

Sexual Coercion is Associated with HIV Risk Behavior Among Female Waiters in Jimma Town, Southwest Ethiopia

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Background: Female waiters are at higher risk of workplace violence including sexual coercion. Even though there are numerous studies on the prevalence of sexual coercion among students, nurses, adolescents, and young pregnant women, studies on the prevalence of sexual coercion among female waiters are limited. Furthermore, there is no evidence existed that show a relationship between sexual coercion and HIV risk behavior in Ethiopia.

Purpose: The purpose of this study was to examine the relationship between sexual coercion and HIV risk behavior among female waiters in Jimma, southwest Ethiopia.

Patients and Methods: We conducted a cross-sectional survey from 1st April to 30, 2018, among 420 female waiters of reproductive age working in the licensed food and drinking establishments in Jimma town. A structured interviewer-administered questionnaire was used to collect data. Statistical analysis was conducted with SPSS version 21 statistical software. A binary logistic regression model was used to determine the association between independent variables and outcome variables.

Results: The lifetime prevalence of sexual coercion among female waiters was 71.4% (95% confidence interval: 67.1–76.8). More than two-thirds (71.6%) of female waiters engaged in HIV-related risk behaviors. Working in the bar (AOR 4.64, 95% CI: 2.15–10.0), being a substance user (AOR 3.37, 95% CI: 1.7–6.7), experiencing sexual coercion (AOR 7.6, 95% CI: 3.8–15.3) were significantly associated with HIV risk behaviors.

Conclusion: A significant number of female waiters experienced sexual coercion and engaged in HIV-risk behaviors. Workplace, substance use, and sexual coercion were significantly associated with HIV risk behavior. As a result, establishments, town health offices, and other stakeholders should work together to safeguard female waiters from the burdens of sexual coercion, HIV risk behavior, and sexually transmitted infections.

Keywords: HIV-related risk behaviors, sexual violence, sexual coercion, female waiters, southwest Ethiopia

Introduction

Nowadays, women are increasingly participating in economic activities.^{1,2} However, they are more vulnerable to workplace violence than men.³ Female waiters are at higher risk of workplace violence including sexual harassment, sexual coercion, and threats of violence.^{3,4} Sexual coercion is one type of violence that is defined as sexual interaction without mutual agreement with a person who has more authority owing to age, physical status, position, or knowledge.⁵ Despite the fact that various studies have been conducted on the incidence of sexual coercion among students, nurses, teenagers, and young pregnant females,^{6–9} There has been little research on the incidence of sexual coercion among female waiters. According to available Ethiopian data, the rate of sexual violence among female waiters is 45.9%.¹⁰

Sexual coercion is linked to a number of risky behaviors, many of which have negative health effects.¹¹ Alcohol consumption habits, family living situations, sexual experience, and social and cultural variables all have an impact on the experience of sexual coercion.¹² According to a recent study, persons who have been subjected to sexual coercion have significant levels of anxiety, sadness, suicidal thoughts, sleep disruptions, chronic illnesses, and other medical problems.¹³

Evidence shows that sexual coercion significantly increases HIV risk behaviors.¹⁴ Experiencing sexual coercion makes it difficult to negotiate safe sexual activities, increasing their exposure to HIV/AIDS.¹¹ Waitresses are at risk of HIV due to the behaviors of the customers compared to the general population.¹⁵ Waiters working in cafes/pastry shops/bars/hotels are also at risk of acquiring HIV due to the nature of their profession, which involves frequent interactions with new clients who are frequently searching for sexual relationships and effect of alcohol use.^{10,15} In 2009, the prevalence of HIV among males and females in Sub-Saharan Africa was 3.4% and 1.4%, respectively.⁶ The prevalence of HIV in Ethiopia shows decrement from 6.2% in 2011 to 3.3% in 2016.¹⁶ However, the trend is varying from region to region. HIV prevalence in Addis Ababa was 1.6%.¹⁷ The prevalence of HIV among students in Jimma was 12.2%.¹⁸ But HIV prevalence among the adult population was 22.1% in women and 24.3% in men.¹⁹

Despite the considerable link between sexual coercion and HIV risk behaviors, it has not been well documented among Ethiopian female waiters. Furthermore, research is focusing on students and commercial sex workers, there is a paucity of research on sexual coercion among female waiters in Ethiopia. This study would be an ideal input for policy maker to design interventions to protect this segment of the population from violence. Thus, the first goal of this study is to determine the burden of sexual coercion and HIV risk among female waiters. The second aim of this research is to determine the relationships between sexual coercion and HIV risk behavior among female waiters working in food and drinking establishments in Jimma town, Ethiopia.

