that she had “never had sex” for one question, but then later answer “yes” to a question that she had used a condom at “last sexual encounter.” It was expected prior to study initiation that questions about personal sexual health history may be hampered by the social desirability to answer sexual questions in a particular manner. However, the extent to which questions around sexual activity elicited inconsistent responses across multiple questions

from respondents was not expected. The decision was made a priori to collect similar data about female student's sexual activity on campus in focus group discussions in anticipation this data collection problem may occur; however it became more important after the self-administered study the numerous inconsistencies with sexual activity questions. As a result, the results of the problematic questions posed by the self-administered survey will first be highlighted followed by a discussion of the focus group discussion results in order to better understand and unpack complex topics.

### *Sexual Activity: Self-Reported Questionnaire Responses*

Figure 5 reveals the percent of women in this study who self-reported as having oral, vaginal, or anal sex as 3.2%, 17.8%, and 1.3% respectively. While 28.6%, 22.0% and 26.2% reported “no” to these activities and 68.2%, 60.2%, and 72.0% were missing.

**Figure 5: Sexual Activity of Female Respondents' (N=997)**



While the precise reasons so many women skipped answering this question is unknown, the assumption is that women were uncomfortable reporting on sexual activity,

or because the response they would have chosen was not on the list. For example, respondents who identify as not having sex may have been confused as to which category to choose because there was no “do not have sex” category.

### ***Sexual Activity on Campus: Focus Group Discussion Responses***

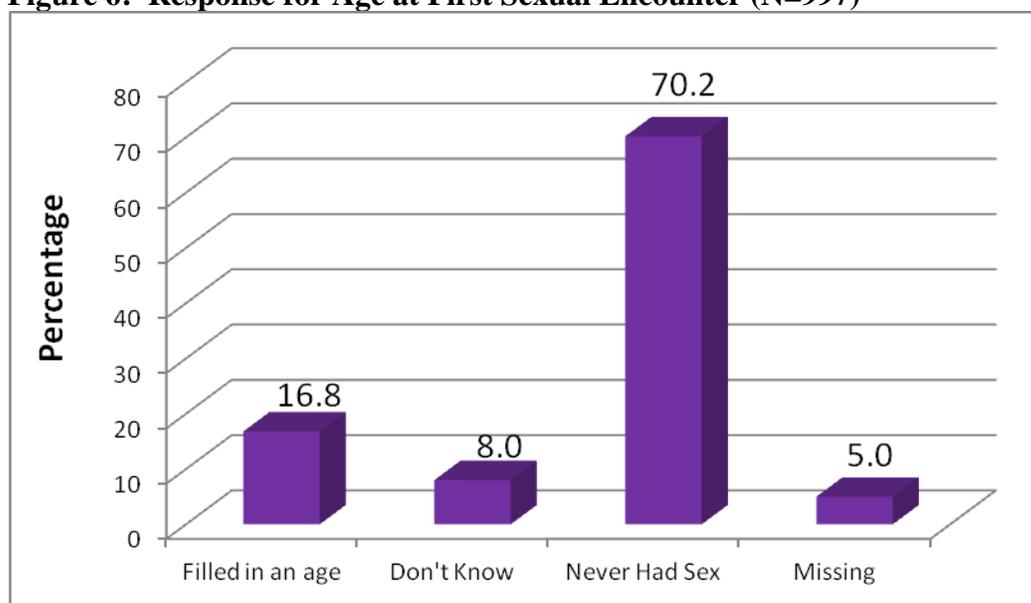
Because asking women to self-report on sexual activity revealed clear methodological issues, this question was asked again in a face-to-face setting during focus group discussions. In focus group discussions, the question was asked in a slightly different manner; women were asked to respond to a series of questions on what percentage of women on campus they perceive take part in a particular activity, such as sex. This way, the question was asked in a manner that did not require them to self-report, but rather asked them to report their perception of all women on campus with regard to sexual activity. Once they reported their perceptions, they were then asked to support their perceptions with information (i.e. why do you think 90% of women on campus have sex? What makes you think this?).

Results from focus group discussions revealed women perceive the majority of women on campus are having sex. Women reported they believed 20-90% of women on campus are having sex. Although there was a range of percentages reported, most (N=62) of the women reported greater than 70% of women are having sex. A smaller group of women (N=15) reported percentages under 50%. This is in stark opposition to what was self-reported by women in terms of sexual activity. This reporting paradox will be explored later; however it is worth keeping in mind when examining the remaining data presented in this chapter.

### *Age at Sex Initiation*

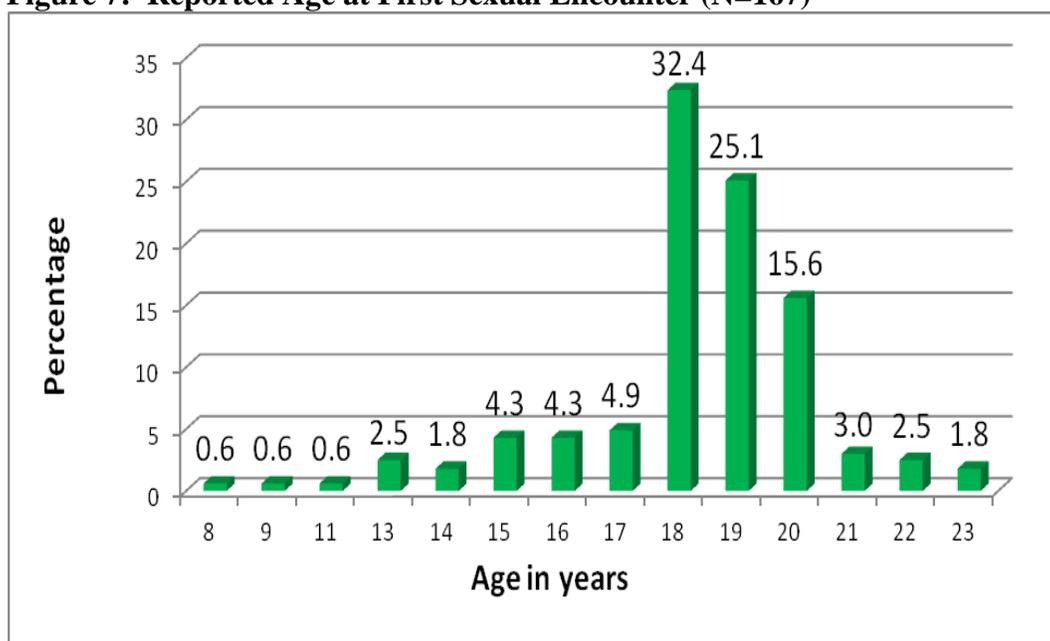
The question of first sexual initiation was asked to understand the average age of sexual activity among this group of women. The literature discusses an established relationship between early sexual debut and engagement in risky sexual behavior, unintended pregnancies, and labor injuries (Bearinger, et al., 2007; Lohman and Billings, 2008; Price and Hyde, 2009; Palermo and Peterman, 2009). Additionally, informal conversations with local Ethiopians, health care providers, administrators, and students revealed an environment in which women report having sex at later ages than in the past. To explore a trend of age at sexual initiation, several questions related to sexual activity were asked. Figure 6 illustrates data on the question asked about age at first sexual encounter, where 16.8% of respondents provide an age, 8.0% said they didn't know their age, 70.2% reported never having sex, and 5.0% did not answer the question.

**Figure 6: Response for Age at First Sexual Encounter (N=997)**



When examining the results of those who reported an age for first sexual encounter (N=167), the range of reported ages was from 8 to 23 years old. While an age of 8 years old does seem young, it is what was reported in this study. The majority (73%) of these women reported their first sexual encounter occurred between 18-20 years of age, with 19.6% reporting age at first sex before the age of 18 years and 7.3% after the age of 20 years. Figure 7 below illustrates all reported ages at first sexual encounter.

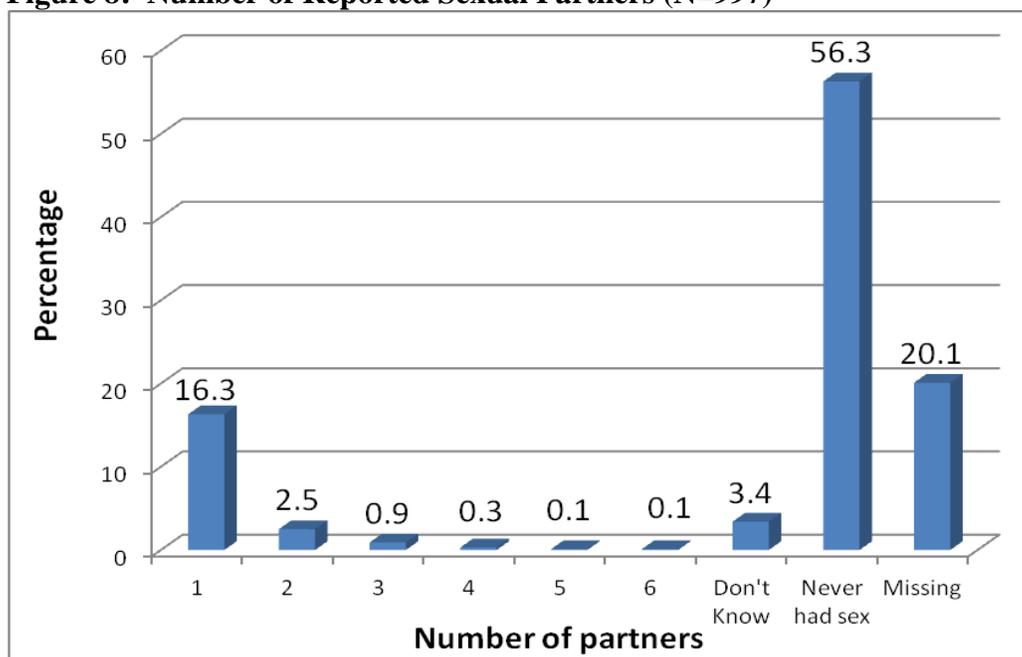
**Figure 7: Reported Age at First Sexual Encounter (N=167)**



When asked about the number of sexual partners, 201 women reported a number, 560 reported never having sex, 34 women reported they did not know, and 202 women did not answer the question. Most of the women who reported having sex (N=162) reported to have only one partner, while 25 women reported having two partners, nine women reported having three partners, three women reported having four partners, one

woman reported having five partners, one woman reported having six or more partners, and 34 women reported not knowing. See the details below in Figure 8.

**Figure 8: Number of Reported Sexual Partners (N=997)**



### *Contraceptive Use: Self-Reported Responses*

With regard to the use of birth control methods, few women reported having used a condom (9%), birth control pills (11%), the rhythm method (10%), or withdraw/pulling out (7%). Between 62-65% of women reported not having sex and between 7-9% of women did not answer the question. This reported sexual inactivity conflicts with Figure 5-8, as well as focus group discussion data, and further illustrates the sexual activity reporting paradox mentioned previously. Table 14 illustrates contraceptive use for those who reported being sexually active.

**Table 14: Birth Control Methods Used by Women Reporting Sexual Activity**

<b>Question</b>	<b>Response</b>	<b>Percentage (%)</b>
Ever Used Condoms (N=295)	Yes	9.2
	No	8.9
	Never Use any type	11.5
Ever Used Birth Control (N=282)	Yes	11.3
	No	7.3
	Never Use any type	9.7
Ever Used Rhythm/Calendar (N=266)	Yes	10.1
	No	9.2
	Never Use any type	7.4
Ever Used Withdraw (N=249)	Yes	7.0
	No	11.0
	Never Use any type	7.0

Condom use among participants who reported having sex was low. Table 15 illustrates 17% of participants who reported having sex, reported ever having sex without a condom, while only 5% reported they have always used a condom. Only 6.6% of participants who reported having sex reported using a condom at last sexual encounter, while 14% reported not using a condom at last sexual encounter.

**Table 15: General Condom Use of Women Reporting Sexual Activity**

<b>Question</b>	<b>Response</b>	<b>Percentage (%)</b>
Ever Had Sex Without Condom (N=219)	Yes	16.9
	No	5.1
Use Condom at Last Sexual Encounter (N=206)	Yes	6.6
	No	14.1

***Contraceptive Methods: Focus Group Discussion Responses***

Women's self-reported birth control and condom use revealed inconsistencies, similar to the sexual activity questions, therefore these questions were also asked during focus group discussions. Results from focus group discussions revealed higher perceived use of oral birth control and condoms among women. Women reported they believed 45-80% of women were using daily oral birth control on-campus. Most (N=55) of the women reported they believed greater than 70% of women are using oral birth control while a smaller group of women (N=22) reported 45-65% of women use oral birth control. With regard to condom use, the perceived use was also higher than the self-reported use. Women reported they believed 20-50% of women on campus use condoms on a regular basis. Most women (N=52) reported between 45-50% of women use condoms while a smaller group of women (N=25) reported condom use to be between 20-40%. Again, these perceived numbers are greater than self-reported numbers of birth control and condom use, and point to a need for examining these variables via mixed methodology.

***Test History: Self-Reported Responses***

With regard to pregnancy and STD testing, approximately 9.6% of women reported yes to ever had a pregnancy test, 17.5% reported yes to ever to had an STD test, and 62.5% reported yes to ever had an HIV/AIDS test. See Table 16 below for specific details.

**Table 16: Female Respondents' Reported Test History (N=997)**

<b>Question</b>	<b>Response</b>	<b>Percentage (%)</b>
Ever Had Pregnancy Test	Yes	9.6
	No	16.8
	Do not know	66.5
	Missing	7.1
Ever Been Tested for HIV	Yes	62.5
	No	6.6
	Do not know	28.8
	Missing	2.1
Ever Been Tested for STD	Yes	17.5
	No	14.6
	Do not know	66.2
	Missing	1.7

The reasons why respondents stated “don’t know” for some of these questions is not known. One possible reason is some participants may have been confused with the categories of possible survey responses. If respondents identified as “not having sex” they may have selected the “don’t know category” since there was no option to choose “do not have sex” (although these respondents should have then answered “no”).

Additionally, there was discussion during the pilot testing of the instrument to take this category (don’t know) out, however many women felt that this was a valid category. The value of the category was linked to many participants mistrust of medical professionals. Meaning, many women believed that medical personal performed tests without knowledge and consent of patients, therefore choosing “don’t know” was plausible in this context.

***Experience with Pregnancy, STDs, and Abortion: Self-Reported Responses***

When participants were asked about personal experience with pregnancy, STD's, sexual assault, and abortion, few participants reported such experience. Approximately 5.4% reported ever being pregnant, 2.8% reported ever having and STD, 4.0% reported ever being raped, and 6.0% reported ever having an abortion. See Table 17 for specific results.

**Table 17: Female Survey Respondents' Pregnancy, STD, Sexual Assault and Abortion History**

<b>Question</b>	<b>Response</b>	<b>Percentage (%)</b>
Ever Pregnant	Yes	5.4
	No	19.7
	Do not know	72.0
	Missing	2.9
Ever Had STD	Yes	2.8
	No	16.6
	Do not know	78.5
	Missing	2.1
Ever Been Raped	Yes	4.0
	No	18.4
	Do not know	74.2
	Missing	3.4
Ever Had Abortion	Yes	6.0
	No	22.1
	Do not know	62.9
	Missing	9.0

Participants may have responded “don’t know” to some of these questions because they fall into the category of respondents that don’t have sex. This would be a reasonable conclusion given the percent of “don’t know” are similar to the percent of

women who responded “don’t have sex” in previous questions. Additionally, as discussed earlier, cultural mistrust in medical professional could explain why so many reported “do not know” with regard to questions on ever being pregnant or ever having an STD. The “do not know” category was intended to be removed after pilot testing from questions on “ever been raped” or “ever had an abortion;” however, the change was not made in the final version administered in Amharic. This mistake was not brought to the PI’s attention until after approximately 400 surveys had been administered, and 1000 copies had been made. In order to remain consistent across all participants, the decision was made to keep the survey as is even though the category of “do not know” does not make sense for these questions.

