Assessment of Risk Factors for HIV/AIDS amongFemale Sex Workers (FSWs) in Dessie Town.

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Declaration

I hereby declare that the dissertation entitled “ASSESSMENT OF RISK FACTORS FOR HIV/AIDS AMONG FEMALE SEX WORKERS (FSWs) IN DESSIE TOWN” submitted by me for the partial fulfilment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not submitted earlier, either to IGNOU or to any other institution for the fulfilment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

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Certificate

This is to certify that Mr. Jemal Ebrahim Seid student of MSW from Indira Gandhi National Open University; New Delhi was working under my supervision and guidance for his/her Project Work for the Course MSWP-001.
His project work entitled “Assessment of Risk Factors for HIV/AIDS among Female Sex Workers (FSWs) in Dessie Town which he/she is submitting is his genuine and original work”.

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Acronyms

AA	**Addis Ababa**
AIDS	**Acquired Immuno Deficiency Syndrome**
ART	**Anti-Retroviral Therapy**
BCC	**Behavioural Change Communication**
CSWs	**Commercial Sex Workers**
EDHS	**Ethiopian Demographic Health Survey**
ETB	**Ethiopian Birr**
FHAPCO	**Federal HIV/AIDS Prevention and Control Office**
FMOH	**Federal Ministry of Health**
FSWs	**Female Sex Workers**
GBV	**Gender Based Violence**
GF	**Global Fund**
HIV	**Human Immuno Virus**
IEC	**Information Education and Communication**
MARPS	**Most At Risk Populations**
MTCT	**Mother to Child Transmission**
NGO	**Non-Governmental Organization**
PLHIV	**Peoples Living with HIV**
STI	**Sexually Transmitted Infection**
UNAIDS	**United Nations for AIDS**
UNFPA	**United Nations Fund for Population Agency**
VCT	**Voluntary Counselling and Testing**
WHO	**World Health Organization**

Table of Contents

Tables

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Abstract

This cross sectional study was conducted in order to describe Risk Factors for HIV/AIDS among Female Sex Workers (FSWs) in Dessie Town. The study population was female sex workers making their business from sex transaction. A total of 184 sex workers were interviewed by questionnaire and 18 sex workers were also addressed through focus group discussion during the period of from October 2013 to January 2014. A structured questionnaire dealing with socio-demographic characteristics, their knowledge about HIV and STI, condom use pattern, pattern of their sexual behaviour with clients and regular non-paying partners, risky behaviour like alcohol, chatt/katt and shisha use, the extent of Gender Based Violence among female sex workers.

Results were presented in frequency and percentage with narration of Focus Group Discussion. The results demonstrate that most of the respondents are not educated higher, from poor family with the monthly income of less than 1000 birr(50USD) per month, most of sex workers engaged into sex work because of poverty, lack of support, parental death, divorce or being widowed and some of course due to peer pressure.

Many sex workers have been engaged in a risky behaviour which lead to acquire HIV easily, they have multiple sexual partner and multiple times sexual action with different clients, most of the respondents also consume alcohol and Katt every day which make them not to use condom correctly and consistently if intoxicated.

Majority of sex workers have better knowledge and awareness about HIV, correct and consistent use of condom with clients, how HIV will and will not be transmitted but their practice of using condom correctly and consistently is not as their knowledge and awareness demonstrated with inconsistent use of condom with paying clients and with their non-paying partners particularly.

It is also found that majority of sex workers are facing different forms of gender based violence (physical, emotional and sexual violence) from insult to threatening by knife and forced sex, uncommon sexual position and forced not to use condom.

It is recommended that HIV and STI prevention programs need to address the special needs of Sex Workers that drive them into the risky behaviours, there is need to establish the knowledge, attitude and sexual behaviour of the clients related to STI and HIV in order to come up with appropriate interventions. Through reduction of alcohol use among sex workers and clients it will be possible to reduce the prevalence of unprotected sex, sexual violence, HIV and other STIs. STI and HIV/AIDS interventions among sex workers should include adult and functional literacy to improve the benefit of the target population and those areas not identified and targeted for further Information, Education and Communication. There is a need to increase awareness on the

importance of correct and consistent condom use among sex workers with all paying clients and non-paying partners. Comprehensive HIV Prevention program must be scaled-up, policies and programs to ensure freedom from violence, abuse and discrimination need to be considered. All people selling sex must be protected from violence, coercion and other forms of abuse. Protection and legal services need to be responsive for all reported cases of violence against Female Sex Workers.

Chapter One

1 Introduction

1.1 Rationale and Justification

Global, Regional and National HIV/AIDS epidemics among female sex workers

It has been more than two decades since HIV became a significant public health issue globally, though all sects of the community are affected by HIV, the global HIV epidemic among female sex workers is higher than the general population which is 11.8%, however the prevalence varied significantly by region, with the highest prevalence found in sub-Saharan Africa. Across regions, HIV prevalence among female sex workers was 13.5 times than the overall HIV prevalence among the general population of women 15-49 years old (WHO, 2011).