Methods and Materials

Study Design, Setting, and Period

From April 1 to 30, 2018, we conducted a cross-sectional study in Jimma, a town 354 kilometers southwest of Addis Ababa. According to the Jimma Town Health Office report, the town's total population for 2017/18 was 199,575 people, with 100,347 men and 99,229 women (of whom 43,916 are women of reproductive age). There are 25 medium clinics, 7 primary clinics, 3 NGO clinics, 8 government clinics, 4 diagnostic labs, 21 pharmacies, and 31 pharmacy stores. The town has two government hospitals (one specialized and one general), one major private hospital, and four health facilities. In the town, there are 65 hotels, 44 cafeterias, 119 restaurants, 24 bars/groceries, and 25 pensions.²⁰

Participants

The study population consisted of all chosen female waiters aged 15–49 years who had worked in licensed food and drinking establishments in Jimma town for at least 6 months and were available at the time of data collection. Female waiters who worked at nightclubs and commercial sex workers were not included.

Sample Size and Sampling Procedure

The required sample size was calculated using single population proportion formula with the assumptions of a margin of error(d)=0.05, a confidence level of 95%=1.96, and a proportion of sexual violence (P =45.9%) from a study conducted in Bahir Dar¹⁰ and by adding 10% non-response rate, final sample size became 420.

In Jimma town, there are 119 restaurants, 24 bars, 65 hotels, and 44 cafeterias. Since it was difficult to include all of the female waiters in those establishments, we randomly selected 36 restaurants, 7 bars, 20 hotels, and 13 cafeterias. Of those establishments, we census female waiters to know the number of female waiters since their number is unknown. Then 420 female waiters were selected randomly, from 1126 female waiters. Permission was sought from the participants and selected establishment.

Data Collection Tool and Procedure

The data were collected by a face-to-face interviewer using a structured questionnaire which was adopted from the coercion experience survey and the 2017 National Youth Risk Behavior Survey.²¹ To guarantee consistency, the questionnaire was written in English and then translated into the local language (Afan Oromo) and back to English by a third person who is fluent in both languages. The instrument is divided into four sections: respondents' socioeconomic factors, their experience with sexual coercion, HIV risk behavior, and their sexual health. Five diploma nurses collected data under the supervision of two BSc nurse supervisors. The data collectors were trained on how to safeguard the participants and respect their privacy. Before the commencement of the interview, consent was obtained from the participants and the establishments. A pre-test on 5% of the total sample size was performed to assure data quality. Each questionnaire was reviewed for completeness and consistency.

Measurements and Study Variables

In this study, the dependent variables were HIV risk behavior and sexual coercion. The independent variables are type of establishments, age, educational status; residency, substance use, and sexual health.

Sexual coercion was measured using composite variables of six items. The 6 questions were answered yes or no over previous months. If they answered yes to either of these six items, the respondents were deemed sexual violence victims. The items include verbal abuse, suffering annoying kissing by force or unwanted touching of private parts by force or unwanted intercourse by force or unwanted sexual intercourse after taking money/gifts/alcohol, or unwanted sexual intercourse by intimidation/shame.¹⁰

HIV risk behavior is defined as an individual's or a partner's activity that enhances the possibility of contracting HIV/AIDS. It is measured by composite variables of four items. The 4 questions were answered yes or no over previous months. If they answered yes to one of these four items, the respondents were deemed sexual violence victims such as alcohol consumption/substance use before the last sex, having multiple sexual partners, having intercourse in exchange for money/goods, and inconsistent condom use with a non-regular partner in the previous 12 months.

Sexual health is defined as a sexual practice that is devoid of compulsion, prejudice, and violence.