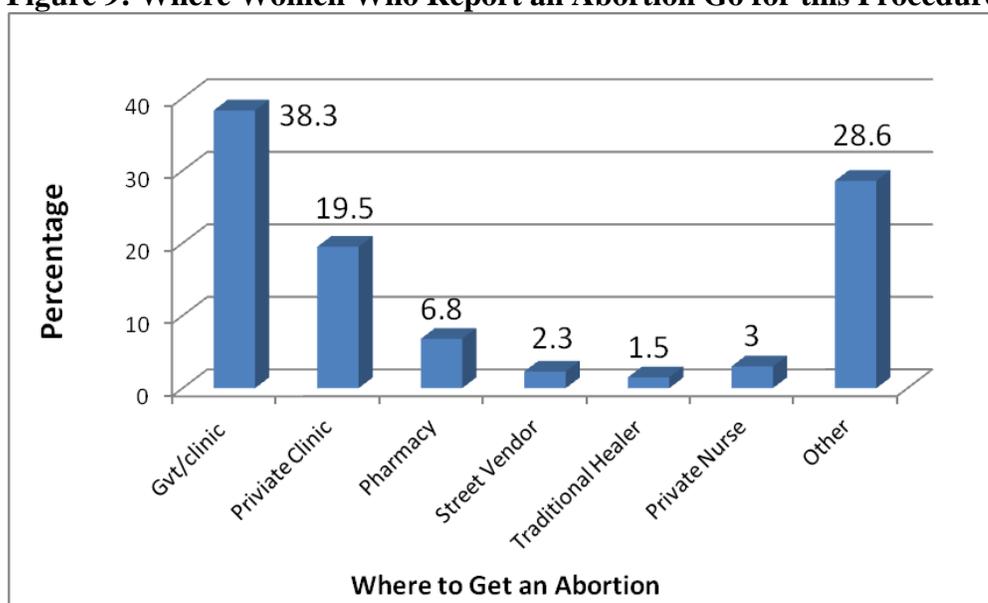
#### ***Experience with Pregnancy and Abortion: Focus Group Discussion Responses***

Similar to the self-reported responses to sexual activity, birth control and condom use, the self-reported pregnancy and abortion responses were also lower compared to focus group discussions. Results from focus group discussions revealed higher perceived experiences of pregnancy and abortion among women on-campus. Women reported they believed 10-30% of women become pregnant at some point during their time at the university. Women in focus group discussions also reported they perceived 5-25% of women on campus have had an abortion at some point in time. The perceived percentages and the self-reported percentages do not vary as greatly for the topics of pregnancy and abortion, however there still appears to be methodological issues with collecting information on these sensitive topics.

### ***Where to Get an Abortion: Self-Reported Responses***

With regard to where participants reported going for abortions if needed, 5.2% reported using a government hospital or clinic, 2.6% reported using a private clinic, 10.5% reported using a pharmacy, 6.5% reported using a traditional healer, and 31.4% reported other. Some examples from the “other” category include: starving one’s self, jumping up and down (to expel the fetus), having someone jump on their stomach (to expel the fetus), and taking several birth control or antibiotic pills at one time for multiple days to spontaneously abort the fetus. See Figure 9 below for details of location where women reported to go for an abortion.

**Figure 9: Where Women Who Report an Abortion Go for this Procedure (N=133)**



### ***Communicating with Partners***

Talking about, and communicating about sex with partners appears to be difficult for women in this study, and many reported not speaking up with regard to their sexual

preferences. About half of the women felt some level of comfort when talking about sex, while the other half felt uncomfortable talking about sex. Only 6.7% of women reported that they speak up about their sexual feelings and only 5.4% reported that they approach their partner for sex. Table 18 below highlights the degrees of comfort that women reported in this study with regard to various questions on sexual communication.

**Table 18: Female Survey Respondents' Reported Sexual Assertiveness (N=997)**

<b>Question</b>	<b>Response</b>	<b>Percent (%)</b>
I feel uncomfortable talking about sex	All of the time	11.0
	Most of the time	8.8
	Some of the time	4.6
	Rarely	10.4
	Never	15.2
	No Sexual Partner	50.0
It's hard for me to say no even when I don't want sex	All of the time	6.7
	Most of the time	5.5
	Some of the time	3.2
	Rarely	6.8
	Never	21.9
	No Sexual Partner	55.9
I speak up about my sexual feelings	All of the time	6.7
	Most of the time	5.7
	Some of the time	4.3
	Rarely	12.8
	Never	25.0
	No Sexual Partner	45.5
I approach my partner for sex when I desire it	All of the time	5.4
	Most of the time	3.8
	Some of the time	3.6
	Rarely	6.7
	Never	18.4
	No Sexual Partner	62.1

***Summary of Mixed Methods Responses of Sexual Activity, Condom and Birth Control Use, and Pregnancy and Abortion***

Given the inconsistencies found in collecting information on sexual activity, condom and birth control use, and pregnancy and abortion, these data were collected utilizing a mixed methods approach. The details of the results are described below and Table 19 provides a side-by-side comparison on how these data differed.

**Table 19: Comparison of Self-Reported Data and Focus Group Discussion Data**

<b>Questions Asked</b>	<b>Self-Administered Survey Responses (%)</b>	<b>Focus Group Discussion Responses (%)</b>
Sexually active women (across multiple questions)	17.8-22.0	70.0-90.0
Oral birth control use	11.3	70.0-80.0
Condom use	9.2	45.0-50.0
Ever Pregnant	5.4	10.0-30.0
Ever Abortion	6.0	5.0-25.0

Although questions were asked in slightly different ways (self-report vs. group report) in the self-administered survey compared to the focus group discussions, the above table demonstrates clear differences in responses provided for both methodologies undertaken. These issues have directed the researcher to question the data with regard to these specific questions, particularly in the self-administered survey. As a result, caution must be taken when interpreting these findings; however, these data also highlight the need to further examine methodologically appropriate ways to collect data about sexual activity in the future. Inconsistent responses across these questions in both quantitative

and qualitative data collection techniques underscores, and further illustrates, the complexity of women's gendered responses about sexuality. The difficulty in eliciting truthful responses is hampered by the social desirability and cultural expectations of women's behavior in Ethiopian society, as well as self-reported methods that may not lend easily to collecting data of a sensitive nature. It is likely that face-to-face interviews about these questions were more reliable given the frequency and consistency in responses across all focus group discussions among women who come from both rural and urban areas. The consistencies found, as well as open and honest communication that occurred in focus group discussions, supports asking sensitive questions in a face-to-face setting in the Ethiopian university context. Although collecting data in multiple ways, both quantitatively and qualitatively, is useful to uncover areas of concern and patterns, sensitive questions may be better suited by collecting through one methodology over another.

### **MULTIVARIABLE ANALYSIS**

The multivariable analysis conducted for this study was undertaken to examine whether there is a relationship between self-reported HIV/AIDS knowledge and other STD knowledge. The idea behind testing this relationship was to understand where sufficient knowledge exists, and where knowledge is lacking. In particular, there are campaigns country-wide to promote HIV/AIDS awareness and education; however, anecdotally there appears to be very little discussion around other STDs outside of HIV/AIDS. This analysis was conducted to understand if there is a relationship between these variables, and make suggestions for future education campaigns.

### *The Model Tested*

Two models were initially tested in this study, however only one model will be presented here due to the second model not yielding results with identified public health significance. The first model tested sought to understand the relationship between knowledge of HIV/AIDS and knowledge of other STDs. This model was chosen based on studies in the HIV/AIDS and STD literature among college students (Huber and Ersek, 2011; Adhikari, 2010; Holland and French, 2011). In contexts such as Africa where the HIV/AIDS pandemic has hit hard, studies suggest that HIV/AIDS knowledge may be high (Marinho et al., 2011; Glick et al., 2009), but how this relates to knowledge of other STDs is lacking from the literature. Many studies use the umbrella term “STI or STD” to encompass HIV/AIDS and other STDs. However, in this context it is thought they are not used synonymously and knowledge of each is quite different. As a result, information related to this topic was explored prior to, and during fieldwork, which led the PI to investigate the following model:

**Model 1:** To test if actual HIV/AIDS knowledge was associated with perceived knowledge of HIV/AIDS, gonorrhea, genital warts, chlamydia, and syphilis.

Prior to testing the model, actual and perceived HIV/AIDS knowledge was assessed by examining several questions and creating two different dichotomous (yes or no) variables (Survey found in Appendix A). Perceived knowledge was assessed by examining how participants assessed their knowledge of HIV/AIDS, gonorrhea, genital warts, chlamydia, and syphilis. The variable created was called “perceived knowledge”

and participants were categorized as either: yes (having knowledge), or no (not having knowledge). If respondents reported having either: a lot, some, or a little knowledge about HIV/AIDS or the other STDs, they were categorized as “having perceived knowledge.” If respondents reported knowing “nothing” about HIV/AIDS or other STDs they were categorized as “not having perceived knowledge.”

Actual HIV/AIDS knowledge was assessed by examining how respondents answered questions about transmission and prevention of HIV/AIDS. This variable was called global HIV/AIDS knowledge, and referred to whether or not respondents had *actual* knowledge of HIV/AIDS. Respondents were categorized as: yes (having global HIV/AIDS knowledge), or no (not having global HIV/AIDS knowledge). If respondents answered all 11 questions about HIV/AIDSs correctly, they were considered to have “global HIV/AIDS” knowledge. If respondents had a mixture of correct and incorrect answers to these questions, they were considered to not have “global HIV/AIDS” knowledge. After the above variables were created, the model was then tested.

### *Univariate Analysis*

Univariate analysis, including  $\chi^2$  tests of association were conducted to assess the unadjusted associations between perceived and actual HIV/AIDS knowledge (model 1). The  $\chi^2$  tests of association were conducted at the  $p \leq 0.05$  level. See Table 20 below for details.

### ***Multivariable Analysis (testing the model)***

Multivariable logistic regression was conducted to look at the adjusted association between outcome and independent variables to assess overall association. Pairwise correlation coefficients were calculated to identify independent variables that convey essentially the same information about the observed data. The final model was assessed for goodness-of-fit using the Hosmer-Lemeshow test. A  $p=0.75$  value was obtained, resulting in failure to reject the null and concluding that the model fit at the 0.05 level of significance. The receiver operator curve was used to assess if the model fits better than chance (50%). The model fit fairly well at 75%. See Tables 21 for specific results.

### ***Outcome Variables***

Several different outcomes were assessed in multivariable analysis. In model one, perceived HIV/AIDS knowledge, and other STD knowledge variables were evaluated.

### ***Independent Variables***

Several independent variables were included in the models tested. These independent variables were chosen based on the literature, in order to compare results from this study to the published literature. For model one these included: class year, marital status, size of town, campus attended, condom use at last sex, actual HIV/AIDS knowledge, and perceived HIV/AIDS knowledge.

Table 20: Unadjusted Characteristics of Perceived HIV/AIDS Knowledge

Characteristics	Perceived Knowledge									
	HIV/AIDS n (%)		Gonorrhoea n (%)		Genital Warts n (%)		Chlamydia n (%)		Syphilis n (%)	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
<b>Class year</b>										
First	73 (24.6)	196 (28.0)	244 (28.3)	25 (18.5)	<b>248 (27.5)*</b>	<b>21 (22.1)*</b>	250 (27.6)	19 (21.1)	241 (28.2)	28 (19.6)
Second	104 (35.1)	232 (33.1)	284 (33.0)	52 (38.5)	<b>290 (32.2)*</b>	<b>46 (48.4)*</b>	306 (33.8)	30 (33.3)	280 (32.8)	56 (39.2)
Third +	120 (40.4)	272 (38.9)	334 (38.8)	58 (43.0)	<b>364 (40.4)*</b>	<b>28 (29.5)*</b>	351 (38.7)	41 (45.6)	333 (40.0)	59 (41.3)
<b>Marital status</b>										
Married	28 (9.4)	83 (11.9)	92 (10.7)	19 (14.1)	99 (11.0)	12 (12.6)	100 (11.0)	11 (12.2)	92 (10.8)	19 (13.3)
Never married	258 (86.8)	599 (85.6)	744 (86.3)	113 (84.0)	775 (86.0)	82 (86.3)	781 (86.1)	76 (84.4)	735 (86.1)	122 (85.3)
Other	11 (3.7)	18 (2.6)	26 (3.0)	3 (2.2)	28 (3.1)	1 (1.1)	26 (2.9)	3 (3.3)	27 (3.2)	2 (1.4)
<b>Size of town</b>										
Addis Ababa	45 (15.2)	130 (18.6)	157 (18.2)	175 (17.6)	<b>167 (18.5)*</b>	<b>8 (8.42)*</b>	167 (18.3)	8 (8.89)	<b>161 (18.9)*</b>	<b>14 (9.8)*</b>
Region Town	66 (22.2)	198 (28.3)	233 (27.0)	264 (26.5)	<b>245 (27.2)*</b>	<b>19 (20.0)*</b>	241 (26.6)	23 (25.6)	<b>233 (27.3)*</b>	<b>31 (21.7)*</b>
Woreda Town	118 (40.0)	242 (34.6)	309 (35.6)	360 (36.1)	<b>310 (34.4)*</b>	<b>50 (52.6)*</b>	322 (35.5)	38 (42.2)	<b>300 (35.2)*</b>	<b>60 (42.0)*</b>
Rural Town	67 (22.6)	127 (18.2)	161 (18.7)	194 (19.5)	<b>176 (19.5)*</b>	<b>18 (19.0)*</b>	174 (19.2)	20 (22.2)	<b>157 (18.4)*</b>	<b>37 (25.9)*</b>
<b>Campus</b>										
Poly	99 (33.3)	232 (33.1)	292 (33.9)	39 (28.9)	306 (33.9)	25 (26.3)	306 (33.7)	25 (27.8)	295 (34.5)	36 (25.2)
Peda	197 (66.3)	468 (66.9)	569 (66.0)	96 (71.1)	595 (66.0)	70 (73.7)	600 (66.1)	65 (72.2)	558 (65.3)	107 (74.8)
<b>Condom use</b>										
No	41 (13.8)	99 (14.1)	116 (13.5)	24 (17.8)	125 (13.9)	15 (15.8)	122 (13.5)	18 (20.0)	116 (13.6)	24 (16.8)
Yes	24 (8.1)	42 (6.0)	56 (6.5)	10 (7.4)	59 (6.5)	7 (7.4)	61 (6.7)	5 (5.6)	59 (6.9)	66 (6.6)
Don't know	208 (70.0)	516 (73.7)	627 (72.7)	97 (71.9)	659 (73.1)	65 (68.4)	661 (72.9)	63 (70.0)	619 (72.5)	105 (73.4)
Refused	24 (8.1)	43 (6.1)	63 (7.3)	4 (3.0)	59 (6.5)	8 (11.9)	63 (7.0)	4 (4.4)	60 (7.0)	7 (4.9)
<b>Global HIV actual knowledge</b>										
Incorrect	40 (13.5)	121 (17.3)	135 (15.7)	26 (19.3)	146 (16.2)	15 (15.8)	<b>140 (15.4)*</b>	<b>21 (23.3)*</b>	<b>129 (15.1)*</b>	<b>32 (22.4)*</b>
Correct	257 (86.5)	835 (83.7)	727 (84.3)	109 (80.7)	756 (83.8)	80 (84.2)	<b>767 (85.6)*</b>	<b>69 (76.7)*</b>	<b>725 (84.9)*</b>	<b>111 (77.6)*</b>
<b>Global HIV perceived knowledge</b>										
Incorrect	--	--	<b>291 (33.8)*</b>	<b>6 (4.4)*</b>	<b>294 (32.6)*</b>	<b>3 (3.2)*</b>	<b>295 (32.5)*</b>	<b>2 (2.2)*</b>	<b>291 (34.1)*</b>	<b>6 (4.2)*</b>
Correct	--	--	<b>571 (66.3)*</b>	<b>121 (95.6)*</b>	<b>608 (67.4)*</b>	<b>92 (96.8)*</b>	<b>612 (67.5)*</b>	<b>88 (97.8)*</b>	<b>563 (66.0)*</b>	<b>137 (96.0)*</b>

\* $\chi^2$  p<0.05 level of significance  
 -- reference category

The unadjusted results showed that those with perceived genital wart knowledge were proportionally more likely to be second year students, from a Woreda town, and have perceived HIV/AIDS knowledge. Additionally, those with perceived syphilis knowledge were proportionally more likely to be from a Woreda town, have correct HIV/AIDS global knowledge, and high perceived HIV/AIDS knowledge. Simply stated, those participants with high perceived knowledge of particular STDs (genital warts and syphilis) had a greater likelihood of being in their second year (for genital warts), from a Woreda town, have high actually HIV/AIDS knowledge (syphilis) and have high perceived HIV/AIDS knowledge. Why perceived knowledge of one STD translates into either greater perceived knowledge of another STD, such as HIV/AIDS is not known.

Additionally, the relationship between perceived knowledge and Woreda town not understood, and deserves further investigation. It would also be beneficial to test actual STD knowledge outside of HIV/AIDS in order to understand true knowledge.