While the relative burden of HIV varies per geographic and epidemic context, sex workers are often found to be at significantly increased vulnerability to HIV through biological, behavioural, and structural risks (UNAIDS, 2009).Sex workers generally have higher numbers of sexual partners and concurrent sexual partnerships as compared to their counterparts in the general population. However, their HIV-related protective behaviours, including high rates of consistent condom use, are generally several times greater than condom use rates among the general population (UNAIDS, 2009).

Since the beginning of the epidemic, sex workers have experienced a heightened burden of HIV across settings, despite their higher levels of HIV protective behaviours (UNAIDS, 2009). Unfairly, sex workers have often been framed as “vectors of disease” and “core transmitters” rather than workers and human beings with rights in terms of HIV prevention and beyond. By gaining a deeper understanding of the epidemiologic and broader policy and social context within which sex work is set one begins to quickly gain a sense of the complex backdrop for increased risk to HIV among sex workers. This backdrop includes the critical role of stigma, discrimination and violence faced by sex workers, as well as, the importance of community empowerment and mobilization among sex workers to address these regressive forces. Unfortunately to date, sex workers’ HIV-related risks and human rights have often gone unattended and global resource allocation (Global Fund, 2011)and funding and investment recommendations related to HIV prevention, treatment and care have not been based on rigorous analysis in terms of the evidence specifically related to sex work (Schwartländer et al 2011).This analysis, in turn, seeks to inform a holistic and evidence-based response to HIV among sex workers in lower and middle income countries

Ethiopia is also one of the countries which are significantly affected by the epidemic, with an estimated one million people living with the virus and approximately 1.5 % of the

population infected (FMOH/FHAPCO Report, 2011). The earliest evidence of HIV infection in Ethiopia was recognized in the 1980s, with the first two cases being reported in 1986. Since then, the disease has spread at an alarming rate. By 1989, HIV prevalence in the general adult population, according to antenatal care-based estimates, was 2.7 per cent, increasing to 7.1 per cent in1997 and to 7.3 per cent in 2000. It declined to 6.6 per cent in 2001, to 4.4 per cent in 2003, and to 3.2 per cent in 2005.The 2005 Ethiopia Demographic and Health Survey (EDHS, 2005) estimate indicate that 1.4 per cent of Ethiopian adults aged between 15 and 49 years are infected with HIV (prevalence among women was nearly 1.9 per cent, whereas that among men was just under 0.9 per cent). More recent estimates based on the harmonization of the antenatal care surveillance-based and the DHS estimates show an overall prevalence of 2.1 per cent in 2007, suggesting stabilizing urban prevalence, and slowly increasing prevalence in rural areas. The overall adult HIV prevalence in Ethiopia has remained low. The HIV prevalence among adults age 15-49 in the 2011 EDHS is 1.5 percent (confidence interval 1.2-1.7 percent).

In Ethiopia, Commercial Sex Workers are also considered as a most-at-risk population segment for HIV infection and their clients play an important role in the spread of HIV to the general population. Surveys of Ethiopian CSWs, demonstrate that Commercial Sex Workers are disproportionately affected by HIV than other segments of population (Woldemariam G. and Annabel E.CSW Survey, 2009).

Sexually Transmitted Infection (STI) is also one of the diseases which can be transmitted through unprotected sex. A more recent study showed a high prevalence of STI, among CSWs attending STI clinics in AA (73% of sex workers were positive for STI), though this sample is likely to have higher prevalence than the general population of CSW (Aklilu, Messele, Tsegaye, et al.2001).Several risk behaviours including multiple partnerships, alcohol consumption, and erratic use of condoms have been associated with STI and HIV among CSWs in Ethiopia (Alen, Kebede, Mitike, et,al., 2006).

It is also important to look at the Human Right aspect in the context of sex work since Human Right is the cornerstone of an Effective Response to HIV. Experience has demonstrated that effective HIV responses are grounded in the respect of human rights, including non-discrimination on the grounds of real or perceived HIV status. Similarly, the respect for the human rights of vulnerable populations is a precondition to their involvement in national responses and the reduction of risk and harm.

As human rights are universal, they apply to all people. Every human being is entitled to the highest attainable standard of health, privacy, liberty and security, freedom of expression and assembly, gender equality, freedom from violence, free choice of employment and just favourable conditions of work, non-discrimination, and the prohibition of forced labour, child labour and trafficking.

The purpose of this study is to identify factors which increase the risk of HIV among FSWs in Dessie town and to put forward possible actions need to be taken based on evidences and understanding the real contexts. Assessing and analysing all related factors which make FSWs at risk of HIV is relevant to design evidence based, effective and purposive program and it is important to conduct such study in this town to come up with comprehensive and meaningful results with indicative further action.