Early sex: means having sexual intercourse before the age of 18.

Food and beverage establishments: - A place where customers may get food and/or drinks. To fulfill the demands of various clientele, it may range from modest low-cost institutions to enormous high-cost structures. It was measured by asking the waitress the type of establishment.

Intergenerational sex is having heterosexual intercourse with non-marital partner 10 or more years old.

Concurrent sex partners: having sex with two or more persons within one month.

Cross-generational sex: Relationships between older men and younger women are examples of cross-generational sex. Sexual intercourse with a male partner ten or more years older vs young ladies whose partner is less than ten years older.

Data Processing and Analysis

The data were coded, recorded, and entered into EPI data version 3.1 before being exported to SPSS version 21 for data cleaning and analysis. Frequencies and summary statistics (mean, standard deviation, and percentage) were used to describe the research population in terms of relevant factors. The degree of relationship between independent and dependent factors was determined using an odds ratio with a 95% confidence interval. After bivariate logistic regression analysis, variables having a P-value of 0.25 were considered for multivariable analysis. Hosmer-Lemeshow goodness of fit was used to assess model fitness. The association was interpreted in terms of the adjusted odds ratio. The p-value of 0.05 was used to determine statistical significance.

Results

Socio-Demographic and Economic Characteristics

Of the total sample, 392 were interviewed making the response rate of the study 93.3%. Out of those, 203 (51.8%) were urban dwellers. The respondents' mean age was 23.32 years, with a standard deviation of 2.83 years. The majority of respondents (371

(94.6%) were not married, and the vast majority (85.7%) did not ever attend school. Around 252 (64.3%) of research participants acknowledged using substances at some point in their lives. More than half of the respondents (64.3%) had an average monthly income of less than 1000 Ethiopian birr (ETB), and 147 (37.5%) of the respondents' households have 3–5 children. (Table 1).

Table 1 Socio-Demographic Characteristics of the Female Waitresses in Jimma Town, Southwest Ethiopia, 2018

Variable	Category	Frequency	Percent (%)
Type of establishment	Bar	42	10.7
	Hotels	133	33.9
	Restaurants	91	23.2
	Cafeterias	126	32.1
Age category	15–19	42	10.7
	20–24	202	51.5
	25–29	148	37.8
Religion	Orthodox	147	37.5
	Catholic	31	7.9
	Protestant	109	27.8
	Muslim	98	25.0
	No affiliation	7	1.8
Educational status	No education	56	14.3
	Primary	112	28.6
	Secondary and above	224	57.1
Ethnicity	Oromo	126	32.1
	Amhara	28	7.1
	Gurage	30	7.7
	Kefa	70	17.9
	Dawro	63	16.1
	Yem	56	14.3
	Others*	19	4.8
Residence	Urban	203	51.8
	Rural	189	48.2
Ever substance use	Yes	252	64.3
	No	140	35.7
Income in month	Greater than 1500ETB	49	12.5
	1000–1500ETB	91	23.2
	Less than 1000ETB	252	64.3

(Continued)

Table I (Continued).

Variable	Category	Frequency	Percent (%)
Family size	3–5	147	37.5
	5–7	147	37.5
	Greater than 7	98	25.0
Father educational status	Illiterate	161	41.1
	Elementary	140	35.7
	High school + above	91	23.2
Live with mother	Yes	98	25
	No	294	75
Live with father	Yes	91	23.2
	No	301	76.8

Note: *Others: Tigre, Wolaita, and Hadiya.

Sexual Coercion Experience

Of the total participants, an unwanted sexual act was (67.9%), unwelcome touch was (58.9%), forced sex was (33.9%), intercourse in exchange for money or gift was (33.9%), and forced sex by intimidation was (25%) (Figure 1). Around 182 (46.4%) of participants experienced forced sexual intercourse. The most common committer of enforced sex was 92 (50.5%) by stranger, 37 (20.3%) by boyfriend, and 14 (7.7%) by teachers. The prevalence of sexual coercion experienced in the last 12 months was 242 (61.7%) (Table 2). Two hundred eighty (71.4%) female waiters experience lifetime sexual coercion. More than one-third 133 (33.9%) of female waitresses are forced at first sex.