Table 21. Adjusted Odds of Perceived Knowledge of Sexually Transmitted Diseases of Participants

Characteristics	Perceived Knowledge				
	HIV OR (95% CI)	Gonorrhea OR (95% CI)	Genital Warts OR (95% CI)	Chlamydia OR (95% CI)	Syphilis OR (95% CI)
<b>Class year</b>					
First	1.00	1.00	1.00	1.00	1.00
Second	0.96 (0.65-1.41)	1.59 (0.90-2.80)	1.40 (0.75-2.6)	0.96 (0.50-1.86)	1.23 (0.74-2.12)
Third +	0.87 (0.61-1.23)	<b>1.75 (1.04-2.93)</b>	0.79 (0.43-1.45)	1.43 (0.79-2.58)	1.50 (0.87-2.40)
<b>Marital status</b>					
Married	1.00	1.00	1.00	1.00	1.00
Never married	0.72 (0.45-1.17)	0.87 (0.48-1.57)	1.13 (0.56-2.30)	1.88 (0.57-2.48)	0.96 (0.53-1.74)
Other	0.57 (0.24-1.38)	0.60 (0.16-1.97)	0.33(0.04-2.77)	1.38 (0.34-5.62)	0.40 (0.82-1.87)
<b>Size of town</b>					
Addis Ababa	1.00	1.00	1.00	1.00	1.00
Region Town	1.04 (0.68-1.64)	1.04 (0.55-1.97)	1.54(0.65-3.67)	1.85 (0.80-4.33)	1.37 (0.70-2.70)
Woreda Town	0.70 (0.45-1.07)	1.40 (0.75-2.58)	<b>3.3 (1.44-7.37)</b>	<b>2.80 (1.22-6.40)</b>	<b>2.33 (1.21-4.49)</b>
Rural Town	0.63 (0.40-1.02)	1.90 (0.97-3.70)	2.0 (0.80-4.98)	<b>2.96 (1.21-7.24)</b>	<b>2.94 (1.46-5.94)</b>
<b>Campus</b>					
Poly	1.00	1.00	1.00	1.00	1.00
Peda	1.10 (0.81-1.48)	1.09 (0.70-1.67)	1.12 (0.72-2.0)	1.21 (0.72-2.01)	1.44 (0.93-2.22)
<b>Condom use</b>					
No	1.00	1.00	1.00	1.00	1.00
Yes	0.78 (0.41-1.46)	1.00 (0.42-2.37)	1.04 (0.38-2.90)	0.59 (0.20-1.76)	0.63 (0.24-1.62)
Don't know	1.13 (0.74-1.72)	0.75 (0.43-1.30)	0.78 (0.40-2.90)	0.63 (0.33-1.18)	0.82 (0.47-1.42)
Refused	0.86 (0.45-1.60)	<b>0.30 (0.10-0.96)</b>	1.06 (0.40-2.83)	0.44 (0.14-1.44)	0.58 (0.22-1.50)
<b>Global HIV actual knowledge</b>					
Incorrect	1.00	1.00	1.00	1.00	1.00
Correct	1.31 (0.89-1.94)	1.21 (0.75-1.98)	0.91 (0.50-1.66)	1.56 (0.91-2.70)	1.59 (1.0-2.52)
<b>Global HIV perceived knowledge</b>					
Incorrect	--	1.00	1.00	1.00	1.00
Correct	--	<b>11.50 (4.99-26.50)</b>	<b>16.5 (5.12-52.7)</b>	<b>23.2 (5.62-95.69)</b>	<b>12.79 (5.56-29.46)</b>

Abbreviations: CI, confidence interval; OR, odds ratio.

The above table demonstrates significance with the following variables: perceived knowledge of gonorrhea, perceived knowledge of genital warts, perceived knowledge of chlamydia, and perceived knowledge of syphilis. Women with perceived knowledge of gonorrhea are 1.75 times more likely to be in their third year or higher compared with female participants without perceived knowledge of gonorrhea (95% CI, 1.04-2.93). Therefore, participants who have a perceived knowledge of gonorrhea is positively

associated with being a third year or higher college student (OR = 1.75; 95% CI, 1.04-2.93). Additionally, women with perceived knowledge of gonorrhea are 0.30 times less likely to refuse to disclose use of condom at last sex. Women with perceived knowledge of gonorrhea are 11.50 times more likely to have global perceived HIV/AIDS knowledge. Women with perceived knowledge of genital warts are 3.3 times more likely to be from a Woreda town and 16.5 times more likely to have global perceived HIV/AIDS knowledge. Women with perceived knowledge of Chlamydia are 2.8 times and 2.96 times more likely to be from a Woreda and rural town respectively as well as 23.2 times more likely to have global perceived knowledge of HIV/AIDs. Lastly, women with perceived knowledge of Syphilis are 2.33 times and 2.94 times more likely to be from a Woreda and rural town respectively and 12.79 times more likely to have global perceived HIV/AIDs knowledge.

In summary, there is a statistically significant association between women who have perceived knowledge of HIV/AIDS and other STDs. Meaning, those women who identify as having knowledge of HIV/AIDS are more likely to also state they have knowledge of other STDS. There is also a relationship between women who have perceived knowledge of genital warts and Chlamydia and being from a Woreda or rural town. A Woreda and rural town are smaller locations than a region town or the capital, therefore why these women identify as having more knowledge of these STDs is currently unknown. However, this apparent relationship, how to translate this information into meaningful public health strategies warrants future investigation.

## CHAPTER 8: WOMEN'S STRATEGIES ON-CAMPUS

### PERCEPTIONS OF DATING RELATIONSHIPS

Defining, labeling, and understanding the complexity of intergender relationships that exist on campus was interpreted from data collected during focus group discussions with both men and women. During these discussions, several questions were asked about “boyfriends” and “girlfriends” on-campus and what defines these relationships. Information was gathered with regard to the duration of these relationships and frequency of sexual activity in these relationships. The goal was to understand the role of these relationships and how they may promote or prevent health, safety, and academic success among students on campus. Specifically, this chapter is addressing specific Aim 4:

**Specific Aim 4:** Identify individual strategies to promote health, safety, and academic success on campus.

#### *Defining Relationships Among University Men and Women*

The topic of “boyfriends” and “girlfriends” repeatedly came up during focus group discussions with university men and women in this study conducted from October-December, 2010. When women were asked about how common it was to have a boyfriend, most respondents agreed that it was common for women on-campus to “take” boyfriends. When men were asked how common it was to have a girlfriend on-campus they generally agreed that most men on-campus “take” a girlfriend. Both men and

women agreed that a common university practice was to “take” a girlfriend/boyfriend, yet how men and women defined a girlfriend and boyfriend was different.

A clear theme that emerged from both women’s and men’s discussions were that women often had two boyfriends: a campus boyfriend and an off campus-boyfriend, while men usually only had a campus girlfriend. The campus boyfriend was commonly referred to as the “academic” boyfriend, while the off-campus boyfriend was referred to as a “sugar-daddy.” These were the exact English words used when both men and women described boyfriend arrangements. Clear and consistent themes emerge with regard not only the use of these labels, but also with the characteristics of these relationships in terms of sexual activity, duration, and utility.

### *Development of Dating*

According to both men and women in this study, students on campus commonly get into these “boyfriend” and “girlfriend” relationships early in their academic career. Women in this study stated that they were even encouraged by more senior female students to “take” a boyfriend immediately upon entering the university in order to succeed academically.

Students reported that dating relationships changed often, and never continued past their graduation from the university. The goal of these relationships was not to lead to something long-term, rather these were transitory and conditional relationships. Men and women stated “boyfriend” and “girlfriend” relationships could last as few as one to two weeks up to several months at a time. Men and women generally had one campus

relationship at a time, but these relationships were commonly quite fluid and short-lived. During male focus group discussions, men described situations where relationship “pairs” would “change” partners with each other. Meaning, one day their girlfriend could be with them, and then another day that relationship could be dissolved and she would now be in a relationship with one of his classmates. Neither men nor women discussed why these relationships would dissolve and then re-emerge with different partners; they simply discussed it as a typical occurrence in the relationship life of students on campus.

### ***Why Women “Take” A Boyfriend***

Women in this study stated they must “take” an academic boyfriend if they are to succeed at the university. In general, women on campus discussed how they lack confidence in their ability to perform academically, and this resonated with their “need” to have an on-campus boyfriend. Women believed that if they did not have a boyfriend, especially during their first year at the university, that they would likely get academically dismissed. Having a boyfriend was even something they heard was a necessary part of university life before they came to campus. They explained we “are not academically prepared like men,” “at home we had so much work to do our studies suffered,” and we “lack confidence in our academics” (Female Focus Group Discussions, November 2010). Men echoed women’s sentiments, and frankly discussed, and almost boasted that they knew women “needed” them. Men recognized and agreed that this academic need was a major reason women sought men on campus to be their boyfriends. Men supported this idea by saying: “we know women need us,” “they are not smart like us,” “we start to get

more phone calls when it is exam time,” and “without us many will fail and get dismissed.” (Male Focus Group Discussion, December 2010).

Once at campus, having a boyfriend was a strategy women employed to succeed academically, and this was viewed as a norm on-campus among students. Based on women’s statements, not being in a relationship was rare. Another strategy women employed while on-campus was to “take” an off-campus boyfriend. Women reported that the purpose of an off-campus boyfriend, or sugar daddy, was to “enjoy” Bahir Dar. By “taking” this off-campus boyfriend women were able to leave campus and enjoy town pleasures such as drinking tea by the lakefront, eating dinner at a restaurant, and going out to bars and drinking beer. These off-campus boyfriends served as a mechanism to enhance women’s new found freedom at the university and for them to “experience” life as they had not previously done before coming to BDU. These off-campus boyfriends were fundamentally different from on-campus boyfriends in two ways: 1) they were older men (30+ years), and 2) they had enough money to take these women out in town.

These men not only allowed women to “enjoy” Bahir Dar and leave the gates of campus, but often times these off-campus boyfriends provided material goods such as clothes, shoes, makeup, and spending money (Female Focus Group Discussions, November 2010). These boyfriends often also benefited the female friends of the women who had off-campus boyfriends. Meaning, a woman who had an off-campus boyfriend usually brought one or more of her female campus friends with her on her date with this boyfriend so they too could partake in the town activities. As a result, women on-campus often pressured one another to take these off-campus boyfriends knowing that they too

could then go with their female friends and “enjoy” Bahir Dar (Female Focus Group Discussions, November 2010). Some women reported how women would strategize with one another and decide who in their group was “the most beautiful” among them, and then she would be expected to “take” an off-campus boyfriend and bring along the other women so they could all reap the benefits (Female Focus Group Discussions, November 2010).

Factors motivating these off-campus boyfriends were never discussed in terms of survival strategies. The women in this study never stated they engaged in these off-campus relationships to “survive” or because they “had no other choice.” Rather, they explained engaging in off-campus relationships for entertainment purposes and to obtain material goods. There is actually fierce competition among women in the dorms as to who can be the most “modern,” who has the best “fashion,” and who is most like an “Addis girl.” As a result, the women who have material goods such as makeup and nice clothes are often the envy among women and viewed as an aspiration of today’s contemporary woman (Female Focus Group Discussions, November 2010). In interviews and during informal conversations with women on-campus who self-identified as poor, these women never stated having an off-campus boyfriend, and as a result, they never had material goods like other women who had off-campus boyfriends. In fact, they discussed rarely having enough money to even purchase soap to clean their body. Instead, these self-identified poor women discussed how they could never afford to purchase school notebooks, wash their clothes, or buy sanitary napkins so they would miss on average 3-5 days of school a month during menstruation (Female Focus Group

Discussions, November 2010; In-depth Interviews, October, 2010; and Key Informant Interviews, 2010). Having an off-campus boyfriend appeared to be more of a luxury than a necessity since off-campus boyfriends did not appear to fill immediate and basic needs of university women in this study. The women that had these off campus boyfriends often bragged about and would openly display the items they would receive, such as body spray and makeup. Therefore, at the surface it does not appear that the off-campus boyfriends fill an immediate need for basic supplies, and it does not appear that the poorest women on campus are taking these off-campus boyfriends. However, further analysis into the true function of off-campus boyfriends would be beneficial to future HIV/STD prevention efforts.

### ***Why Men “Take” A Girlfriend***

Men discussed taking “girlfriends” as easy, convenient, and a way to pass time for them. Men stated they knew women “needed” them so it was fairly easy for them to have a girlfriend if they wanted. Men openly discussed during focus group discussions that because they knew women needed them to succeed academically they had easy access to women, and if desired, could have girlfriends. They spoke very matter of fact about the ease in which they went in and out of these girlfriend relationships. While some of this discourse may have been a product of boasting and demonstrating their masculinity in front of their peers, there was still an underlying element of truth to the passé nature of these relationships that even the women shared. Campus men did not provide material

goods to campus women like off-campus men did, but they did have value in assisting women with passing courses and they were keenly aware of this.

In addition to being relationships of convenience or ease, men also discussed having a girlfriend as a strategy to reduce academic stress and pressure. Men in this study viewed the sexual encounters that occurred in these relationships as a way to reduce the stress and tension in their lives. They spoke about sex as a way to “take a break” from their rigorous academic schedules and “relieve tension,” and “reduce stress.” Men at Poly (the Engineering campus) particularly voiced this sentiment. They are thought to have the most difficult academic course loads on campus; therefore they believed they had more of need to “relieve stress.” While Peda male students did not necessarily share this sentiment, Poly students repeated this justification for why they “needed” girlfriends more than their male peers with what they perceived as easier studies.

While discussing the strategy to reduce tension through sexual relations with their girlfriends, men also stated that sometimes seeking sex with their girlfriend was not the best use of their time. They stated that having sex with their on-campus girlfriend was not always “time saving.” Therefore, when they felt they did not have enough time to meet up with their girlfriend, they may turn instead to prostitutes in town (Male Focus Group Discussions, November 2010). Men viewed going to prostitutes as a “time saving” strategy because they wouldn’t have to “talk” or “warm up” (foreplay) a prostitute as they would their girlfriend (Male Focus Group Discussions, December 2010). When asked about sex with prostitutes, men stated they would not always have intercourse with a prostitute because they may not have enough money and/or they were

worried about getting a disease. Instead, they would often seek a prostitute to have her manually stimulate him and not have intercourse. To the men who discussed this in the study, this practice was a safe, cheap, and quick alternative to having sex with their girlfriend given their perceived demanding course load (Male Focus Group Discussions, December 2010).

### *The Meaning of These Relationships*

Both men and women agreed in this study that these “boyfriends” and “girlfriends” do not lead to long-term relationships and they exist to serve a particular purpose. For women, this purpose is to get academic assistance and to gain sexual experience. For men, the purpose is to relieve stress and to take a break from what they perceive as their rigorous academic course loads. Although many men reported that women were more inclined to want these relationships to be long-term compared to men, women’s responses did not support this idea.

When participants were asked about what happens when graduation occurs, the result was unanimous from men and women. They all stated that nothing happens; the relationship simply dissolves immediately and rarely continues after either one leaves BDU. Two male participants described it as follows:

“When we graduate, there is nothing more...we simply say ciao and we will never see each other again. It is the way it is at university.” (Male Focus Group Discussion, December 2010).

“There is no real love in these relationships and maybe only 10% last long-term” (Male Focus Group Discussion, December 2010).

Some participants described this dissolution of the relationship in practical terms relating to geography and the finances involved in keeping up these relationships:

“If we are from far away from each other we would never see each other again so there is no purpose” (Female Focus Group Discussion, November 2010).

“If we do not have a job after graduation we go back to live with our family. If we live in a rural area and we have no money how could it work?” (Male Focus Group Discussion, December 2010).

Lastly, men and women discussed these relationships as never leading to marriage, thus explaining another reason why these relationships are short-lived and why they never continued into the future. When women were asked if they would ever marry a male peer that attended university, they provided a range of responses, all leading to an answer of no. Most of the responses centered on Ethiopian cultural norms as well as economic security as reasons for these relationships not leading to marriage. Examples of responses included:

“I do not get to choose who I marry and my parents would not approve of any relationship I chose, so it cannot continue after I leave BDU” (Female Focus Group Discussion, November 2010).

“If I get the choice, I want to marry an older man. I think an older man will have a job and be able to take care of a family. It is better to marry an older man who has more experience.” (Female Focus Group Discussion, November 2010).

“I do not ever want to marry a university girl because she has too much experience. I want to find a girl from the rural areas who does not have the same experience.” (Male Focus Group Discussion, December 2010).

“The women at the university are too fast. They want to experience everything they could not before, so this is not the type of girl I want to marry.” (Male Focus Group Discussion, 2010).

“The women at the university are not good. They do not have the same religion as the women in the rural places. They also do not listen to men because after

university they have this education that gives them more confidence and independence. (Male Focus group Discussion, December 2010).

Therefore, based on cultural norms on marriage, distance between partners in the relationship, and the money involved to visit each other, these relationships did not last past graduation. Generally, men and women went into these relationships knowing they would not last long, and most did not want them to last past their time at BDU.

### *Sexual Activity in Dating Relationships*

Men and women discussed sexual activity in boyfriend and girlfriend relationships in slightly different ways. Women discussed sex as “commonplace” and an expectation for women to have sex when in these boyfriend relationships. They also discussed the difficulty of negotiating condom use during sexual encounters with their boyfriends, and the fears they had about getting pregnant. Although some women also feared getting HIV/AIDS, most women were more concerned with getting pregnant and no women discussed fears of contracting any other STDs. The following illustrates these fears:

“Even if we want him to use a condom it is not always up to us. We cannot force him to use it [a condom] because we have no power”(Female Focus Group Discussion, November 2010).

“We all know it is important to use a condom because we do not want to get pregnant and we do not want a disease but it is difficult to ask for this””(Female Focus Group Discussion, November 2010).