1.3 Research Objectives.

1.3.1 General Objectives.

To assess behavioural, structural and biomedical risk factor of HIV transmission among female sex workers inDessie Town.

1.3.2 Specific Objectives

1.3.2.1 To describe socio demographic characteristics of respondent's in-terms of age, educational status, level of income and duration in commercial sex work practice.

1.3.2.2 To assess factors which increased risk of HIV infection among female sex workers (behavioural, structural and biomedical).

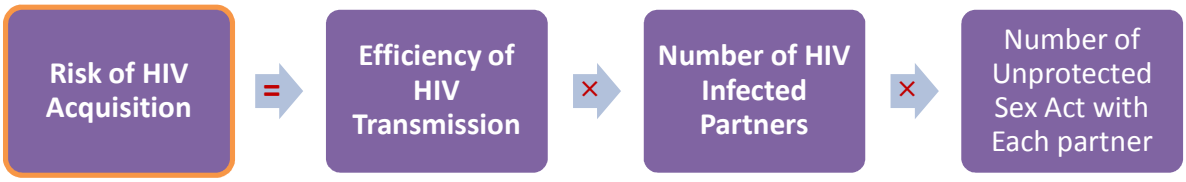
1.3.2.3 To understand the level of condom use among female sex workers and its determinants among CSWs in Dessie Town.

1.3.2.4 To understand patterns of sexual behaviour among CSWs including patterns in partnerships, and related sex behaviour.

1.3.2.4 To understand level of Gender Based Violence among Female Sex Workers and responsive actions taken following violence.

1.4 Conceptual Frame Work

According to WHO, the risk of HIV infection is determined by the total number of unprotected sex acts with an HIV infected partner and the efficiency of HIV transmission, which can be framed as



Frame work of Biomedical or behavioural risk factors for HIV Acquisition.

Proxy markers of this equation have been shown to be associated with HIV infection. These include higher number of clients, duration of sex work and an inconsistent condom use. A high background prevalence of STI, which increase transmission efficiency places sex workers and clients at higher risk for HIV acquisition and of transmitting HIV.

1.5 Operational Definitions

HIV: Human Immunodeficiency Virus (HIV), a lent virus that belongs to the retrovirus group, is said to cause HIV/AIDS. HIV is belonging to a family of viruses called retroviruses; the virus can be transmitted from person to person. Acquired Immunodeficiency Syndrome (AIDS) has emerged as one of the most serious public health problems in all over the world.

AIDS: Acquired Immuno Deficiency Syndrome) is a medical condition. People develop AIDS because HIV has damaged their natural defences against disease.

BCC: Behaviour Change Communication is an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual; community and societal behaviour change; and maintain appropriate behaviours

HIV AIDS Information Education and Communication (IEC)

Information Education and Communication can be used to motivate people to adopt and maintain healthy practices and life styles. IEC is useful in educating the public regarding the various misconceptions. IEC can be used to raise awareness, promote desirable practices, mobilize sectors of society to integrate message, train health workers and create supportive environment for the care and rehabilitation of persons with HIV/AIDS

Comprehensive Knowledge about AIDS

Comprehensive knowledge about HIV/AIDS is defined as (1) knowing that both condom use and limiting sex partners to one uninfected partner are HIV prevention methods, (2) being aware that a healthy-looking person can have HIV, and (3) rejecting the two most common local misconceptions in Ethiopia-that HIV/AIDS can be transmitted through mosquito bites and by supernatural means.

HIV/AIDS-Related Knowledge among Female Sex Workers

Knowledge of how HIV is transmitted is crucial to enable people to avoid HIV infection, especially for young people, who are often at greater risk because they may have shorter relationships and thus more partners or may engage in other risky behaviours.

Female Sex Workers /Commercial Sex Workers

Female Sex Workers/Commercial Sex Workers are those women whose age is between 15-49 years who make sex for money or receive money transaction for providing sex for their clients, who may make their transactional sex business in Bars, Hotel, Red-lights/Straits or Home Based.

Transactional Sex

Transactional sex involves the exchange of sex for money, favours or gifts. Transactional sexis associated with a high risk of contracting HIV and other sexually transmitted infections due to compromised power relations and the tendency to have multiple partnerships.

Dessie: Dessie is a Town found in Amhara Regional State of Ethiopia, the Town is located in the North East which is 400 KM away from Addis Ababa.

Risk Behaviour: Risk Behaviour is any behavioural risk factors which lead an individual to acquire HIV virus from other infected person.

Non Paying Partners: Those sexual partners of Female Sex Workers who don't pay and have sexual contact frequently ("Baluka" with their terms, meaning informal husband).

Paying Clients: Those clients who pay for sex with commercial sex workers.

Consistent Condom Use: Consistent condom use is appropriate use of condom with all partners or clients at any time.