Regarding the outcome of forced sex, 63 (16.1%) of the female waitress had unwanted pregnancies and 56 (14.3%) ended an abortion at least one time (Table 2).

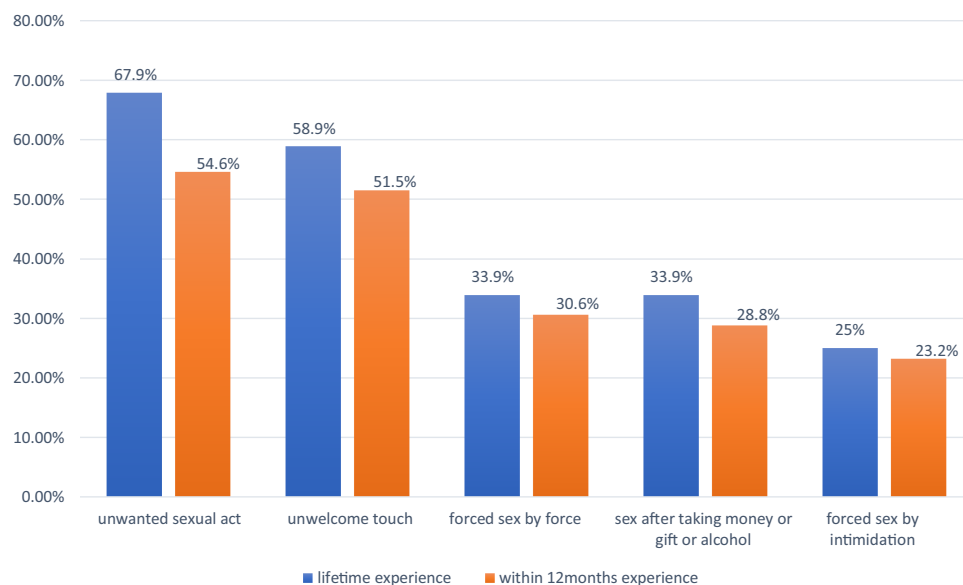


Figure 1 Type of sexual coercion experienced by female waiters in Jimma Town, 2018.

Table 2 Sexual Coercion Experience Among Female Waitresses in Jimma, Ethiopia. 2018

Variables	Categories	Frequency	Percentage %
Ever had forced sex	Yes	182	46.4
	No	210	53.6
Perpetuator of forced sex	Stranger	92	50.5
	Boyfriend	37	20.3
	Teachers	14	7.7
	Relatives	14	7.7
	Brothers' friend	9	4.9
	Neighbors	15	8.2
Lifetime experience of sexual coercion	Yes	280	71.4
	No	112	28.6
Timing of sexual coercion	For the first time (first sex)	133	47.5
	For more than two times	147	52.5
Sexual coercion experienced in the last 12 months	Yes	242	61.7
	No	150	38.3
The outcome of forced sex			
Unwanted pregnancy	Yes	63	16.1
	No	329	83.9
The outcome of pregnancy (termination)	Yes	56	88.8
	No	7	11.2

HIV Risk Behaviors

About 161 (41.1%) of the female waitresses reported having regular (cohabiting) boyfriends and 301 (76.8%) have ever had sexual intercourse. Of those, around 161 (41.1%) female waitresses initiate sex early. Peer pressure 98 (32.6%), promised from a partner 56 (18.6%), personal desire 42 (13.9%), force 28 (9.3%), and marriage 35 (11.6%) were the causes of sexual initiation.

More than half of the study participants, 203 (51.8%) had multiple sexual partners. The research participants' sex concurrency rate was 37.5%. Around 112 (37.2%) of female waiters who initiated intercourse reported having sexual contact with partners older than 10 years. In terms of substance use before the last sexual intercourse, 91 (30.2%) of those who started sexual intercourse reported substance use in the last sex, whereas 210 (69.8%) did not. More than two-thirds (67.4%) of those waitresses used condoms in their most recent sexual encounters. The usage of condoms with all non-regular partners in the previous intercourse was every time for 112 (37.2%) (Table 3).