“Mostly we [women] want to use a condom because we do not want to get pregnant. Also, we are worried about AIDS, but more worried about getting pregnant. We are here to get an education, not to get pregnant. But, then there are many women who get pregnant and then they have to get an abortion” (Female Focus Group Discussion, November 2010).

“I don’t trust that the condom will work so it is not that important for my boyfriend to use one.” (Female Focus Group Discussion, November 2010).

“My boyfriend does not like how it [sex] feels with a condom. He says it is not good this way so I never ask that he uses a condom. I want to please him and make it good for him and if he does not want to use one then I am okay with this.” (Female Focus Group Discussion, November 2010).

“If I trust my boyfriend then there is no need for condoms”(Female Focus Group Discussion, November 2010).

Men discussed sexual activity in their girlfriend relationships as occurring on men’s terms. Men often stated they would call their girlfriend when they needed a study break or when they needed to relieve stress. Or, sometimes after they met to study or do homework they would then have sex with their girlfriends. Most of the time the sex encounters would take place in “the space” on campus because this is the only place they could go to be alone (Male Focus Group Discussions, December 2010). Men, like women, stated their biggest fears were that their girlfriend would get pregnant. Men also state they feared contracting HIV/AIDS, but they did not express fears about other STDs. Men were so afraid their girlfriend would get pregnant some would even bring emergency birth control to their sexual encounters and force their girlfriend to take the pills after they had sex. These views are illustrated by the following:

“When we want to have sex all we need to do is call our girlfriend and she will come. It is up to us when we want to have it [sex]” (Male Focus Group Discussion, December 2010).

“Because I don’t want my girlfriend to get pregnant I bring pills [emergency birth control] for when we have sex. After we have the sex I will make her take the pills. I do not want her to get a baby.” (Male Focus Group Discussion, December 2010).

“Sometimes I use a condom, but not always. It depends on if I have a condom. Mostly I prefer not to use a condom because it is better without”(Male Focus Group Discussion, December 2010).

“Condoms are not that trusty and because they break a lot I don’t prefer them. That is why I have my girlfriend take pills...because then I know she will not get pregnant”(Male Focus Group Discussion, December 2010).

“I worry about HIV/AIDS so I usually wear a condom. But, if there is not one available, or there is not enough time, then I will not use one” (Male Focus Group Discussion, December 2010).

Based on focus group discussions, condom use is difficult for women to negotiate. Additionally, fear of pregnancy drives both men and women to either use condoms or for women to take emergency birth control (or be forced to take it). Little discussion focused around using condoms for fear of HIV/AIDs and other STDs, or taking daily oral birth control as a preventative measure for pregnancy. Having a condom and having enough time for use appear to be the primary factors in whether or not condoms are used in sexual encounters. Another factor in condom use has to do with the idea of when “a known partner becomes a safe partner.”

### ***When a “Known” Partner Becomes a “Safe” Partner***

When men were asked about condom usage during sex, the idea of when a “known partner becoming a safe partner” emerged as a theme. Men explained that they would use a condom in the beginning of their sexual relationship with their girlfriend, but when they got to “know” her, they would stop using condoms. Men were asked at what point in time they “knew” their partner, and most responded that they felt they “knew” their partner after two or three sexual encounters (Male Focus Group Discussions,

December 2010). The idea of when a “known partner becomes a safe partner” is described by the following quotes:

“Once we know our girlfriends then it is no longer necessary to use a condom, it is then safe” (Male Focus Group Discussions, December 2010).

“After two or three times with sex I think I know my girlfriend so I don’t need a condom” (Male Focus Group Discussions, December 2010).

“It will take maybe three times until I know my girlfriend enough and then I do not use a condom” (Male Focus Group Discussions, December 2010).

“If I know her, then why would I need a condom? Using a condom is admitting that one of us is not safe.” (Male Focus Group Discussions, December 2010).

Men believed they “knew” their partner after spending enough time with her.

Knowing their partner had nothing to do with being tested for STDs or discussing the sexual histories of partners, but instead with spending time together and having sex a few times. Time spent together was then translate into “trust” in the relationship, so much so that men believed protection was no longer necessary. This discussion was taken a bit further by explaining that if either the man or woman in a relationship wanted to use a condom then it was assumed they had something to hide. Even though both men and women wanted to prevent pregnancy, condom usage was stigmatized as something only “diseased” people needed to use (Male and Female Focus Group Discussions, November-December 2010).

This topic of “when a known partner becomes a safe partner” was not discussed among women, presumably because they were not the ones in the sexual relationship to decide if condoms were used or when they were no longer necessary. Women in this study felt it was ultimately up to men whether condoms were used. Women may suggest

condom use to men, but this stance was not common, nor did it ensure condoms would actually be used in sexual encounters. Further, women stated that they would not continue to ask their boyfriend to use a condom at subsequent sexual encounters if condom use did not occur after asking or suggesting use at their first encounters.

## **PERCEPTIONS OF CONDOMS AND BIRTH CONTROL**

During focus group discussions, men and women were asked about their perceptions of condom and birth control use. They were asked specifically about the acceptability of condom and birth control use today and perceptions of the pros and cons of condom and birth control use. The results of what men and women said will be discussed below.

### ***Condom Use Acceptability***

When women were asked about cultural acceptability of condom use today, a range of responses were provided. Many women felt condoms were accepted today because they are cheap and easy to access. However, other women felt condoms are still not culturally accepted because if a woman is suggesting condom use then she is admitting to having sex with another man. Also, women discussed that men do not like condoms because they report decreased sensation and reduced pleasure during sex. The following quotes illustrate the range of women's responses:

“People have become aware of condoms and they are easy to use” (Female Focus Group Discussion, November 2010).

“Condoms are cheap enough for street boys to use” (Female Focus Group Discussion, November 2010).

“If a woman is using or carrying a condom she is admitting to having sex with more than one guy. Condom use is a sign of cheating and disease” (Female Focus Group Discussion, November 2010).

“It depends on where you grow up if you accept condoms are not. If you are from rural areas you may be scared to use them because you have not had exposure before” (Female Focus Group Discussion, November 2010).

“This awareness raising about condoms goes on only in the cities. There [in the city] it is no longer shameful” (Female Focus Group Discussion, November 2010).

“It is more accepted now because people are getting more and more modernized” (Female Focus Group Discussion, November 2010).

Men also expressed the belief that condoms are generally acceptable today in Ethiopia. They stated that more people their age are receptive to using condoms; they too mentioned that condoms were easy and cheap to obtain. However, men did state that women carrying condoms is still culturally shameful, and that women who do this are viewed in a negative light. Men offered more information as to why condoms are not used, rather than simply the acceptability of condom use mentioned by women. Men generally felt condoms are acceptable, but that it was dependent on the circumstances. For example, they stated men who may be under the influence of alcohol or Khat are less likely to use condoms. Men also discussed that “losing hope” was a reason for lower condom use. Meaning, if a man has already engaged in a lot of risky sex, or he has observed others around him die of HIV/AIDs, he himself may have lost hope and therefore may not wear condoms during sex. The following quotes illustrate general male perceptions of condom use:

“It is okay for men to carry condoms, but if they are not always easily available” (Male Focus Group Discussion, December 2010).

“If a female carries condoms that means she is too experienced and then we worry that she has disease” (Male Focus Group Discussion, December 2010).

“It is more about losing hope than it not being acceptable. Because many have already had a lot of risky sex they have lost hope and think they probably already have something” (Male Focus Group Discussion, December 2010).

“Condoms are not as available at Poly, but men and women accept using condoms mostly” (Male Focus Group Discussion, December 2010).

Overall, men and women believed that condom use was generally acceptable today, but that factors such as availability, reduced pleasure during sex, being under the influence of substances, or having a feeling of hopelessness could lead to lower condom use.

### ***Condom Pros and Cons***

Generally, women who participated in focus group discussions believed that the pros of condoms are: HIV and pregnancy prevention, inexpensive cost, and availability/accessibility. Generally, women described the cons of condoms as: not preventing pregnancy and STD's 100% of the time and not being used properly. In every focus group discussion, women described a lack of awareness on how to use condoms properly among students on campus translating into either lower or inconsistent use and risk to HIV/AIDs and other STDs. Discussion also covered condoms not being approved by God, reducing male pleasure, promoting sex, and getting stuck in women. See Table 8 for specific responses.

When men were asked about pros and cons of condom use, they generally responded by stating why condoms would and would not be used. They did not specifically talk about “pros” vs. “cons,” rather they talked about why they themselves (or other men) would likely use a condom or would not use a condom. Men said condoms were not always used because of reduced pleasure, implication that you didn’t trust your partner, use not considered natural, and condoms are not needed with inexperienced women on campus. Men also stated since students on campus are young, appear healthy, and are “spiritual” and “believe in God” there was no need to use condoms. Many men discussed not being able to “control” their feelings during sex, because of so many emotions, or being under the influence of substances, as reasons why condoms were not used. Lastly, the issue of “time” was discussed by men stating that because they were often having sex in “the space” they had to be quick with sex in order to not be caught by guards or other students. As a result, condoms were not always used because they were rushing to finish. Men’s specific responses can be found in Table 23.

**Table 22: Women’s and Men’s Responses to Condom Use Pros and Cons**

<b>Women’s Responses</b>	
<b>Condom Use Pros</b>	<b>Condom Use Cons</b>
<ul style="list-style-type: none"> <li>• Prevent HIV</li> <li>• Prevent Pregnancy</li> <li>• Cheap</li> <li>• Available Everywhere</li> </ul>	<ul style="list-style-type: none"> <li>• If used improperly may get HIV, STDs, and pregnant</li> <li>• Does not prevent pregnancy and STD’s 100% of time</li> <li>• Can get stuck in woman</li> <li>• Not approved by God</li> <li>• Promotes Sex</li> <li>• People don’t know how to use properly</li> <li>• Guys don’t like because it decreases their</li> </ul>

	pleasure/changes feeling of sex <ul style="list-style-type: none"> <li>• Because of high emotions during intimacy it gets improperly used</li> </ul>
<b>Men's Responses</b>	
<b>Why Condoms are Used</b>	<b>Why Condoms are Not Used</b>
<ul style="list-style-type: none"> <li>• Many people use them</li> <li>• Prevent HIV</li> <li>• Prevent Pregnancy</li> <li>• Cheap</li> <li>• Available (usually)</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced sensation/satisfaction</li> <li>• Using a condoms mean you don't trust your partner</li> <li>• No need to use because women are inexperienced</li> <li>• We are healthy and spiritual</li> <li>• Condoms are fabricated, chemical, and might infect us-not natural</li> <li>• Because of our religion we may not be interested to use</li> <li>• Don't fear HIV/AIDs only fear pregnancy</li> <li>• Even with prostitutes we rarely use them- we don't think it's necessary</li> <li>• We can't "control" our feelings</li> <li>• There is not always enough time</li> <li>• We may be under the influence of alcohol or Khat</li> </ul>

### ***Birth Control Acceptability***

Women discussed that generally oral birth control and injections are accepted, but not as accepted as condoms. Women explained taking birth control is not a private activity for them; because they live with so many other women in a dorm room (8-16 people) they do not want to take them in what they perceive as "the public." Even though most confirmed birth control pills' acceptability, the activity of taking pills when publicly viewed is considered shameful. Also, because women have either heard of, or

experienced side effects from oral birth control or injections, they were not as inclined to use them. Women did not discuss the cost of birth control as being prohibitive, in fact they usually stated the cost was “cheap” or they knew they could get them free at the reproductive health clinic (although they did not want to be seen going to this office).

Men stated that they were “happy” if women took oral birth control or got injections because then they worried less about them getting pregnant. Men generally spoke about birth control being acceptable to them, as well as in Ethiopia. Some men that stated use was against religion, but the prevention of pregnancy seemed to outweigh the potential sacrilegious action of taking birth control. Their acceptance of oral birth control was highlighted above by the actions of some men bringing emergency birth control to sexual encounters. The women who work at the reproductive health office stated that both men and women seek emergency contraception from this office (Key Informant Interviews, November 2010). Therefore, oral birth control and injections are generally accepted among men and women on campus that participated in this study.

### ***Birth Control Pros and Cons***

When women were asked about the pros and cons of birth control, a range of response were provided. When women discussed birth control they referred to oral birth control and injections only, as these are the types that are commonly used among campus women. Even though Intrauterine devices (IUD’s) are available in Bahir Dar Town, women did not have knowledge or experience with IUD’s. Oral birth control is cheap (3 birr/\$.17) and free on campus. Most women who had experience either themselves with

birth control, or knew other women who used birth control, usually reported a negative experience with oral birth control. The injectable birth control was also reported to be used by women on campus, but not as common as oral birth control.

Women discussed the pros of birth control to be: preventing unwanted pregnancy, helping with family planning, reducing women's burden in the household, and being easy and cheap to access. The cons of birth control that women listed mostly revolved around health side effects they have either heard of or experienced themselves. The main health effects that were listed include: infertility, irregular menstruation, spots on the face, weight gain/loss, and psychotic outbreaks. Additionally, many women stated oral or injected birth control was not approved by God, and therefore against Orthodox Christian religion to take. See Table 24 for specific responses of women.

Men generally answer this question about pros and cons of birth control based on what they had heard from other women. Like women, the believed perceived health side effects lead many women to not use birth control, as well as they believed women would take birth control to prevent pregnancy. The specifics of what men stated are found below in Table 23:

**Table 23: Women's and Men's Reported Pros and Cons of Birth Control**

<b>Women's Responses to Oral Birth Control or Injections</b>	
<b>Birth Control Pros</b>	<b>Birth Control Cons</b>
<ul style="list-style-type: none"> <li>• Prevents unwanted pregnancy</li> <li>• Helps for family planning</li> <li>• Reduces female burden in household</li> <li>• Households can be better economically</li> </ul>	<ul style="list-style-type: none"> <li>• Causes infertility</li> <li>• Leads to irregular menstruation</li> <li>• Spots on the face (called martiat/madiat in Amharic)</li> <li>• Swelling of the feet and legs</li> </ul>

<ul style="list-style-type: none"> <li>• People can unplanned sex without worry</li> <li>• Everyone can access it cheaply</li> </ul>	<ul style="list-style-type: none"> <li>• Injections lead to losing hair</li> <li>• Pre-cancer tumors</li> <li>• Overweight and underweight</li> <li>• Mental retardation of baby</li> <li>• Changes women's behavior (emotions out of control)</li> <li>• May get pregnant</li> <li>• Lose your mind-if menstrual cycle is not "normal"</li> <li>• Body will adapt to it and you will get pregnant</li> <li>• Not approved by God</li> <li>• Helps to spread HIV/AIDS</li> </ul>
<b>Men's Responses</b>	
<b>Why Women Use Birth Control</b>	<b>Why Women Do Not Use Birth Control</b>
<ul style="list-style-type: none"> <li>• Prevents unwanted pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Causes problems with menstruation</li> <li>• Cause spots on face</li> <li>• Causes problems having babies in the future</li> <li>• It is not natural</li> <li>• It is not religious</li> </ul>

Both men and women discussed potential health side effects and cultural reasons as to why women may not use birth control. Both groups recognized the positive reasons for using birth control, specifically preventing pregnancy and family planning. However, recognizing the positives of both birth control and condom use did not always translate into actual use among male and female students. Therefore, students were asked to discuss what could be done on campus to make condom use and birth control more acceptable, accessible, and available.

### *What Can Be Done to Promote Condom and Birth Control Use*

Men and women were asked to provide their ideas on what could be done at BDU to promote condom and birth control usage. Women recommended campus-wide attention and awareness given to using condoms and birth control. Female and male students suggested more places to get condoms such as giving out condoms to women at the entrance gates (and not just to men), having condom vending machines, and having condoms available at campus clinics, and in the dorms. Other suggestions from men and women included: educating about condom and birth control use through clubs on campus, having religious students advise others religious students about these subjects, and providing life skills training covering various health topics (such as pregnancy, abortion, sexual health, and hygiene). Lastly, women discussed having senior students (both male and female) available to teach other students how to use a condom properly and hold open discussions on the topics of birth control and condom use. The idea being that if more students knew how to use them properly, maybe they would not be as apprehensive to practice safe sex in the future. Men did not discuss lack of knowledge in terms of using a condom properly as reasons for not practicing safe sex, however this does not mean this is not an issue and should not be taught on-campus.

In summary, boyfriend and girlfriend relationships were described by participants as commonplace on campus. Intimate relationships were normal, and almost expected, for women to “take” an “academic” boyfriend in order to succeed academically. Additionally, women may also “take” an “off-campus” boyfriend in order to “enjoy” Bahir Dar. Both men and women agreed that these boyfriend and girlfriend relationships

involved sex, and that condom use occurred in the beginning, but after they “knew” each other condom use usually ceased. Perceptions of condom use and birth control varied among men and women, but both groups generally agreed that condom and birth control are accepted today, although there were many reasons stated by both as to why they are not used. Women reported low condom use because of reduced pleasure to their partner and “God’s disapproval.” Men reported low condom use due to reduced pleasure, believing that women are not experienced and therefore not diseased, not being approved by God, and having lost hope. Women reported not wanting to use birth control due to the many health side effects they believed resulted such as: irregular menstruation, spots on the face, and psychotic episodes. Men believed that women did not want to use birth control due to the health side effects and not being natural or religious.