Alchol, Khat and Shisha Users

Khat (CataEdulisForsk) is a leaf with pseudo amphetamine like effects (some level of'highness') that is habitually chewed in areas in East Africa and Yemen. The active ingredient inkhat that has a stimulant effect is nor pseudoephedrine. Shisha is a kind of substance which is smoked with tube with bottle glass which stimulate and exite an individual who takes it, is made of apple ingredients.

Gender Based Violence:

Gender based violence is defined as violence that is directed at individuals on the basis of their sex. Though boys and men can also be the target of such violence, women and girls tend to comprise the majority of victims. Gender based violence can include sexual violence, emotional and psychological abuse, forced prostitution, trafficking for forced labour or prostitution, sexual exploitation, sexual harassment, harmful traditional practices (e.g. female genital mutilation, early marriage and forced marriage) and discriminatory practices based on gender.

Independent Variable

Socio Demographic Factors

Age: Age will be determined as complete years of the respondents at the time of interview, minimum age of respondent is 15 and maximum age of respondent is 49

Education: It refers to the Education level of the interviewed sex worker. In this study education levels are categorized as No formal education, Primary Education, Secondary Education, Some College or University Courses.

Income Level: It refers to monthly income of the sex worker in Birr

Family Income: It refers to the total family income of all family members per a month.

1.6 Limitation of the Study

Due to the conservative culture among women in Ethiopia, female sex workers might not have answered accurately for some of the culturally-sensitive questions such as use of condoms, sex with multiple partners and drug use; evidently this may raise the issue of bias.

Chapter II

Review of Related Literature

Globally and nationally, there arefew studies conducted targeting female sex workers and their level of exposure for HIV/AIDS and associated risk factors. In the following section this few literatures have been reviewed and presented briefly

2.1 HIV/AIDS among female sex workers

Ethiopia is one of the countries hit hard by HIV/AIDS and faced the multifaceted devastating effects in all aspects. Female Sex Workers are also highly affected by HIV and served as one source of infection to the general population. According to the Ethiopian Federal HAPCO report of 2011, HIV prevalence is declining from year to year in Ethiopia, with 1.5 percent of the population age 15-49 HIV positive. Women have a higher HIV prevalence (1.9 percent) than men (1.0 percent). For both women and men HIV prevalence increases substantially as the number of lifetime sexual partners increases.

The overall adult HIV prevalence in Ethiopia has remained low. The HIV prevalence among adults age 15-49 in the 2011 EDHS is 1.5 percent (confidence interval 1.2-1.7 percent), and it was 1.4 percent (confidence interval 1.1-1.8 percent) in the 2005 EDHS. Though the national level HIV prevalence is declining, the prevalence among female sex workers remains higher and is increasing.

2.2 STI: Prevalence and effects on HIV transmission among Female Sex Workers

The burden of other STIs is also high among sex workers. According to 2011, EDHS report, half to two thirds of sex workers typically have a curable STI at any one time in their life. In some settings, 10% or more have an active genital ulcer and over 30% have reactive syphilis serology. Gonorrhea and Chlamydia infection may be found in a third or more of sex workers and many women have multiple infections. Where testing has been done, approximately three out of five sex workers have evidence of herpes infection. Sex workers also report that it is not uncommon for them to have sex with a man who has a genital ulcer (EDHS,2011).

An STI in either the client or the sex worker or in either sexual partner facilitates the transmission of HIV from an infected person by several mechanisms: increased contact with blood, secretions from penile ulcers; high seminal viral load of HIV from men, and disruption of the mucosal barriers in women, which undermines the innate defences of the vagina and cervix that fuel HIV transmission (WHO Preventing HIV among sex workers in Sub Saharan Africa, November.2011).

2.3 Knowledge, Attitude and Practices on HIV/AIDS and other STIs.

One's knowledge and attitude matters to determine necessary action to live quality and safe life, sex workers and clients should have access to high-quality informational and educational opportunities. Information about HIV prevention, treatment, care and support is essential, but it is not sufficient on its own to address the HIV-related needs of sex workers and their clients. Effective learning takes place through dialogue and other participatory approaches that are relevant to learners' everyday lives and tailored to their specific language and concerns (UNAIDS Guidance Note on HIV and Sex Work, March.20).

Information and education programmes should focus not only on the basics about HIV risk, prevention, treatment and care, but alsocover sexual health, rights, obligations, responsibilitiesand opportunities for individual and collective action. Effective approaches require the coordinated use of diverse methods, including peer outreach and education;facilities based counselling, print materials and mass media, and should always be age-specific, gender-responsive, and scientifically accurate and culturally appropriate. (UNAIDS Guidance Note on HIV and Sex Work, March.2009).