One hundred fifty-four respondents (39.3%) have ever accepted money or gifts in return for sexual intercourse, and 147 respondents (37.5%) have ever gotten money/gifts from their most recent non-regular partners. One hundred thirty-three (90.5%) of those who engaged in transactional intercourse used condoms (Table 3). Of the total study participants, 281 (71.7%) of the participants had at least one of the HIV-related risk behaviors.

Table 3 HIV-Related Risk Behaviors Among Female Waitresses of Jimma Town, Southwest Ethiopia, 2018

Variable		Frequency	Percent
Have a regular boyfriend currently	Yes	161	41.1
	No	231	58.9
Ever had sexual intercourse	Yes	301	76.8
	No	91	23.2
Early sexual initiation	Yes	161	41.1
	No	231	58.9
Multiple sexual partners	Yes	203	51.8
	No	189	48.2
Concurrent sex	Yes	147	37.5
	No	245	62.5
Have HIV risk behavior	Yes	281	71.7
	No	111	28.3
Intergenerational sex	Yes	112	37.2
	No	189	62.8
Substance use before sex	Yes	91	30.2
	No	210	69.8
Condom use in last sex	Yes	203	67.4
	No	98	32.6
Frequency of condom use with all non-regular partners	Every time	112	37.2
	Almost every time	105	34.9
	Sometimes	63	20.9
	Never	21	7.0
Experienced money or gifts in exchange for sexual intercourse.	Yes	154	39.3
	No	238	60.7
Transactional sex	Yes	147	37.5
	No	245	62.5
Condom use after transactional sex	Yes	133	90.5
	No	14	9.5

Sexual Health

More than half of the respondents 238 (60.7%) ever been tested for HIV. Of the total study participants, 217 (55.4%) female waitresses ever received HIV counseling services.

Sexually transmitted diseases were investigated, and 322 (82.1%) of respondents had heard of STDs and could describe at least one STD symptom. The reported symptoms were vaginal discharge (41.1%), foul-smelling discharge

Table 4 Sexual Health Among Female Waitresses in Jimma, Ethiopia. 2018

Variables	Categories	Frequency	Percentage
Parental discussion/communication about sexual health	Yes	49	12.5
	No	343	87.5
Parental coherence	Yes	203	51.8
	No	189	48.2
Ever have been tested for HIV	Yes	238	60.7
	No	154	39.3
HIV risk reduction counseling	Yes	217	55.4
	No	175	44.6
Heard about sexually transmitted diseases	Yes	322	82.1
	No	70	17.9

(21.4%), genital ulcer (26.8%), genital itching (17.9%), pain/burning during urination (23.3%), lower abdomen discomfort (10.7%), genital rash (14.3%), and swelling in the groin (1.8%) (Table 4).

Factors Associated with HIV Risk Behavior Among Female Waiters

Workplace, age, substance use, residency, and sexual coercion were all substantially linked with HIV risk behavior after controlling for potential confounding factors in a multivariable logistic model.

Female waiters working in bars were 4.6 times higher odds to engage in HIV risk behaviors compared to their counterparts (AOR 4.64, 95% CI: 2.15–10.0). The odds of engaging in HIV risk behaviors among female waiters who

Table 5 Factors Associated with HIV Risk Behavior Among Female Waitresses in Jimma Town, 2018

Variable	Category	Have HIV Risk Behavior		COR (95% C.I.)	AOR (95% C.I.)
		Yes (%)	No (%)		
Workplace	Cafeteria	36(39.6%)	55(60.4%)	1.00	1.00
	Bar	40(95.2%)	2(4.8%)	5.6(3.0–10.1)	4.64 (2.15–10.0) *
	Hotel	106(79.7%)	27(20.3%)	0.93(0.51–1.7)	1.2 (0.56–2.70)
	Restaurant	99(78.6%)	27(21.4%)	0.18(0.042–0.8)	0.13 (0.02–1.13)
Residence	Urban	119(58.6%)	84(41.4%)	1.00	1.00
	Rural	162(85.7%)	27(14.3%)	4.2(2.58–6.94)	1.7 (0.91–3.45)
Age	15–19	7(16.7%)	35(83.3%)	1.00	1.00
	20–24(1)	139(68.8%)	63(31.2%)	0.09(0.038–0.215)	0.17(0.067–0.456)
	25–29(2)	135(91.2%)	13(8.8%)	0.019(0.007–0.05)	0.03(0.01–0.09) *
Parental communication	Yes	28(57.1%)	21(42.9%)	1.00	1.00
	No	253(73.8%)	90(26.2%)	2.1(1.14–3.89)	0.08(0.43–1.00)

(Continued)

Table 5 (Continued).