Men and women reported low usage of condoms and birth control, but high acceptance of both. Participants believed increased awareness and education efforts are needed on campus to increase usage of condoms and birth control. Specifically, women believed that teaching people how to use a condom properly was of great importance. Men also believed a general raising the awareness of condom and birth control use on campus was needed. They believed there should be greater access and availability on campus to obtain condoms. Such availability was discussed as having more condoms available at the entrance gates, condom machines, campus clinics, and in the dorms. It was clear from discussions with both men and women they believe the idea of condom use and birth control needed to become more accepted and utilized on-campus. They saw

education and increasing availability and accessibility as means to achieve this and something both students and administration should take serious.

## CHAPTER 9: DISCUSSION AND CONCLUSIONS

### OVERVIEW

Over the past several decades, colleges and universities all over the world have focused efforts on making campuses more equitable and attainable for men and women, yet the college experience remains impacted by gender inequities (Rowan, 2002; Kelly and Torres, 2006; Smith et al., 1994). Recognizing that an important step in reducing global poverty means addressing gender inequalities, MDG3 was created in an attempt to address disparities, and Ethiopia is a case study on how to implement MDGs in a given context.

Many factors influencing the health and welfare of female students were examined in this study. Through a mixed methods approach, data collection was designed to assess the local social, cultural, economic, and environmental conditions for female students at BDU. This study suggests that women's health and equity issues in university settings need more than specific health responses. The interplay of gender and development requires theoretically guided approaches to yield relevant responses. In the case of BDU, it can be argued that through implementing MDG3 at the university, women are paying a price in terms of their health and social risk. Ethiopia provides a case study to ask important questions about who is vulnerable in a period of social change, and to understand the pathways to empowerment and positive health outcomes. There are some key lessons that can be learned by examining Ethiopia as the *poster child* for global MDG3 efforts.

A summary of the key results of this study are found in the sections below, followed by study limitations, strengths, discussion, and steps forward.

### ***Gender Roles and Expectations (Specific Aim 1)***

Chapter 5 outlined female participants' perceptions of gender roles and what it meant to them to be an Ethiopian woman. Women were asked how their roles, if at all, had changed prior to and after coming to the university. This chapter also examined what male and female participants in the study had heard about BDU prior to coming to the university and what their experiences had been after coming to BDU. The key points are found below:

- Women in this study reported their perceived ideas of what a “good” Ethiopian woman should be, which often included an attentive and faithful wife, a mother, and a woman who is tolerant of many conditions.
- Women did not report wanting to forgo marriage altogether, but they did discuss having the choice and the ability to delay marriage as a result of having an education, leading to greater economic opportunities, independence, and choice.
- Pursuing a university education translated into a reduced physical workload for women, and their first opportunity to fully concentrate on their course work.
- Women's new found freedom and absence of family places them in uncharted territory that may or may not expose them to uncomfortable situations such as harassment and unsafe practices such as risky sexual encounters.
- Men reported the least change after coming to the university compared to their life at home before BDU. At home, men were privy to freedom and had time to devote to their studies, so unlike women, men experienced a less drastic change with regard to household work obligations.
- Men consistently reported that the coursework was very difficult and that the course requirements were too much.

- Both men and women reported the main reason they decided to attend BDU was because they got assigned by the government and they did not want to lose out on this opportunity.
- Men and women equated BDU's reputation of dismissing "a lot" of students as meaning they would be getting a "quality" education and a good job some day.

### *The Institutional Space and Safety on Campus (Specific Aim 2)*

Chapter 6 described the organization and structure of BDU and discussed the various gender related issues administrators, staff, and students identified as problematic on-campus. The size and structure of BDU were outlined followed by a description of the various clubs and organizations available on campus. The views of administrators, staff, and male and female students were examined to understand issues of resource availability, safety, and security on campus. The key points are found below:

- In general, women's harassment on-campus is viewed and recognized as a problem and a daily issue that women must face.
- There was no agreement amongst administrators, staff, or students as to what could be done to stop this harassment on campus even though this was a prevalent theme.
- With regard to safety, women stated that the dormitories are the safest place on-campus, because they are free from male harassment and policy is enforced here.
- Female participants identified the libraries, cafeterias, and walk-ways as places that at time may be unsafe because these places lend themselves easily to harassment and enforcement of policy does not occur, or rarely occurs.
- It is in "the space" where risky behaviors such as unprotected sex and substance use is occurring and nothing is currently being done to prevent this activity from occurring or promoting safer practice in these places, "The space" is viewed as unmanageable and unregulated environment where campus security rarely goes.

### ***Knowledge and Risk Taking Behaviors (Specific Aim 3)***

Chapter 7 outlined participant's self-reported knowledge of HIV/AIDS and other STDs. Based on self-reports and focus group discussions, the sexual health histories and recent sexual encounters of participants were examined. Women's self-reported assertiveness and confidence in communicating during sexual relationships were explored. This chapter provided results of exploratory data analysis with associated descriptive statistics as well as the selected model used for univariate and multivariable analyses. Lastly, this chapter highlighted information collected during focus group discussions that supplemented and assisted in explaining several inconsistencies revealed in the data collected from the self-administered survey. The key points are found below:

- The majority of women accurately reported answers to questions on HIV/AIDS transmission and ways to prevent contraction of HIV.
- Fewer women reported knowledge on other STDs outside of HIV/AIDS such as syphilis, genital warts, chlamydia, and gonorrhea.
- 17-20% of women self-reported being sexual activity depending on the question that was asked (i.e. number of partners, condom use, last sexual encounter, etc.).
- Focus group discussions revealed that women's perception was that 20-90% of their peers on campus were sexually active with a majority estimating >70%.
- The majority (73%) of women self-reported their first sexual encounter to occur between 18-20 years of age, with 19.6% reporting age at first sex before the age of 18 years and 7.3% after the age of 20 years.
- Of the 221 women who reported number of sexual partners, most (N=162) reported to only have one partner.
- With regard to the use of birth control methods, few women self-reported having used a condom (9%), birth control pills (11%), the rhythm method (10%), or withdraw/pulling out (7%).

- In focus group discussions, women reported they believed that 45-80% of women were using daily oral birth control on-campus, with a majority estimating >70%.
- In focus group discussions women reported they believed that 20-50% of women on campus use condoms on a regular basis, with a majority estimating 45-50%.
- Approximately 5.4% of women self-reported as ever being pregnant, 2.8% reported ever having an STD, 4.0% reported ever being raped, and 6.0% reported ever having an abortion.
- In focus group discussions, women reported they believed that 10-30% of women become pregnant at some point during their time at the university and that 5-25% of women on campus had an abortion at some point in time.
- With regard to where participants self-reported going for abortions if needed, 5.2% self-reported using a government hospital or clinic, 2.6% reported using a private clinic, 10.5% reported using a pharmacy, 6.5% reported using a traditional healer, and 31.4% reported “other.”
- Talking about, and communicating about sex with partners, appears to be difficult for women in this study. Only 6.7% of women reported that they speak up about their sexual feelings and only 5.4% reported that they approach their partner for sex.
- Multivariable logistic regression was conducted to look at the adjusted association between knowledge of HIV/AIDS and knowledge of other STDs. There was a statistically significant positive association between women who identify as having knowledge of HIV/AIDS and knowledge of other STDs. Is this easier, did I change the meaning?
- There is also a significant positive relationship between women who have perceived knowledge of genital warts and Chlamydia and being from a Woreda or rural town. Why this is the case is not known, and this relationship warrants future investigation.

#### ***Dating Relationships and Perceptions of Birth Control and Condoms (Specific Aim 4)***

Chapter 8 examined the complexity of intergender relationships that exist on campus by analyzing the data from focus group discussions with both men and women.

During these discussions, several questions were asked about “boyfriends” and “girlfriends” on-campus and what defines these relationships. Information was gathered with regard to the duration of these relationships and frequency of sexual activity in these relationships. The key points are found below:

- Reports of intimate relationships were normal, and almost expected for women to “take” an “academic” boyfriend in order to succeed academically.
- Women may also “take” an “off-campus” boyfriend in order to “enjoy” Bahir Dar.
- Both men and women agreed that these boyfriend and girlfriend relationships involved sex, and that condom use occurred in the beginning, but after they “knew” each other condom use usually ceased.
- Men believed they “knew” their partner after spending enough time with her. Knowing their partner had nothing to do with being tested for STDs or discussing the sexual histories of partners, but instead with spending time together and having sex a few times.
- Women reported low condom use because of reduced pleasure to their partner and “God’s disapproval.”
- Men reported low condom use due to reduced pleasure, believing that women are not experienced and therefore not diseased, not being approved by God, and having lost hope of avoiding HIV/STDs.
- Women reported not wanting to use birth control due to the many health side effects they believed resulted such as: irregular menstruation, spots on the face, and psychotic episodes.
- Men believed that women did not want to use birth control due to the health side effects and not being natural or religious.
- Men and women reported low usage of condoms and birth control, but high acceptance of both.
- Male and female participants believed increased awareness and education efforts are needed on campus to increase usage of condoms and birth control.

- Specifically, women believed that teaching people how to use a condom properly was of great importance.
- Men and women believed there should be greater access and availability on campus to obtain condoms. Such availability was discussed as having more condoms available at the entrance gates, condom machines, campus clinics, and in the dorms.

## **LIMITATIONS**

One limitation of this study was the use of self-report for the quantitative portion of this study, which may be subject to social desirability and recall bias. Because the self-administered questionnaire did address a number of topics that students may have felt were personal in nature, students may not have accurately reported information on sexual activity, contraceptive use, and pregnancy and abortion history. While the self-administered survey may have failed to accurately capture data on these topics, the focus group discussions may have yielded more honest responses provided that the face-to-face nature of this method lent more easily to collecting sensitive data in this context. A second limitation is the generalizability of the results. Given that students self-selected to participate in this study, and were not randomly selected, this group of women and men may not be representative of all students on campus. The women and men that participated in this study are likely different in a variety of ways from students who chose not to participate in the study. For example, these students may be more outgoing and invested in the topic compared to other students on campus. A third limitation is the cross-sectional design of this study. This design excludes examination of causal inferences and potential variation in the assessed study variables over time. A fourth

limitation is several respondents' did not answer all of the questions, particularly with regard to sexual activity, pregnancy, STD history, and condom and birth control use. Missing data resulted in a relatively high percentage of descriptive statistics being incomplete. However, given the relatively high homogeneity of the study population with regard to demographics, this information is simply considered missing, and cannot be used to address the variability in data, but is not thought to have biased the study results. A fifth limitation was the use of an instrument that was not validated in its entirety for the self-administered survey. While aspects of this instrument are validated, in its entirety, it is not a validated instrument. Part 2 and 3 of the self-survey was modified from larger surveys (U.S. National Survey of Adults and Adolescents and the Africa National Survey of Adolescents) and parts 4 and 5 were used in their original form. However, a thorough review of the literature was conducted in order to construct an instrument that could be administered to a university population in a developing country, minimizing limiting effects. Therefore, the internal validity of this instrument does not appear to be an issue, although the external validity (generalizability) is a limitation. This instrument did yield insight into the issues female students face on campus and how to construct relevant solutions.

## **STRENGTHS**

Despite these limitations, this study has a number of strengths. The mixed methodology approach has clear advantages. One, the narratives collected through qualitative measures allowed the researcher to put meaning and "lived experiences" to the numbers collected through quantitative measures. Two, mixed methodology allowed for

a more complete and broad suite of research questions to be asked on similar and different topics through quantitative and qualitative instruments. Three, the quantitative and qualitative data taken together provide a more nuanced picture of the health and welfare of female students on campus, as well as an understanding of the complex environment of gendered sexuality on campus which would not have been captured by one method alone. As a result, mixed methodology highlighted the need to collect data of a sensitive nature in a way that makes sense in a given context. Four, mixed methodology allowed for the results to be more generalizable and applicable to higher education settings globally.

The multidisciplinary nature of this research has linked wide audiences and has the potential to engage various stakeholders interested in women's health in general and higher education in particular. This research has proposed that the present-day conditions that women face in the university setting must be taken into account to create an environment where women can not only achieve optimal health, but also that their experiences can contribute to larger issues of women's health through "empowerment," and "equity" strategies at the global level. By utilizing an anthropological approach in this public health research, higher education was used as a lens in which to examine the health and welfare of female students as a socially embedded and dynamic process. Utilizing this approach to study of women's empowerment in higher education, and associated health outcomes, has provided substantive knowledge, offered relevant conceptual frameworks, and methodological insights to the field of gender and development. This study has made a significant and needed contribution to the limited

body of literature on women's health experiences at university campuses throughout the world.

## **DISCUSSION**

Guided by feminist scholarship, this study examined gender as a normative cultural construct, influenced by both space and time in a given society (Butler, 1990). Gender orders, and is ordered, by other social institutions such as economy, ideologies, family, politics, religion, and the media (Lorber, 1994: 232). The process of gender equality and empowerment is contested and can involve "negotiation" rather than a simple adoption of new gender policies. As a result, this research examined the ways in which women resisted or conformed to gender ideologies in the university, and how this was expressed in terms of health decisions and health outcomes. This research examined ways to make higher education a transformative process for both women and men, and not just a process of assimilating women into male dominated domains.

Inhorn (2006) reminds us to examine ethnographic themes within women's health, and this study has identified several. First, by examining the cultural construction of women's bodies this research focused on the ways in which female students perceive themselves as Ethiopian women, both inside and outside the university gates, and how their gendered experiences are embodied, contested, and socially and historically situated in an environment where male masculinities and feminine subjugation plays out in their everyday lives. For example, women must balance what it culturally means to be a "good Ethiopian woman," with the social and cultural ramifications it carries for women once they do obtain a higher education. Second, examining the health-demoting effects of

patriarchy has contributed to our understanding of the ways in which male dominance in the university setting contributes to specific examples of gender oppression such as violence against women in terms of harassment, as well as women's inability to negotiate safe sex (Inhorn, 2006). Important to the examination of patriarchy, is to understand the power women have to make decisions regarding their health, and how at times this power is impeded. For example, sexual activity within dating relationships is often not forced; however, women are coerced into having sex in exchange for assistance with their academic work. Further, the power women have in these relationships is impeded because they cannot negotiate condom use, and they remain in these relationships in order to succeed academically. Third, by examining the politics of women's health within the university context we can begin to understand the ways in which women's health becomes a site of overt and covert political struggles (Inhorn, 2006). For example, women feel the only place on campus where they are safe is in the dorms; the walkways, cafeterias, and libraries are unsafe places where security presence is needed and policies should be enforced. However, because policies are either absent, or not enforced, the campus environment is a site where unregulated behavior is allowed to occur, and men are allowed to assert control over women. Fourthly, this research included men in study participation (administrators, staff, and students) as a way to fully understand women's social context and to support strategies that engage men as agents of change in women's health initiatives (Dudgeon and Inhorn, 2004).

Understanding gender as an embodied social structure provides a promising approach to unpack the complex terrain of gender and health (Connell, 2011) within the

university setting. The perspectives presented in this paper emphasize that gender as a social structure arises in history, and is always open to historical change. This does not mean that gender orders always progress in the same direction; there are multiple paths that gender orders take. Embodiment takes the shape of what Connell refers to as the “reproductive arena” (Connell, 2011). In this arena, the reproductive possibilities of human bodies are historicized (i.e. given specific social forms), in a constantly changing and contested process extending through historical time. At the core of patriarchal gender orders is the institutionalized control of women’s reproductive capacities by men (Connell, 2011). Attempts by women to break this control can be seen in this study, as well as in women’s quests around the world to obtain a higher education, in order to “make better lives” for themselves. This study highlights the fact that if femininities are subject to contestation, so too are masculinities. Women’s experiences within the university involve gender orders that privilege men and subordinate women. Men typically arrive at the university with better academic preparation, better English language skills, and greater confidence in their ability to succeed. Gender dynamics are not just a question of women’s vulnerability or empowerment, but also involve centrally, the masculinities and agency of men that operate within the same environment as women.

While some may argue that the hegemonic masculinities expressed by men on campus, such as the harassment of women, is a socially endorsed behavior that contributes to the subordination of women, it may not be this simple. For example, the behaviors of men that put women at risk for violence and exposure to risky sex do not simply arise from a traditional masculinity (Silberschmidt, 2004). Instead, they arise

from the partial breakdown of the former gender order, under pressures of political power, poverty, and economic change (Silberschmidt, 2004). They involve attempts by men in new and precarious situations, such as women in the university setting “competing” with them for an education, to re-assert power, and claim their status on new terms. Or, sugar-daddy relationships that are present outside the university gates that offer women to capitalize on their new found freedom and release from the confines of the domestic arena, while also exposing them to risky situations. In this study, there have been countless examples of how men actively strive to keep women down, and the continual subjugation of women threatens their academic, physical, and emotional well-being.