According to the study conducted in Assossa town, among female sex worker respondents, 103 (49.2%) didn't mention any of the symptoms of STIs in womenand 106(50.8%) mentioned at least one of the symptoms. The study showed that though FSWscan explain about HIV/AIDS transmission and some signs of STI, most of sex workers obtain the information from friends, relatives and informal communications among peers (Ethiop.J.Health Dev.2009).

2.4 Attitude and experiences for HIV testing and counselling.

HIV Testing and Counselling is the only means to know one's status whether infected by HIV or not, Female Sex Workers should check their status at least every six months (WHO, 2011). But some studies showed that as Female Sex Workers attitude towards HIV Testing and Counselling is very poor and much work should be done to raise their level of awareness and improve the demand for testing and counselling. From the study

conducted in Assosa on Behavioural Survey for HIV/AIDS among the general population and female sex workers, it was found out that 124(59.3%) of FSWs had no intention to take voluntary HIV testing andcounselling (*Ethiop.J.Health Dev. 2009)*.

2.5 Hazardous alcohol use, unsafe sex and sexual violence.

Use of alcohol among clients and sex workers at the time of purchasing sex is common. A frequent explanation for having had unprotected sex is that both the sex worker and the client were intoxicated during intercourse. In addition to affecting sexual decision-making and judgment, alcohol use also hampers condom negotiation skills. Research in Cape Town, Durban and Pretoria of South Africa found that alcohol and other drugs are commonly used prior to work to lower inhibitions and give women the courage to approach clients. Many of these women explained that they always used condoms, except when intoxicated (Ugly Mugs and Dodgy Punters, 2008).Sexual intercourse when one or both partners are under the influence of alcohol is risky because the couple may not be fully aware of their actions, which may lead to failure to use a condom.

2.6 Vulnerability, Social and other contextual factors for HIV transmission among Female Sex Workers

2.6.1Socioeconomic and occupational context of sex work.

Overall, most sex work takes place within an unhealthy and unregulated working environment, with little or no promotion of safer sex, scant control over a client's behaviour and encouragement for a high client turnover. In areas with economic insecurity, especially food insecurity, sex work is often seen as the best option for women, especially those with dependents or relatives as a key motivator for sex work.

A study conducted in Nigeria showed that hunger and food insecurity was particularly strong predictors of unsafe sexual behaviour among sex workers. The effect of poverty or relative deprivation on sexual decision-making is highly complex (Dickson-Gomez J et al.2006).

Sex workers from rural areas had mostly left home to avoid the “drudgery of farming and domestic work or an unwelcome marriage” (UNFPA, Young Positive Global Coalition on Women and AIDS, 2007). Profound vulnerability, evident at a number of different levels, is prevalent throughout settings in Sub-Saharan Africa. Often, this heightened vulnerability is embedded in the settings themselves. For example, sex work often occurs on major roads, which pass through rural areas. These rural areas, compared with urban ones, have fewer health services and little access to health information, prevention messages and condoms. Some groups in sex work settings face even higher levels of social isolation and HIV infection than others(Dickson Gomez J. et al. (2006).

2.6.2 Structural context, laws and policies regarding sex work

According to the UNAIDS 2011 report, in many countries, laws, policies, discriminatory practices, and stigmatizing social attitudes drive sex work underground, impeding efforts to reach sex workers and their clients with HIV prevention, treatment, care and support programmes. Sex workers frequently have insufficient access to adequate health services; male and female condoms and water-based lubricants; post-exposure prophylaxis following unprotected sex and rape; management of sexually transmitted infections, drug treatment and other harm reduction services, protection from violence and abusive work conditions; and social and legal support. (UNAIDS Report on Global AIDS Epidemic, 2006)

Inadequate service access is often compounded by abuse from law enforcement officers. Documented and undocumented migrants working in sex work often face particularly severe access barriers as a result of linguistic challenges, exclusion from the services that are available locally, and minimal contact with support networks. Even where HIV information and services are accessible to sex workers, such services often fail to comply with human rights standards and insufficiently engage clients, the controllers and managers of sex work or take account of the local social and cultural context. Similarly, in many countries, official policies principally focus on reducing or punishing the suppliers while ignoring the consistent demand for paid sex. (UNAIDS Report on Global AIDS Epidemic, 2006).