Variable	Category	Have HIV Risk Behavior		COR (95% C.I.)	AOR (95% C.I.)
		Yes (%)	No (%)		
Parental coherence	Yes	134(66.0%)	69(34.0%)	0.55(0.35–0.87)	0.93(0.46–1.87)
	No	147(77.8%)	42(22.2%)	1.00	1.00
Family income	≥1500ETB	141(74.6%)	48(25.4%)	2.04(1.06–3.92)	0.07(0.02–0.3) *
	1000–1500 ETB	56(53.3%)	49(46.7%)	5.25(2.65–10.39)	2.12(0.74–6.02)
	<1000ETB	84(85.7%)	14(14.3%)	1.00	1.00
Substance use	Yes	204(72.6%)	48(43.2%)	3.47(2.2–5.5)	3.38(1.7–6.7) *
	No	77(27.4%)	63(56.8%)	1.00	1.00
Father's educational status	Illiterate	134(47.7%)	27(24.3%)	0.23(0.13–0.42)	0.59(0.24–1.43)
	Elementary	98(34.9%)	42(37.8%)	0.5(0.29–0.86)	1.41(0.64–3.11)
	High school + above	49(17.5%)	42(37.8%)	1.00	1.00
Lifetime Sexual coercion	Yes	231(82.5%)	49(17.5%)	5.8(3.59–9.354)	7.6(3.8–15.3)**
	No	50(44.6%)	62(55.4%)	1.00	1.00
Live with mother	Yes	56(57.1%)	42(42.9%)	0.4(0.25–0.66)	1.37(0.49–3.83)
	No	225(76.5%)	69(23.5%)	1.00	1.00
Live with father	Yes	49(53.8%)	42(46.2%)	0.34(0.21–0.56)	0.9(0.33–2.58)
	No	232(77.1%)	69(22.9%)	1.00	1.00

Notes: *p-value less than 0.05, **p-value less than 0.001.

had ever used substances were three times higher than non-substance users (AOR 3.38, 95% CI: 1.7–6.7). Those who encountered sexual coercion in their life time were 7.6 times higher in having HIV risk behavior compared to their counterparts (AOR 7.6, 95% CI:3.8–15.3) (Table 5).

Discussion

There has been little research on sexual coercion among Ethiopian female waiters. This finding would be an input for policymakers to design interventions and strategies aimed at lessening the impact of sexual coercion and HIV risk behaviors among female waiters. According to this survey, 71.4% of female waiters have experienced sexual coercion at some point in their lives (95% CI: 67.1–76.8). More than two third (71.6%) of female waiters engaged in HIV-related risk behaviors. Furthermore, working in a bar, substance use, and experiencing sexual coercion were all linked to HIV risk behaviors.

The finding of this study showed that more than two third of female waiters faced lifetime experience of sexual coercion. This finding was high compared with the study conducted in Ethiopia¹⁰ and Uganda.²² This may be due to females being more likely to face sexual violence than others which may increase the prevalence.³ The other justification may be due to the larger sample size of the current study and the nature of the workplace that makes them more vulnerable to sexual violence including sexual coercion. This is supported by a different piece of literature that outlines that the workplace has a direct association with sexual coercion which can increase the prevalence of sexual coercion.^{23–25} This finding implied that health bureaus should organize and work together with stakeholders working in the area and deliver interventions to decrease the prevalence of sexual coercion. Furthermore, the establishments should have laws and procedures in place to safeguard female waiters from sexual coercion and non-sexual risk behaviors such as Khat chewing and alcohol use at work. This is

supported by evidence that showed that lack of adequate awareness regarding the rights and obligations and lack of formal employment procedures in the establishments expose the female waiters and thus awareness creation should be done by different stakeholders.³ Thus, those findings imply policy and practice.