While there is no standard formula for applying a gender analysis to public health problems, there are common concerns that need to be taken into account. Any analysis needs to consider simultaneously the shape of the gender order and its historical transformations, the pattern of institutional and interpersonal relations, and the body-reflexive practices in which health consequences are produced (Connell, 2011). Gender cannot be treated as an independent variable and health status as a dependent variable. The power dynamics that organize gender categories, and set boundaries around them, lead to a marginalized pattern of gender practice, and can itself be considered a public health problem. Men’s and women’s health are not fundamentally separate fields; they are linked both through institutions of health care and through the larger gender dynamic of society.

There is a clear need for continued reflection and analysis of gendered relationships, structures, and actions across the educational process in order to assess quality in terms of greater fairness and distribution of resources as well as the nature and value of the educational experience for men and women (Aikman et al., 2011). There needs to be a greater questioning of the gender based biased nature of schooling as Stromquist (2008) calls for, as well as a close examination of the complexities of gendered power in local, regional, and global settings (Unterhalter, 2008). As a result, prevention strategies and policies aimed at gender and development issues must keep this in mind in order to make a lasting impact.

## **STEPS FORWARD**

More than ten years after the development of the MDG's there is a pressing need to ensure that gender equality issues are at the heart of understanding that educational opportunities and gendered power in local settings (the school, the classroom, and the campus environment) are complex. The social and educational conditions that maintain gender inequalities need to be better understood to promote human dignity and women's potential (Aikman et al., 2011). To achieve gender equality, deep-seated barriers to the equality of opportunity for both sexes need to be removed. The implementation of initiatives and development of enforcing policy that addresses both process and power in the educational setting is needed.

Attaining MDG3 necessitates going beyond patchy implementation of policies and programs; instead, reform must take the form of concerted government efforts that

treat gender equality as a human right. The approach to capacity building within the university must be bottom up, not top down, which requires a reflection and critical examination of issues raised in this study grounded in the grassroots reality of the university environment. Approaching gender and education from a rights based approach necessitates education to be democratic and foster active participation, and to transform the power structures that maintain women's position of marginality or disadvantage. It must overcome a culture of silence that perpetuates violence against women, both inside and outside of the university. The education attained in the university must be relevant and meaningful, and needs to respond to the different identities and needs of both men and women in different contexts, influenced by social, ethnic, linguistic, and economic backgrounds.

The research carried out here has provided knowledge and evidence of a deepening and broadening understanding of women's gendered educational experiences in the university setting. This research serves to illustrate that while there have been strides in providing women with higher educational opportunities throughout the world, there is still much to be done to make this process equitable, attainable, meaningful, and safe.

This study is a case study of one university, but the conditions present for women at BDU occur all over the world. Many factors contribute to women's experiences at BDU. One, women are vulnerable; they are not academically prepared to be at the university and they often lack the necessary confidence to compete in classes with their male peers. Two, men harass women on-campus and convince women not to use

condoms during sex. Three, a hierarchy of risk emerges for women (and men) where the biggest concern is first to avoid academic dismissal, followed by not getting pregnant, and lastly not contracting HIV/AIDS. Key to recommendations is to fully understand and recognize the factors at play and address them in a way that changes the ethos of the university.

Important to prevention efforts, is also to address the epidemiology of HIV in Ethiopia (2.4% prevalence) in general, and Bahir Dar Town in particular (22.0%). The dynamics of students' sexual behaviors on-campus can contribute to the increase in HIV/STDs and fuel this epidemic. Enhancing our understanding of these relationships, and how to invoke behavior change, is important to inform HIV/STD prevention programs. Clearly, the HIV/AIDS epidemic is sustained not only by biological factors, but also by the social and institutional fabric that either supports or prevents the spread. In this study, women had knowledge of how HIV/AIDS is contracted; however, women reported no power to negotiate safer sex practices such as condom use. Thus, prevention strategies need to target and contend with women's limited ability to negotiate safer sex practices during sexual activity. It is important for policy makers to understand the reality that many young African women need to engage in sexual relationships to increase social and economic status and prevention efforts should take this into account when attempting to reduce the spread of the epidemic.

Results from this study have important implications for public health and could easily be translated into both programmatic objectives as well as curricula to be used on college campus throughout the world, and in particular at BDU. The results of this study

suggest that interventions should enhance women's power to make decisions and their ability to access resources. As pointed out earlier, it is not enough to simply bring women to the university and provide them resources and expect them to be "empowered." The power dynamics that continue to keep women down must be addressed to allow them the opportunity to rise to the level of their male peers. Results also suggest men should be engaged in the process of ensuring women's equity on campus in order to address these deeply entrenched gender dynamics at play in the university setting. Multi-level interventions are needed to address the underlying causes of, and ways to better support, the needs of men and women on campus.

Drawing on the above, utilizing a three-prong efficacy approach to better equip women is one prevention measure that should be utilized. This three-prong approach includes increasing the self, collective, and leadership efficacy of women on campus. Providing women with the opportunity to attend the university alone will not transform their lives; in fact, it may actually put them at more risk if the conditions at the ground-level are not right. The risk that is present for women goes beyond physical risk; it is also about risk to identity. By attending BDU, women risk not being accepted into their community if they fail or do not get a job. Women also risk not getting married because after attending the university they are often viewed as being "too experienced" and men prefer less experienced women. Lastly, women also risk contracting HIV/STDs by engaging in risky sexual relationships on and off campus. By utilizing an efficacy approach, women can begin to mount the self and collective agency they do have and

move the current university experience away from an environment of risk to an environment of opportunity and empowerment.

The case study of Ethiopia provides important lessons learned and an understanding of how to effectively implement strategies to address MDG3. It should be used to teach the global world about environmental readiness and implementing MDGs in various contexts. Using Ethiopia as an example, the question becomes, in the absence of environmental readiness, can strategies to achieve MDG3 actually shift the environment of risk? The results of this study suggest, yes. The current BDU environment has forced women into strategies that have questionable outcomes and make them vulnerable in their quest to achieve and education and be empowered. The implementation of MDG3 at BDU has resulted in unintended health consequences (i.e. risk sex, abortions, unwanted pregnancies) for women, and has actually shifted SDH in this context. Recognizing that there are many strategies that people take to reduce harm (i.e. emergency birth control), and that there are many forms of risk (physical, cultural, social) at play in people's decision making process is important when implementing MDGs. Further, understanding the various harm reduction strategies and multiple levels of risk present, is important when creating and implementing behavior prevention strategies. Acknowledging the relationships that exists between the policies and culture of the institutional environment, the behaviors men and women take to reduce risk, and the strategies women engage in to be academically successful, is the only way to effectively implement MDGs and to move from and an environment of risk to an environment of opportunity.

## APPENDIX A: SELF ADMINISTERED SURVEY

Survey ID Number:

### Self-Administered Questionnaire

Date: \_\_\_\_\_ Campus (circle one):      Poly      Peda

**Instructions:**

Thank you for agreeing to participate in this study by taking this survey. The survey should take approximately 30-45 minutes to complete. Your answers will be kept confidential and you are not required to answer questions you do not want to. Answer questions to the best of your ability. Upon completion of this survey you will receive a health information packet, notebook, pen, and coffee/tea voucher for your time. You may begin now.

**PART 1: GENERAL INFORMATION**

The following are general questions about your background. Please respond by either filling in the blank or circling your choice.

1. What is your age in years? \_\_\_\_\_

2. What is your academic year?

1<sup>st</sup> year      2<sup>nd</sup> year      3<sup>rd</sup> year      4<sup>th</sup> year      5<sup>th</sup> year      Refuse

3. What academic college are you enrolled in? \_\_\_\_\_

4. What is your marital status?

Married      Never Been Married      Divorced      Widowed

Refuse

5. What is your religion?

Orthodox      Muslim      Protestant      Jehovah-Witness      Catholic      No Religion

Other: \_\_\_\_\_

Refuse

6. What is your ethnic group?

Tigray      Afar      Amhara      Oromiya      Benishangul-Gumuz

SNNP      Gambela      Harari      Addis Ababa      Dire Dawa

Other: \_\_\_\_\_

Refuse

7. Are you from?

A rural town      Woreda town      Urban City      Addis Ababa

8. What is your household size (total number of people living in your household)? \_\_\_\_\_

9. How many of your brothers and sisters in your family have attended University (including you)? \_\_\_\_\_

10. How many women in your family have attended University (including you)? \_\_\_\_\_

**PART 2: HEALTH KNOWLEDGE & ATTITUDES**

This section deals with questions about your knowledge and thoughts on various health issues. We are interested in knowing your opinion and knowledge on the issues in this section.

1. The first question deals with some of the things facing people your age today. What do you think are some of the issues facing people your age today? Please check all boxes that apply.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Alcohol use                        | <input type="checkbox"/> Khat use                      | <input type="checkbox"/> HIV/AIDS         | <input type="checkbox"/> Pregnancy                     |
| <input type="checkbox"/> Financial problems                 | <input type="checkbox"/> Academic Marks                | <input type="checkbox"/> Food/nutrition   | <input type="checkbox"/> Sexually Transmitted diseases |
| <input type="checkbox"/> Access to Healthcare               | <input type="checkbox"/> Abortion                      | <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Problems with boyfriend       |
| <input type="checkbox"/> Problems with friends              | <input type="checkbox"/> Knowledge about health issues | <input type="checkbox"/> Safety           |  |
| <input type="checkbox"/> Other (fill in your answer): _____ |  |   |  |

2. The next questions ask about the places you get information about relationships and sexual health issues such as pregnancy, sexually transmitted diseases, and condom use. Please list in the space below places you get your information. Examples include: mother, friends, doctor.

- |   |   |                                  |                                 |
|---|---|----------------------------------|---------------------------------|
| <input type="checkbox"/> Mother                 | <input type="checkbox"/> Father                       | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| <input type="checkbox"/> Friend                 | <input type="checkbox"/> Teacher                      | <input type="checkbox"/> Doctor  | <input type="checkbox"/> Nurse  |
| <input type="checkbox"/> Do not get information | <input type="checkbox"/> Other (fill in blank): _____ |                                  |                                 |

3. The next questions are about virginity. Is a girl considered a virgin if...

- |   |     |    |            |        |
|---|-----|----|------------|--------|
| A. She has oral sex?                                  | Yes | No | Don't Know | Refuse |
| B. She has vaginal sex that does not break the hymen? | Yes | No | Don't Know | Refuse |
| C. She has vaginal sex that does break the hymen?     | Yes | No | Don't Know | Refuse |
| D. She has anal sex?                                  | Yes | No | Don't Know | Refuse |

4. The next questions are about pregnancy. Can a girl get pregnant...

- |   |     |    |            |        |
|---|-----|----|------------|--------|
| A. The first time she has sex?                            | Yes | No | Don't Know | Refuse |
| B. If a boy withdraws before ejaculating or coming?       | Yes | No | Don't Know | Refuse |
| C. If she has sex standing up?                            | Yes | No | Don't Know | Refuse |
| D. Is she washes herself thoroughly immediately after sex | Yes | No | Don't Know | Refuse |

5. The next questions are your opinion about different types of birth control or protection, such as birth control pills or condoms. In your opinion are birth control pills effective at doing the following:

- |                         |     |    |            |        |
|-------------------------|-----|----|------------|--------|
| A. Preventing Pregnancy | Yes | No | Don't Know | Refuse |
| B. Preventing HIV/AIDS  | Yes | No | Don't Know | Refuse |

- C. Preventing other sexually transmitted diseases                      Yes    No    Don't Know    Refuse
6. In your opinion are condoms effective at doing the following:
- A. Preventing Pregnancy    Yes    No    Don't Know    Refuse
- B. Preventing HIV/AIDS    Yes    No    Don't Know    Refuse
- C. Preventing other sexually transmitted diseases                      Yes    No    Don't Know    Refuse
7. Please indicate if you agree or disagree with the statements below. There are no right or wrong answers. Circle the answer that best describes your opinion.
- A. A male condom should always be put on before sexual intercourse starts.  
 Agree            Disagree            Don't Know            Refuse
- B. A male condom should be put on the penis only if the penis is full erect or stiff.  
 Agree            Disagree            Don't Know            Refuse
- C. A male condom can be used more than once.  
 Agree            Disagree            Don't Know            Refuse
- D. Using a male condom reduces sexual pleasure.  
 Agree            Disagree            Don't Know            Refuse
- E. Using a male condom is a sign of not trusting your partner.  
 Agree            Disagree            Don't Know            Refuse
- F. It is not that big of a deal to have sex without a condom once in a while.  
 Agree            Disagree            Don't Know            Refuse
- G. Unless you have a lot of sexual partners you don't need to use condoms.  
 Agree            Disagree            Don't Know            Refuse
- H. Buying condoms is embarrassing.  
 Agree            Disagree            Don't Know            Refuse
- I. Buying condoms is shameful.  
 Agree            Disagree            Don't Know            Refuse
- J. Buying condoms is admitting you have something to hide.  
 Agree            Disagree            Don't Know            Refuse
- K. Condoms break a lot.  
 Agree            Disagree            Don't Know            Refuse
- L. It is hard to bring up the topic of condoms.  
 Agree            Disagree            Don't Know            Refuse
- M. Sex without a condom is not worth the risk.  
 Agree            Disagree            Don't Know            Refuse
8. How much do you know about the following sexually transmitted diseases:
- A. HIV or AIDS                      A lot                      Some                      A Little                      Nothing                      Don't Know                      Refuse

B. Gonorrhea	A lot	Some	A Little	Nothing	Don't Know	Refuse
C. Genital warts	A lot	Some	A Little	Nothing	Don't Know	Refuse
D. Chlamydia	A lot	Some	A Little	Nothing	Don't Know	Refuse
E. Syphilis	A lot	Some	A Little	Nothing	Don't Know	Refuse

9. For EACH of the following please tell me if you can get a sexually transmitted disease or not Can sexually transmitted diseases be contracted by:

A. Kissing	Yes	No	Don't Know	Refuse
B. Having oral Sex	Yes	No	Don't Know	Refuse
C. Having Vaginal Sex	Yes	No	Don't Know	Refuse
D. Having Anal Sex	Yes	No	Don't Know	Refuse

10. For each of the following please tell me if sexually transmitted diseases can cause this or not, or if you don't know. Can sexually transmitted diseases cause:

A. Some kinds of cancer?	Yes	No	Don't Know	Refuse
B. Problems having children?	Yes	No	Don't Know	Refuse
C. Increase risk for HIV/AIDS?	Yes	No	Don't Know	Refuse

11. The following are statements about HIV/AIDS. Please circle the answer that best describes your opinion.

- A. Is it possible for a healthy looking person to have HIV/AIDS?  
Yes      No      Don't Know      Refuse
- B. At present is there a cure for HIV/AIDS?  
Yes      No      Don't Know      Refuse
- C. Is there a vaccine available that protects a person from getting HIV/AIDS?  
Yes      No      Don't Know      Refuse
- D. If a person has multiple sexual partners are they more at risk for getting infected with HIV/AIDS?  
Yes      No      Don't Know      Refuse
- E. Can using un-sterile needles for injection be a source of spreading HIV/AIDS?  
Yes      No      Don't Know      Refuse
- F. Can a person get HIV/AIDS by attending school with someone who has HIV/AIDS?  
Yes      No      Don't Know      Refuse
- G. Can a person get the HIV/AIDS by sharing food with a person who has AIDS?  
Yes      No      Don't Know      Refuse
- H. Can a person get HIV/AIDS because of the curse of God or other supernatural means?  
Yes      No      Don't Know      Refuse
- I. Can people get HIV/AIDS virus from mosquito bites?

Yes                  No                  Don't Know                  Refuse

**J. Can having sex with only one faithful sexual partner reduce the risk of HIV/AIDS?**

Yes                  No                  Don't Know                  Refuse

**K. Can a person avoid HIV/AIDS by avoiding sex?**

Yes                  No                  Don't Know                  Refuse

**L. Can using a condom every time during sex reduce the risk of HIV/AIDS?**

Yes                  No                  Don't Know                  Refuse

**M. There are special medications that people infected with HIV/AIDS can get from the doctor or nurse?**

Yes                  No                  Don't Know                  Refuse

### **PART 3: PERSONAL SEXUAL HEALTH HISTORY/BEHAVIOR**

The following questions will be about your personal behaviors and sexual experiences. If there are any questions you feel uncomfortable with you do not have to provide an answer. Please keep in mind that your answers will be kept confidential.