According to Commission on AIDS in Asia, 2008 report, the demand for sex work may be affected by social and cultural norms and individual circumstances, including work-related mobility and spousal separation; social isolation and loneliness; access to disposable income and attitudes based on harmful gender norms, including a desire for sexual dominance and sense of entitlement, which may manifest in sexual and economic exploitation and violence against sex workers. When addressing HIV in the context of sex work, policies and programmes should not only focus on the needs of sex workers themselves but also address factors that contribute to the demand for paid sex.A number of complex factors may also contribute to entry into sex work. For sex workers, these factors range along a continuum that extends from free choice to forced sex work and trafficking. (Commission on AIDS in Asia,2008)

2.6.3 Social Stigma and Discrimination on Sex Workers

By the virtue of being human, every individual has a right to live free of discrimination and stigma as a result of his/her work. Nonetheless Sex work is highly stigmatized in many societies, and thus, most sex workers face some degree of stigma and discrimination. Sex workers should be able to participate in all aspects of community life free from economic, cultural, or social marginalization, including sex workers living with HIV. Building supportive environments and developing and strengthening strategic partnerships can help reduce the stigma and discrimination of sex workers face. HIV programmes have a crucial role in assisting communities to identify and change stigmatizing attitudes and behaviours related to HIV and sex work and to foster a spirit of tolerance andinclusion. Health service personnel, law enforcement officers, the judiciary, social welfare personnel should be specifically targeted for training and sensitization (Mapping Transactional Sex on the Northern Corridor Highway in Kenya, Ferguson AG. Morris CN. 2007) .

Young migrants frequently move to the city to escape childhood marriages or to assume responsibility for contributing to family income, sometimes as sole providers. Measures are needed to prevent children and young people from being recruited into sex work,

including ensuring the availability of educational and work opportunities, addressing family and social breakdown, increasing awareness of the health and other risks associated with sex work, ensuring the availability of social protection safety nets (including those required to mitigate the impacts of AIDS) and ensuring that all forms of child labour are eliminated (UNAIDS Guidance Note on HIV Prevention for Sex Workers,2009).

Addressing structural determinants of HIV risk and vulnerability is inevitably challenging, as such approaches seek to alter complex and longstanding social, economic, political and environmental factors. While some may argue that structural interventions are too time consuming or open-ended or that they divert resources from immediate HIV control priorities, it is clear that the epidemic will not be reversed, nor will progress on HIV be sustained, unless effective action is taken to address the structural factors that increase HIV risk and vulnerability. (UNAIDS Guideline Note on HIV and Sex Work March, 2009).

2.6.4 Sex workers living with HIV

For sex workers living with HIV, the stigma surrounding HIV is compounded by the stigma associated with sex work, which often further diminishes their access to essential HIV services. Sex workers living with HIV require access to the standard of HIV treatment, care and support services on a non- discriminatory basis. For sex workers who test positive, support and quality counselling that addresses potential discrimination and loss of income should be readily available. Education and encouragement about healthy living and positive prevention can help protect their sexual and reproductive health andwell-being, avoid other sexually transmitted infections, delay HIV disease progression, avoid development of resistant strains of HIV and opportunistic infections, and prevent further transmission of the virus (UNFPA Young Positives and the Global Coalition on Women and AIDS 2007).

Increased access to antiretroviral therapy creates the need and opportunity for long term, sustainable strategies that engage sex workers in life-long positive prevention. The success of antiretroviral therapy in reducing illness and prolonging life can alter people's perceptions of risk, including by sex workers and their clients, underscoring the need to couple treatment scale-up with the simultaneous expansion of access to

focused HIV prevention services (UNAIDS, UNFPA and WHO Position Statement on Condoms and HIV Prevention,2004).

2.7 Gender based violence and elimination effort on violence against sex workers.

2.7.1 Modelling the Impact of Violence against Sex Workers

Findings demonstrate the urgent need to address violence against sex workers to protect their human rights and reduce HIV among both sex workers and the adult general population.In Kenya, reductions in the prevalence of violence against female sex workers could avert over 5,300 new infections among sex workers and 10,000 new infections among adults. In Ukraine, reductions in the prevalence of violence against sex workers could avert over 1,400 new HIV infections among sex workers, and over 4,000 in the adult population within a five-year time span (WHO Preventing HIV among sex workers in sub Saharan Africa, November, 2009).

2.7.2 Elimination of violence against sex workers.

Sex workers are often victimized by violence, including gender-based violence, perpetrated by clients, controllers, managers of sex work establishments, law enforcement officers and other government officials (Rhodes T.Simic, M.LZikic B Police Violence and Sexual Risk among female sex workers, 2008). Sex workers may also experience violence and discrimination from intimate partners, families, neighbours, partners and work colleagues (International AIDS alliance Annual Review, 2006). They are sometimes coerced into providing sex to police in exchange for freedom from detainment, arrest and fines. Violence is associated with unprotected sex and heightened risk of HIV transmission. All people selling sex must be protected from violence, coercion and other forms of abuse, and be ensured of their rights to legal assistance and access to judicial and extra-judicial mechanisms. Experience teaches that violence towards sex workers can be reduced when law enforcement agencies, the judiciary, health services, and other arms of government are engaged and cooperate fully with sex worker organizations and other civil society groups. Actions to protect sex

workers should include addressing clients' misuse of alcohol and consequent violence towards sex workers (International HIV/AIDS Alliance Annual Reveiw, 2006)

2.8 Patterns of Clients and Partners of sex workers

According to the WHO frame work, HIV transmission can also be determined by number of unprotected sex and status of sexual partners, the UNAIDS Guidance note on HIV and Sex Work described that, the clients of sex workers reflect a cross-section of the population, representing all ages, economic classes, and ethnic backgrounds. In many countries, men who buy sex represent the most important source of new HIV infections, risking HIV transmission to their wives and partners and can serve a core transmitter to the general population.