We found that the prevalence of HIV risk behavior among female waiters was 71.6%. This finding is higher than a study done in Uganda (59%).²⁶ This might be because of the research population. In Uganda, the research population consists of female waiters and other participants. However, the subjects in this study are all female waiters. Another possible explanation is that sexual coercion is common in this research, which may increase the possibility of HIV-related risk behavior. There is evidence that waitresses participate in behaviors that enhance their chances of contracting HIV.²⁷

This study identified that female waiters who were working in bars were 4.6 times more likely to engage in HIV-risk behavior than female waiters working in cafeterias. This may be due to the customer flow being high in the bar compared to the cafeteria then increases the possibility of getting exposed to behaviors that increase HIV risk behaviors. Furthermore, alcohol use is more common in bars than in cafeterias which can increase HIV risk behaviors. The finding of this study implied that HIV prevention efforts must target female waiters to prevent the further spread of HIV to the general population.

In this study, female waiters who had ever used substances were three times more likely to engage in HIV risk behavior than non-substance users. This finding was harmonized with the study conducted in the Jimma zone, Ethiopia (23) and Uganda (17). Substance use may create psychological discomfort, rendering female waiters unable to control themselves, exposing them to unsafe sexual activity and subsequently HIV risk behaviors. Evidence suggests that alcohol use is a mediator for HIV risk behaviors, causing physiological discomfort and subsequently increasing HIV risk behavior.^{28,29} Evidence shows that substance use is associated with HIV risk behaviors among female waiters.³⁰

Sexual coercion was shown to be substantially linked with HIV risk behavior. One possible reason is that sexual coercion makes it difficult for women to negotiate safe sex and have sex without using a condom, which increases HIV risk behaviors. Furthermore, suitability customers' behaviors in the food and beverage may be changed after alcohol intake, which may expose the waiters to violence and then to HIV risk behaviors. This is backed by other studies that show a link between sexual coercion and HIV risk behavior.^{31–33}

Strengths and Limitations of the Study

The research's strength includes it addresses a not well-studied population as well as the greater sample size. Owing to the sensitive nature of the research issue, participants may have underreported risk behaviors as a consequence of a social desirability bias in face-to-face interviews. There was a chance of recollection biases when determining certain sexual behaviors. Another weakness of the study is its cross-sectional design.

Conclusion

Nearly two-thirds of female waitresses had a lifetime experience of sexual coercion. This study also revealed a significant number of female waitresses engaged in HIV-risk behavior. Working in a bar, substance use, and experiencing sexual coercion were all linked to HIV risk behaviors. Policymakers should put in place current legal penalties that protect women from gender-based violence by raising policy understanding about the burden and consequences of sexual coercion.

Data Sharing Statement

The data sets used in this work are accessible upon reasonable request from the corresponding author. After the defense, the thesis was uploaded to websites. Thus, the unpublished thesis paper is available on the Jimma University repository website³⁴ (<https://repository.ju.edu.et/handle/123456789/4152>).

Ethical Approval

The Jimma University Institute of Health's Institutional Review Board authorized the study procedure. A permission letter was acquired from the Population and family health department, and the Jimma town health office wrote an official letter of cooperation to the individual FDEs. The study was conducted in line with the Declaration of Helsinki. Before the interviews, all research participants were told about the purpose of the study, and agreement was acquired.

Confidentiality was guaranteed. For participants under 18 years, informed voluntary consent was obtained from their parents/guardians.

Acknowledgment

The authors would like to thank Jimma University, the Jimma town health office, the Jimma town culture, and tourist office, all research participants, and data collectors for their cooperation and contributions to this work.

Author Contributions

All authors contributed significantly to the study, whether in the conception, study design, execution, data acquisition, analysis, and interpretation, or drafting, revising, or critically reviewing the article; gave final approval of the version to be published; agreed on the journal the article be submitted; and agree to be accountable for all aspects of the study.

Funding

This research was funded in part by Jimma University. However, the funder had no involvement in the data collection, analysis, and interpretation, as well as the paper authoring.

Disclosure

The authors report no conflicts of interest in this work.

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