1. People your age often feel pressure from a lot different places. Do you ever feel pressure to do the following?

A. Smoke Cigarettes?	Yes	No	Don't Know	Refuse
B. Drink beer or alcohol?	Yes	No	Don't Know	Refuse
C. Have Sex with a boyfriend?	Yes	No	Don't Know	Refuse
D. Have sex for gifts, school fees or money?	Yes	No	Don't Know	Refuse
E. Take nude photographs for money?	Yes	No	Don't Know	Refuse

2. Have you ever been with someone in an intimate or sexual way?                  Yes    No    Don't Know    Refused

3. Have you ever had oral sex?                  Yes    No    Don't Know    Refused

4. Have you ever had vaginal sex?                  Yes    No    Don't Know    Refused

5. Have you ever had anal sex?                  Yes    No    Don't Know    Refused

6. How old were you when you first had sexual intercourse?

\_\_\_\_\_ (fill in age)                  Don't Know                  Never Had Sex                  Refuse

7. How old was the man you first had sexual intercourse with?

\_\_\_\_\_ (fill in age)                  Don't Know                  Never Had Sex                  Refuse

8. What was the main reason you first had sexual intercourse with this person?

Married/upon marriage	Natural feelings/felt like it	Partner insisted/partner wanted sex
Influence from friends	Expectation of gifts/money	Wanted to get pregnant/have a baby
Was forced	Other_____	Don't Know

Never Had Sex

Refuse

9. With how many people have you had sexual intercourse?

1 person

2 people

3 people

4 people

5 people

6 or more people

Don't know

Refused

10. Are you currently in a sexual relationship?

Yes

No

Don't Know

Refuse

11. When was the last time you had sexual intercourse?

Within the last two weeks

Within the last four weeks

Within the last six months

Within the last year

One or more years

Had sex only one time

Never had sex

Don't Know

Refuse

12. In general, when you have sexual intercourse how often do you use any birth control method?

All of the time

Most of the time

Some of the time

Never

Have not had sex

Don't Know

Refuse

13. In general, when you have sexual intercourse how often do you use a condom?

All of the time

Most of the time

Some of the time

Never

Have not had sex

Don't Know

Refuse

14. Below is a list of types of birth control or protection measures. For each one, please indicate if you have ever used this method during sexual intercourse:

**A. Condoms**

Yes

No

Never Use any type of birth control or protection

Don't Know

Refuse

Do not have sex

**B. Birth Control Pills**

Yes

No

Never Use any type of birth control or protection

Don't Know

Refuse

Do not have sex

**C. The Rhythm or calendar method**

Yes

No

Never Use any type of birth control or protection

Don't Know

Refuse

Do not have sex

**D. Withdrawal or pulling out**

Yes

No

Never Use any type of birth control or protection

Don't Know

Refuse

Do not have sex

15. Have you ever had sexual intercourse without a condom?

Yes

No

Do not have sex

Refuse

16. The last time you had sexual intercourse did you use a condom?

Yes

No

Do not have sex

Refuse

17. What are the reasons for you **NOT** to use condoms? (circle all that apply)

Always Use Condoms                      Dislike Condoms                      I can't discuss it with my sexual partner  
 Can't Find Condoms                      Condoms are too expensive                      I am in love with my partner  
 I trust that my partner is disease-free                      My partner does not like condoms  
 I do not have sexual relations

Other: \_\_\_\_\_ (fill in)

18. Have you ever had a pregnancy test?                      Yes    No    Don't Know    Refuse

19. Have you ever been tested for HIV?                      Yes    No    Don't Know    Refuse

20. Do you know anyone who has HIV or AIDS?                      Yes    No    Don't Know    Refuse

21. Have you ever been tested for a sexually transmitted disease?                      Yes    No    Don't Know    Refuse

22. Do you know anyone who has had a sexually transmitted disease other than HIV/AIDS?

Yes                      No                      Don't Know                      Refuse

23. Are you currently trying to get pregnant?                      Yes    No    Don't Know    Refuse

24. Do you think there is any chance you are pregnant?                      Yes    No    Don't Know    Refuse

25. Have you ever been pregnant?                      Yes    No    Don't Know    Refuse

26. Have you ever tried to end a pregnancy?                      Yes    No    Don't Know    Refuse

27. If you have ever tried to end a pregnancy where did you go?

Government clinic/hospital                      Private clinic/hospital                      Drug shop/Pharmacy                      Street vendor

Traditional healer/herbalist                      Mobile Clinic                      Private Nurse/midwife                      No Place

Have not tried to end pregnancy                      Other: \_\_\_\_\_                      Refuse

28. Have you ever had a sexually transmitted disease?                      Yes    No    Don't Know    Refuse

29. Have you ever been raped or sexually assaulted?                      Yes    No    Don't Know    Refuse

30. Have you ever had sex with an instructor to get a good grade?                      Yes    No    Don't Know    Refuse

31. There are a lot of reasons why people may not get tested for. For each, please indicate if this is a reason why you would **NOT** to get tested. You have not gotten tested because:

A. It is too Expensive?                      Yes    No    Don't Know    Refuse

B. You are afraid of what people might think?                      Yes    No    Don't Know    Refuse

C. You do not think you are at risk?                      Yes    No    Don't Know    Refuse

D. You do not want to know?                      Yes    No    Don't Know    Refuse

E. You do not know where to go to get tested? Yes No Don't Know Refuse

F. You do not know what is involved in getting tested? Yes No Don't Know Refuse

32. There are a lot of reasons why people may not get tested for STD's. For each, please indicate if this is a reason why you would NOT to get tested. You have not gotten tested because:

G. It is too Expensive? Yes No Don't Know Refuse

H. You are afraid of what people might think? Yes No Don't Know Refuse

I. You do not think you are at risk? Yes No Don't Know Refuse

J. You do not want to know? Yes No Don't Know Refuse

K. You do not know where to go to get tested? Yes No Don't Know Refuse

L. You do not know what is involved in getting tested? Yes No Don't Know Refuse

#### **PART 4: Sexual Assertiveness**

This inventory is designed to measure the degree of sexual assertiveness you have in the sexual relationship with your partner. This is not a test, so there are no right or wrong answers. Please answer each item as accurately as you can by placing a number by each question as follows:

0= All of the time

1=Most of the time

2=Some of the time

3=Rarely

4=Never

5=No sexual partner (skip to next section- section 5)

1. I feel uncomfortable talking about sex.

2. I feel that I am shy when it comes to sex.

3. I feel uncomfortable talking to my friends about sex.

4. It is hard for me to say no even when I do not want sex.

5. I feel uncomfortable telling my partner what feels good.

6. I speak up for my sexual feelings.

7. I am reluctant to insist that my partner satisfy me.

8. I find myself having sex when I really do not want it.

9. It is easy for me to discuss sex with my partner.

10. I find myself doing sexual things that I do not like.
11. Pleasing my partner is more important than my pleasure.
12. It is hard for me to be honest about my sexual feelings.
13. I try to avoid discussing the subject of sex.
14. I approach my partner for sex when I desire it.

#### **PART 5: Condom and Birth Control Use**

The following items are intended to measure people's opinions about the use of condoms and birth control. There are no right or wrong responses to any of these statements. Please respond even if you are not sexually active or have never used (or had a partner who used) condoms or birth control. In such cases indicate how you think you would feel in such a situation.

Please read the following statements and indicate next to each question the response that best fits your feeling about the statement. For example, if you agree with a certain statement, place an A next to the question.

SD= Strongly disagree

D= Disagree

U= Undecided

A= Agree

SA= Strongly Agree

1. In my opinion, condoms are too much trouble.
2. Condoms are unreliable.
3. Condoms are pleasant to use.
4. I would be willing to try a condom, even if I never used them before.
5. I intend to try condoms.
6. I just don't like the idea of using condoms.
7. Condoms are inconvenient.
8. I would avoid using condoms if at all possible.
9. Condoms are uncomfortable.
10. Most women don't like their partners to use condoms.
11. I would be comfortable suggesting that my partner and I use a condom.
12. I would feel comfortable taking oral birth control.
13. If I used oral birth control I would not use condoms.
14. I would tell my partner that I am taking oral birth control.

15. I would feel embarrassed to buy oral birth control.
16. Most women on campus feel comfortable using oral birth control.
17. Oral birth control is against Orthodox Christianity (or my religion)
18. I intend to use oral birth control.

## APPENDIX B: IN-DEPTH INTERVIEW GUIDE FOR FEMALE STUDENTS

Survey ID Number:

In-Depth Interview Guide: Situational Questions

Date: \_\_\_\_\_ Campus (circle one):      Poly      Peda

### PART 1: GENERAL INFORMATION

The following are general questions about your background. Please respond by either filling in the blank or circling your choice.

1. What is your age in years? \_\_\_\_\_

2. What is your academic year?

1<sup>st</sup> year      2<sup>nd</sup> year      3<sup>rd</sup> year      4<sup>th</sup> year      5<sup>th</sup> year      Refuse

3. What academic college are you enrolled in? \_\_\_\_\_

4. What is your marital status?

Married      Never Been Married      Divorced      Widowed

Don't Know      Deleted "refuse" b/c it didn't make sense

5. What is your religion?

Orthodox      Muslim      Protestant      Jehovah-Witness      Catholic      No Religion

Other: \_\_\_\_\_ Refuse

6. What is your ethnic group?

Tigray      Afar      Amhara      Oromiya      Benishangul-Gumuz

SNNP      Gambela      Harari      Addis Ababa      Dire Dawa

Other: \_\_\_\_\_ Refuse

7. Are you from?

Addis Ababa      Region Town      A rural town      Woreda town

8. What is your household size (total number of people living in your household)? \_\_\_\_\_

9. How many of your brothers and sisters in your family have attended University (including you)? \_\_\_\_\_

10. How many women in your family have attended University (including you)? \_\_\_\_\_

**Instructions**

First, we will be asking you some general questions about women's sexual and reproductive health. Second, we will be asking you a series of questions related to various scenarios you or other women on campus may find themselves in. This interview will take approximately 1 hour to complete. Thank you for your interest and cooperation.

**Opening Questions**

1. Tell me about your experience as a female student on campus. What has been difficult? What has been easy? Why did you decide to come to Bahir Dar University?

2. Do you know of any resources available for women on campus (academic, financial, health, etc.)? If so, what are they?

3. Have you ever used any of these resources on campus (financial, academic, health, etc.)? If so, how did you find them?

4. Are there any resources that are not currently on campus that you wish were in place? (i.e. academic assistance, health access, etc.).

5. What characteristics do you think women need to have to be a successful student at BDU?

6. Why do you think some women have not made it to their second year and above and others have?  
Meaning, what does it takes to make it to your second year and above and then finally graduate?

7. What has helped you to be a successful student?

8. Is there anything that would help you to be a more successful student? Or, anything else you would like to share with us about being a female student at BDU?

**Situational Questions:**

Now I am going to ask you about various scenarios you or other women your age may find themselves in. Please tell me how you would respond if you were put in these situations. There are not right or wrong answers and if you feel uncomfortable answering a question you are do not have to answer it.

1. If you thought you had an STD what would you do?

2. If you had a question about pregnancy who would you talk to?

3. If you had access to free condoms would you use them? Why or why not? Do you think other people would use them? Why or why not?

4. Do you think it's difficult for women your age to use oral birth control? Why or why not?

5. If you were walking on campus at night would you feel safe traveling alone? Why or why not?

6. If you wanted to get tested for a HIV would you know where to go? Do you know how much would it cost?

7. If you wanted to get tested for a Sexually Transmitted Disease (STD) would you know where to go? Do you know how much would it cost?

8. If you thought that someone was going to harm you or force you to do something while you were on campus what would you do?

9. If someone was harassing you on campus what would you do?

10. If you had a problem with a male student what would you do?

11. If you had a problem with a male instructor what would you do?

12. Do you feel safe in the dorms? Why or why not? Do men every come into the dorms? What happens if they do?

13. Do you feel safe in the library? Why or why not?

14. What do you think could be done to improve campus safety?

15. What do you think could be done on campus to improve campus health?

16. What services do you think should be available on campus specifically for women?

17. How did you find the survey? Why did you decide to participate?

## APPENDIX C: FEMALE FOCUS GROUP DISCUSSION

### DIRECTIONS:

**Focus Group Discussion: Prevention, Promotion, and Intervention Activities (females only)**

Name of Research Assistants \_\_\_\_\_

Date: \_\_\_\_\_

Number of Attendees: \_\_\_\_\_

### Introduction:

Good afternoon. My name is \_\_\_\_\_ and these are my colleagues \_\_\_\_\_. Thank you for coming and agreeing to take part in this discussion. A focus group is a relaxed discussion. We are here today to discuss what activities you think should be done at BDU to help female students. I am also interested to know what you feel you can do as individuals, as a group, and what BDU can do for women on campus. I am not here to share information, or to give you my opinions. Your perceptions and opinions matter and I am interested to hear them from you. There are no right or wrong or desirable or undesirable answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you really think and how you really feel.

### Focus Group Procedure:

My colleagues will be taking notes during this discussion so that I don't miss anything you have to say. You were explained the study procedures and I want to remind you that everything you say is confidential. No one will know what you said and who said what. Names will not be recorded in our notes and you are asked not to identify yourself when you give your answers. I want this to be a group discussion, so feel free to respond to me and to other members in the group without waiting to be called on. However, I would appreciate it if only one person did talk at a time. The discussion will last approximately 1 hour. There is a lot I want to discuss, so at times I may move us along a bit. Are there any questions before we begin?

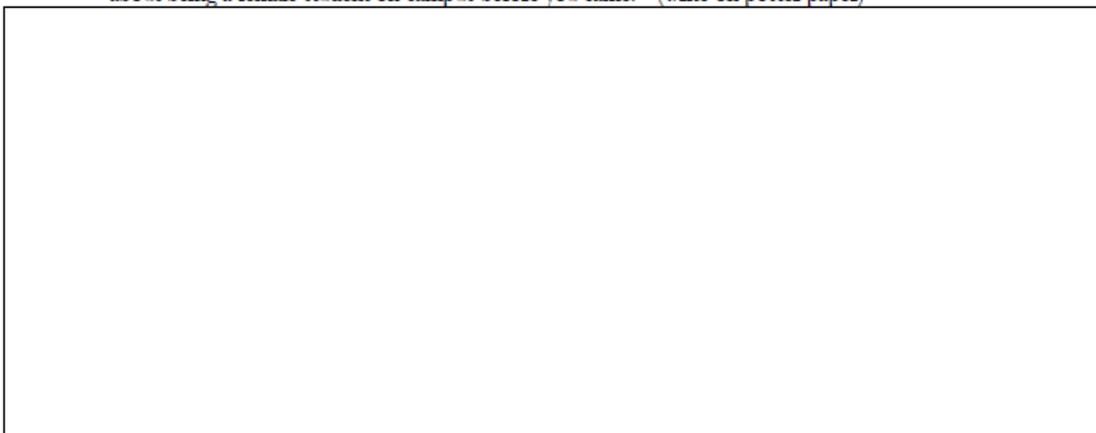
**Discussion Questions:****Group Introduction**

1. Have each girl say their name, what year they are, and what department they are in.

**About BDU**

Break the girls into groups of 4-5 girls. Give them a piece of paper and tell them to answer the following questions:

1. Why did they decide to come to BDU? What did they hear about BDU before coming? What did you hear about being a female student on campus before you came? (write on poster paper)



2. How were things different before and after coming to the university for you? (as a group question and get them to answer). **Follow-up:** how has your role as a woman changed before and after coming to BDU?



Give each girls 8 pieces of small paper and they will write one answer for each question asked below. After asking each question, collect the pieces of paper and put the answers on the wall.

Ask them what they think about the answers and get them to discuss a bit more (why are the numbers so different? Why are they so similar? Do they agree? Do they disagree? Etc.?).

1. What percentage of women on campus do you think have sex?

2. What percentage of women on campus do you think use birth control pills?

3. What percentage of women on campus do you think use condoms?

4. What percentage of women on campus do you think have a boyfriend on campus?

5. What percentage of women on campus do you think have a boyfriend off campus?

6. What percentage of women on campus do you think have sex with a male professor for a grade?

7. What percentage of women on campus do you think get pregnant?

8. What percentage of women on campus do you think have an abortion?

#### STD Knowledge Game

Ask for 5 volunteers. Give each volunteer a sign with a named "STD" (HIV/AIDS, Gonorrhea, Genital warts, Chlamydia, Syphilis). As a group, first have them identify if each disease is caused by a "virus" or "bacteria" (they will tape these on the wall where they belong—there will be signs that say "virus" or "bacteria").

#### Bacteria:

Chlamydia  
Syphilis  
Gonorrhea

#### Virus:

HIV/AIDS  
Genital warts (caused by Human papilloma virus- HPV).

#### Cure: (can get out of body 100%)

Chlamydia- can use antibiotics to rid from body  
Syphilis- can use antibiotic- easier to get rid of if diagnosed early  
Gonorrhea- can use antibiotics to get rid of

#### No Cure: (cannot get out of body 100%)

HIV/AIDS- can take medication to delay the progression, but will always have it  
Gonorrhea – no medication and body usually gets rid of the virus after 1-3 years

Safest to Least Safe Place on Campus

1. Give each girl one piece of paper and ask her to list all the places on campus she frequents and categorize them on the line of "safest" to "least safest" place.