HIV information and services must be accessible for those who purchase sex. Specific education campaigns must be developed with and for clients, who can be reached not only in sex work settings but in other occupational and recreational environments. Successful service delivery strategies for clients include those focusing on truck drivers; heavy transport; tourists and business travellers; men who are separated from their families for long periods; migrants; uniformed services, including police; construction, mining and infrastructure projects; or seafarers. In devising strategies to reach sex work clients, programme planners should engage sex workers, who can help identify settings where sex work occurs.(Ferguson AG, Morris CN (2007) Mapping Transactional Sex on the Northern Corridor High way in Kenya, Health and Place).

Clients who are reached with educational and prevention programmes can become a positive force for demanding safer sex. In addition to messages about safer sex, condom usage and health seeking behaviours, programmes focused on clients should encourage clients to behave respectfully and responsibly toward sex workers, and should include zero tolerance for violence and abuse.

2.9 Patterns of condom use among female sex workers

Condom is one of the protective measured to be used during sexual intercourse and it has to be used correctly and consistently. Female Sex Workers need to have adequate knowledge about the importance of condom and how to use it. One study conducted in Uganda showed that most female sex workers are using condom with their clients always but they will not use it with their regular partners. The study showed 138 sex workers out of 191 (72.3%) reported having used a condom while 53 out of 191 (27.2%) had never used condoms before (Simon Sentumbwe, 2009).

Customer is "king" in condom negotiation.

According to the research conducted in Nigeria on HIV-related perceptions among sex workers on July,2011, sex work is fraught with risks. These may include physical violence from clients, intimidation from older or moreexperienced sex workers who may feel threatened by the arrival of younger women, bullying and sexual harassmentby unscrupulous law enforcement agents, demands for sexual and other favours from brothel managers/landlords, andeconomic manipulation and outright exploitation by several other go-betweens. Within the context of a skewed power imbalance, most sex workers found a way of defending their non-use of condoms. Most blamed clients, some of whom, they said, were not interested in using condoms. The women wholly absolved themselves and shifted responsibility to men. A woman described the conflicting decision-making process: "Because of money, maybe you don't have any money at your room that day and that person come want to give you Nira, 20,000 (about ten times the normal rate) and if he said that he will not use condom, and you look you don't have money, you will just have to collect that money."

Another mentioned: "The thing there is that men might not agree to use condom because they said they are not enjoying it by using condom, then you being a woman you don't have money to eat. You will agree to do it like that without condom, so that you may even use it to get money to eat."(HIV/AIDS Research and Palliative Care, July. 2011)

In summary, according to the review of related studies and reports (WHO HIV prevention guideline for sex workers, UNAID guidance note on prevention of HIV among commercial sex workers and Survey on Commercial Sex Workers in Ethiopia and other

related studies) in different countries, female sex workers are still remain at high risk for HIV/AIDS, the factors which make them at risk differ from place to place and from community to community and it will be imperative to make formative studies to identify the real causes and factors of being at risk for HIV among female sex workers in Dessie Town.

Chapter Three

Research Methodology

3.1 Research Design.

This study is a cross-sectional descriptive study. The study is conducted in Dessie town located in North East of Addis Ababa at 400 KM.

Study Area and Study Period

The study was conducted in Dessie Town from November 1st, 2013 to May 5, 2014.

3.2 Study Population

The study populations are female sex workers between the ages of 15-49 years who make sex for money. The sex workers were taken from establishments like hotels, bars, brothels and streets.According to the information obtained from the Deissie Town Bureau of Labor and Social Affairs (BoLSA), it is estimated that as there are nearly 1800 Female Sex Workers in the Town making their business in Bars, Red-lights, hotels and home based establishments.

3.3 Sampling Technique

Since prostitution is not recognized work in Ethiopia and as such there are no licensed or registered sex workers in the town, a probability samplingalone wasnot possible because the exact number and identity of prostitutes not known. Combinations of purposive and accidental sampling approach were adopted. As point of contact, Bars, Hotels, Home based establishments and the Drop-In-Centres in the town were used and 'snowball'' sampling method were also used to select prostitutes working in the road sides/streets, since it will be difficult to identify street sex workers who come to visit Drop-In-Centres in the day time. Totally 184 sex workers were interviewed and this is determined by using a Sample Size Calculator with confidence level of 95%, confidence interval of 7 with 50% percentage of level of accuracy.