Example:

\_\_\_\_\_Dorm\_\_\_\_\_ Cafeteria\_\_\_\_\_ Library\_\_\_\_\_ Campus at night\_\_\_\_\_

SafestLeast Safe

2. Then, as a group, ask them to do this same activity on the poster paper.

**Follow up:** Ask them to give reasons for their answers and write their discussion below:

**Condoms and Oral Birth Control Pill Use**

In small groups, have them answer the following questions:

1. What are the positives and negatives of using condoms?
2. What are the positives and negatives of using oral birth control pills?

As a large group, answer the following question:

3. Do you think condoms are more accepted today? Why or why not? Why do you think some people do not like the idea of condoms?

4. Do you think oral birth control pills are more accepted today? Why or why not? Why do you think some people do not like the idea of birth control pills?

**Resources and Programs needed/wanted**

Break the girls into **small groups** of 4-5 girls. Give them a piece of paper and tell them to answer the following questions:

1. What specific programs or activities do you think should be created or implemented for women on campus?

As a **LARGE GROUP** answer the following questions

2. What do you think you can do as an individual to help other women on campus?

3. What do you think all of you as a group of women you can do to help women on campus?

4. What do you think BDU should do to help women on campus?



5. If they mention tutorials as a needed resource, then ask them which tutorials specifically they would want?



**Closing:**

Thank you for coming and participating in today's focus group. I appreciate all of your discussion and thank you for your honesty and willingness to discuss these topics. As a reminder, all of what you discussed today will remain confidential and nothing you said today will leave this room. If there is anything else you would like to share or if have any questions please ask me.



## APPENDIX D: MALE FOCUS GROUP DISCUSSION GUIDE

### DIRECTIONS:

#### Focus Group Discussion: Prevention, Promotion, and Intervention Activities (females only)

Name of Research Assistants \_\_\_\_\_

Date: \_\_\_\_\_

Number of Attendees: \_\_\_\_\_

#### Introduction:

Good afternoon. My name is \_\_\_\_\_ and these are my colleagues \_\_\_\_\_. Thank you for coming and agreeing to take part in this discussion. A focus group is a relaxed discussion. We are here today to discuss what activities you think should be done at BDU to help female students. I am not here to share information, or to give you my opinions. Your perceptions and opinions matter and I am interested to hear them from you. There are no right or wrong or desirable or undesirable answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you really think and how you really feel.

#### Focus Group Procedure:

My colleagues will be taking notes during this discussion so that I don't miss anything you have to say. You were explained the study procedures and I want to remind you that everything you say is confidential. No one will know what you said and who said what. Names will not be recorded in our notes and you are asked not to identify yourself when you give your answers. I want this to be a group discussion, so feel free to respond to me and to other members in the group without waiting to be called on. However, I would appreciate it if only one person did talk at a time. The discussion will last approximately 1 hour. There is a lot I want to discuss, so at times I may move us along a bit. Are there any questions before we begin?

#### Discussion Questions:

##### About BDU- GROUP POSTER

Break the guys into groups of 4-5 girls. Give them a piece of paper and tell them to answer the following questions:

1. Why did they decide to come to BDU?

2. What did you hear about BDU before coming?

**LARGE GROUP DISCUSSION:**

3. How have things been different before and after coming to the university for you?

**Engagement in Risky Behavior:**

Give each guy small pieces of paper to write one answer for each question asked below. After asking each question, collect the pieces of paper and put the answers on the wall.

1. What percentage of men on campus do you think have sex?

2. What percentage of men on campus do you think use condoms? Follow-up questions: Where do most men get condoms? (pharmacy, clinic, etc?)



3. What percentage of men on campus do you think have girlfriend on campus? Follow-up questions: What is the purpose of this girlfriend? (love, sex, marriage, etc.). Are these relationships long-term, or do they change often?



4. What percentage of men on campus do you think have a girlfriend off campus? Follow-up questions: What is the purpose of this girlfriend? (economic, to have fun, marriage, etc.?)



5. What percentage of men on campus do you think have more than one girlfriend? Follow-up question: how often does this happen? Do the other girls know about each other? If so, what do they think about this?

6. What percentage of women on campus do you think have sex with a male professor for a grade? Follow-up questions? What do you think about this? Does it ever happen that men have sex with a female instructor for a grade?

7. What percentage of women on campus do you think get pregnant? Follow-up: would you say that most campus pregnancies are unwanted?

8. What percentage of women on campus do you think have an abortion? Follow-up: If your girlfriend gets pregnant, who decides if she will get an abortion?

9. What percentage of men on campus do you think would get emergency birth control pills for their girlfriend if she needed them?

#### Condom Use

1. What are reasons that men do not like to use condoms? Meaning, what are the negative side effects you have heard of.

2. In a relationship, who usually initiated condom use? The man or woman? If a woman carried condoms or asks her boyfriend to use a condom, what would her boyfriend think?

1. Do you think oral birth control pills are accepted today by men? Would most boyfriends be okay with their girlfriend taking any form of birth control?

2. Why do you think some people do not like the idea of birth control pills? Is there anything that could be done on campus to promote birth control use more?

Women's Challenges Resources and Programs needed/wanted

1. What do you think are some of the challenges women face on campus?

2. What do you think you as men can do to help women on campus?

3. What do you think BDU should do to help women on campus? Do you think women should get more help than men? Why or why not?

**Closing:**

Thank you for coming and participating in today's focus group. I appreciate all of your discussion and thank you for your honesty and willingness to discuss these topics. As a reminder, all of what you discussed today will remain confidential and nothing you said today will leave this room. If there is anything else you would like to share or if have any questions please ask me.





8. I have heard that BDU is known for dismissing a lot of students. Is this true? If so, why do you think this is? And, how does this impact female students?

9. Is there anything else you would like to share with me regarding women's health, safety, and academic success on campus?

Survey ID Number:
-------------------

**Key Informant Interview Guide (For Campus Health)**

Date: \_\_\_\_\_ Campus (circle one): Poly      Peda

**Introductions/Instructions**

Good afternoon. Thank you for agreeing to meet with me and take part in my study. My name is Michelle Gamber and I am doing research here at BDU about female student's health and safety. If you have any questions about my study I would be happy to share. I would like to ask you a series of questions related to the gender-based policies, procedures, and resources in place at BDU and what you see as challenges. There are not right or wrong answers and if you feel uncomfortable answering a question you are do not have to answer it. If you do not have questions, we can begin now.

**Questions:**

1. What services are available for women on campus? What are the associated costs?
2. What are the policies about providing health services for women?
3. What are the biggest health concerns of women on campus?
4. What do you think that BDU can do to assist women?
5. What do you see as challenges in assisting women in their health on campus?
6. What else do you think campus health could do to improve women's health?

**Closing:**

Thank you for taking the time to meet with me today. I appreciate all of your discussion and thank you for your honesty and willingness to discuss these topics. As a reminder, all of what you discussed today will remain confidential and nothing you said today will leave this room. If you have any questions please ask me.







**APPENDIX F: MALE SUBSTANCE USE SURVEY, IN-DEPTH INTERVIEW,  
AND FOCUS GROUP DISCUSSION**

Survey ID Number:

**Self-Administered Questionnaire**

Date: \_\_\_\_\_ Campus (circle one):      Poly      Peda

**Instructions:**

Thank you for agreeing to participate in this study by taking this survey. The survey should take approximately 15-20 minutes to complete. Your answers will be kept confidential and you are not required to answer questions you do not want to. Answer questions to the best of your ability. Upon completion of this survey you will receive a pen and a coffee/tea voucher for your time. You may begin now.

**PART 1: GENERAL INFORMATION**

The following are general questions about your background. Please respond by either filling in the blank or circling your choice.

1. What is your age in years? \_\_\_\_\_

2. What is your academic year?

1<sup>st</sup> year      2<sup>nd</sup> year      3<sup>rd</sup> year      4<sup>th</sup> year      5<sup>th</sup> year      Refuse

3. What is your marital status?

Married      Never Been Married      Divorced      Widowed      Refuse

4. What is your religion?

Orthodox      Muslim      Protestant      Jehovah-Witness      Catholic      No Religion

Other \_\_\_\_\_ Refuse

5. What administrative region are you from?

Tigray      Afar      Amhara      Oromiya      Benishangul-Gumuz

SNNP      Gambela      Harari      Addis Ababa      Dire Dawa

Other \_\_\_\_\_ Refuse

6. Are you from?

A rural town      Woreda town      Urban City      Addis Ababa

7. What is your household size (total number of people living in your household)? \_\_\_\_\_

8. How many of your brothers and sisters in your family have attended University (including you)? \_\_\_\_\_

**PART 2: SUBSTANCE USE HISTORY & SUBSTANCE USE PERCEPTIONS**

The following questions will be about your personal behaviors with alcohol, tobacco, and Khat.

1. Have you ever used the following substances?

A. Cigarettes?	Yes	No	Don't Know	Refuse
B. Beer or alcohol?	Yes	No	Don't Know	Refuse
C. Khat?	Yes	No	Don't Know	Refuse

2. Have you used the following substances in the last 30 days? (check all that you have used)

- A. Cigarettes
- B. Alcohol
- C. Khat

3. Have you used the following substances in the last week? (check all that you have used)

- A. Cigarettes
- B. Alcohol
- C. Khat

4. On average, how much money do you spend a month on the following?

- A. Cigarettes \_\_\_\_\_ birr
- B. Alcohol \_\_\_\_\_ birr
- C. Khat \_\_\_\_\_ birr

5. On average, how many cigarettes do you smoke a day?

\_\_\_ 0      \_\_\_ 1-3      \_\_\_ 4-6      \_\_\_ more than 6

6. On average, how many alcohol drinks do you have in a week?

\_\_\_ 0      \_\_\_ 1-3      \_\_\_ 4-6      \_\_\_ more than 6

7. On average, how many hours do you spend chewing Khat in a week?

\_\_\_ 0      \_\_\_ 1-3      \_\_\_ 4-6      \_\_\_ more than 6

8. When you chew Khat, who do you most often chew with?

\_\_\_ my university friends      \_\_\_ friends outside the university      \_\_\_ Alone      \_\_\_ don't chew Khat

Other: \_\_\_\_\_

9. When you chew chat, at what time of day do you chew?

\_\_\_ morning      \_\_\_ afternoon      \_\_\_ evening      \_\_\_ don't chew Khat

## 10. When you chew chat, where do you chew?

\_\_\_\_\_ dorm room      \_\_\_\_\_ in the "space" on-campus      \_\_\_\_\_ Khat Bet      \_\_\_\_\_ don't chew Khat

Other: \_\_\_\_\_

## 11. Why do you use alcohol? (circle all that apply)

A. Reduce stress (tension)      B. Have fun with friends      C. Pass time      D. Forget about problems

E. Peer pressure      F. I feel good when I do it      G. Don't use

## 12. Why do you smoke cigarettes? (circle all that apply)

A. Reduce stress (tension)      B. Have fun with friends      C. Pass time      D. Forget about problems

E. Peer pressure      F. I feel good when I do it      G. Don't use

## 13. Why do you chew Khat?

A. Reduce stress (tension)      B. Have fun with friends      C. Pass time      D. Forget about problems

E. Peer pressure      F. I feel good when I do it      G. Don't use      F. Other: \_\_\_\_\_

## 14. In the last 12 months....

## A. Have you ever thought that your Khat chewing was a problem?

Never or almost never      Sometimes      Often      Always or nearly always      Don't use Khat

## B. Has the thought of not chewing any Khat made you worried or anxious?

Never or almost never      Sometimes      Often      Always or nearly always      Don't use Khat

## C. Ever worried about your Khat chewing?

Never or almost never      Sometimes      Often      Always or nearly always      Don't use Khat

## D. Have you ever wished you could stop chewing Khat?

Never or almost never      Sometimes      Often      Always or nearly always      Don't use Khat

## E. Have you found it difficult to go without chewing Khat?

Never or almost never      Sometimes      Often      Always or nearly always      Don't use Khat

## 15. Do you think chewing Khat has negative health consequences?

Yes      No      Maybe      Not Sure      Don't Use Khat

## 16. Do you think that chewing Khat has positive health effects?

Yes      No      Maybe      Not Sure      Don't Use Khat

## 16. Do you think chewing Khat is a problem among university men in your class?

Yes      No      Maybe      Not Sure      Don't Use Khat

17. Do you think consuming alcohol is a problem among university men in your class?

Yes                      No                      Maybe                      Not Sure                      Don't Use Khat

18. Do you think smoking cigarettes is a problem among university men in your class year?

Yes                      No                      Maybe                      Not Sure                      Don't Use Khat

17. Which of the following are positive effects of chewing Khat (check all that apply)?

Feel good                       Stay awake                       Have deep thoughts/discussions  
 Can focus                       Stave hunger                       Have high energy                      Other: \_\_\_\_\_

18. Which of the following are negative effects of chewing Khat?

Stomach problems                       Mouth/teeth problems                       trouble sleeping  
 anger/violence problems                       Money problems                       problems having sex  
Other: \_\_\_\_\_

19. Is it culturally acceptable for women to chew Khat?

Yes                      No                      Maybe                      Not Sure                      Refuse

20. Is it acceptable for people to chew Khat alone?

Yes                      No                      Maybe                      Not Sure                      Refuse

## Male Key Informant Interview Guide

Date: \_\_\_\_\_

**PART 1: GENERAL INFORMATION**

The following are general questions about your background. Please respond by either filling in the blank or circling your choice.

1. What is your age in years? \_\_\_\_\_

2. What is your academic year?

1<sup>st</sup> year      2<sup>nd</sup> year      3<sup>rd</sup> year      4<sup>th</sup> year      5<sup>th</sup> year      Refuse

3. What is your marital status?

Married      Never Been Married      Divorced      Widowed

Deleted "don't know" b/c it didn't make sense      Refuse

4. What is your religion?

Orthodox      Muslim      Protestant      Jehovah-Witness      Catholic      No Religion

Other: \_\_\_\_\_      Refuse

5. What is your ethnic group?

Tigray      Afar      Amhara      Oromiya      Benishangul-Gumuz

SNNP      Gambela      Harari      Addis Ababa      Dire Dawa

Other: \_\_\_\_\_      Refuse

6. Are you from?

A rural town      Woreda town      Urban City      Addis Ababa

7. What is your household size (total number of people living in your household)? \_\_\_\_\_

8. How many of your brothers and sisters in your family have attended University (including you)?

\_\_\_\_\_

**Instructions**

We will be asking you some general questions about alcohol, tobacco and Khat consumption. This interview will take approximately 45 minutes to complete. Thank you for your interest and cooperation.

**Questions**

1. Tell me about your experience with Khat. When did you first start?
2. Is it common for students at BDU to chew Khat? Where do students chew Khat and with whom do they chew?
3. Why do you think students chew chat?
4. What is considered to be a "normal" amount of chewing Khat?
5. In your opinion, what kind of people chew Khat?
6. In your opinion, if someone chews Khat, does that mean they are more likely to use other substances? If so, what do they typically use? (i.e. tobacco or alcohol)
7. Some people say that when you chew Khat you get a small "high." In your experience, what is the difference between the "high" you get from consuming coffee versus when you chew Khat?

**Male Focus Group Discussion: Khat consumption**

Name of Research Assistants \_\_\_\_\_

Date: \_\_\_\_\_

Number of Attendees: \_\_\_\_\_

**Introduction:**

Good afternoon. My name is \_\_\_\_\_ and these are my colleagues \_\_\_\_\_. Thank you for coming and agreeing to take part in this discussion. A focus group is a relaxed discussion. We are here today to Khat chewing among university students. I am not here to share information, or to give you my opinions. Your perceptions and opinions matter and I am interested to hear them from you. There are no right or wrong or desirable or desirable answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you really think and how you really feel.

**Focus Group Procedure:**

My colleagues will be taking notes during this discussion so that I don't miss anything you have to say. You were explained the study procedures and I want to remind you that everything you say is confidential. No one will know what you said and who said what. Names will not be recorded in our notes and you are asked not to identify yourself when you give your answers. I want this to be a group discussion, so feel free to respond to me and to other members in the group without waiting to be called on. However, I would appreciate it if only one person did talk at a time. The discussion will last approximately 1 hour. There is a lot I want to discuss, so at times I may move us along a bit. Are there any questions before we begin?

**Discussion Questions:**

1. Why do people your age chew Khat?
2. How does one begin chewing Khat? At what age and in what setting do people start?
3. When people chew Khat, what is considered "normal" chewing? Meaning, where and when do people chew? With whom do they chew? And for how long do they chew?
4. What happens to a person when they chew Khat? (i.e. what does it feel like?)
5. What are the positives and negatives associated with chewing Khat?
6. Is chewing Khat a male or female activity? Is it okay for a females to chew Khat?
7. What kind of men chew Khat? What kind of women chew Khat?
8. When people chew Khat, is it common for people to use other substances at the same time? (i.e. alcohol and tobacco)
9. When you chew Khat with people, do you feel you get to know someone in a deep way? Why or why not?

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