3.4 Data Collection Tools and Methods.

A detailed interview protocol with a combination of open and closed ended questions were developed, knowledge questions were also drawn from standardized tools of CDC. Focus Group Discussion was also another method of data collection particularly for those issues related with gender based violence, condom use and other socio cultural factors.

The questionnaire classified into four categories: socioeconomic profiles of the workers, Knowledge about HIV/AIDS and STI, risk behaviours, need and access for testing and counselling and Gender Based Violence. Age at first sexual intercourse (intra-marital and extramarital), monthly income and sources of knowledge, risky behaviours, partner and condom use pattern asked about with open-ended questions, while questions on the other variables were closed-ended.

Focus Group Discussion (FGD) was employed to sharpen ideas not received using the questionnaire interview and to promote understanding of the participant's perspectives. It was used to answer questions on what drove young women into sex work, what they will do if they face violence from their clients or partners and their opinion about condom use. It focused on participant's feelings, practices and firmly held beliefs. Three focus group discussion were held for home based, red-light (street) and Bar and Hotel sex workers. Each focus group consisted of 7-8 sex workers who were randomly selected from those who participated in the questionnaire interview.

3.5 Data Collection Procedures

Two day training for research assistants and supervisors conducted. The training enabled to standardize data collection and to orient all involved in the study. In the training, criteria for selecting the sex workers were explained and the data collectors were supervised on daily basis

3.6 Pre-test of the questionnaire

Questionnaireswere developed and translated in to local language (Amharic) and pretested to ensure that the questions and questionnaire administration techniques are appropriate, 10 female sex workers were interviewed by trained female interviewers.

3.7 Data analysis plan

The collected data entered using SPSS Version 20 and cleaned by examining inclusion criteria, distributions, range checks, consistency checks, the questionnaire included in data analysis, associations between categorical data were examined using chi-square tests.

3.8 Inclusion and Exclusion Criteria

Those females who received money for sex services and express themselves as sex workers were included in the research.

Those who are eligible for the study were FSWs, aged 15 to 49 working in Bars, Hotels, Red lights/Districts (Local homes where individual CSWs work from their own home), and home based establishments selling locally brewed alcohol. All respondents are self-identified as being engaged in to commercial sex work. Sex workers also must be willing to participate in the study and are working as a sex work now and at least for the last three months.

Chapter Four

Results

The purpose of this study is to identify factors which increase risks of HIV/AIDS among FSWs in Dessie Town. The study is conducted in Dessie town from November, 2013 to January, 2014. In the study 184 FSWs were participated and out of these 50 were from Hotels (venue based), 41 were from Bars, 33 were from street/red lights and the remaining 60 were from home based establishments.

4.1 Socio - Demographic Characteristics

Table 4.1: Demographic Characteristics

Age	Age Category By Year	Frequency	Percentage (%)
1	Below 20	18	9.9
2	From 21-25	71	39.2
3	From 26-30	82	45.3
4	From 31-35	7	3.9
5	Above 35	3	1.7
Work Place			
1	Hotel	50	27.2
2	Bars	41	22.3
3	Street or Red-lights	33	17.9
4	Home Based	60	32.6
Religion			
1	Orthodox Christian	86	46.7
2	Muslim	56	30.4
3	Other Christian	18	9.8
4	Don't want to tell	24	13
Ethnicity			
1	Amhara	120	65.2
2	Oromo	26	14.1
3	Tigrian	37	20.1
4	Others	1	0.5
FSWs Family Monthly Income			
1	Below 200 birr	23	12.8
2	From 200-500 birr	70	39.1
3	From 500-1000 Birr	51	28.5
4	Above 1000 Birr	35	16.6
FSWs Monthly Income from Sex Work			
1	Less than 500 Birr	18	10.3

2	500-1000 Birr	73	41.7
3	1000-2000 Birr	58	33.1
4	Above 2000 Birr	26	14.9

As presented in the table, there were 18(9.9%) respondents whom theirage is below 18 years, 71(39.2%) are between 21-25 years, 82(45.3%) are between 26-30 years, 7(3.9%) are between 31-35 years and the rest 3(1.7%) are above 35 years.

FSWs are also identified based on the place of work, from the total respondents 27.2% of them are working in Hotels (venue based), 22.3% are working in Bars, 17.9% are in Streets and the remaining 32.6% are working in Home Based Establishments (Local Beer House).In terms of religion 46.7% are Orthodox Christians, 30.4% are Muslims, 9.8% are from other sects of Christianity and the remaining 13.0don't want to explain their religion.

Based on ethnicity, 65.2% of respondents are Amhara, 20.1% are Tigrian, 14.1% are Oromo and the remaining 0.5% is from other ethnic group. The data from the respondents on Family's monthly income indicates that 12.8% family get below 200 Birr, 39.1% of respondents family get with the range of 200-500 birr, 28.5% of respondents family get within the range of from 500-1000 birr and the remaining 16.6%% get above 1000 birr.

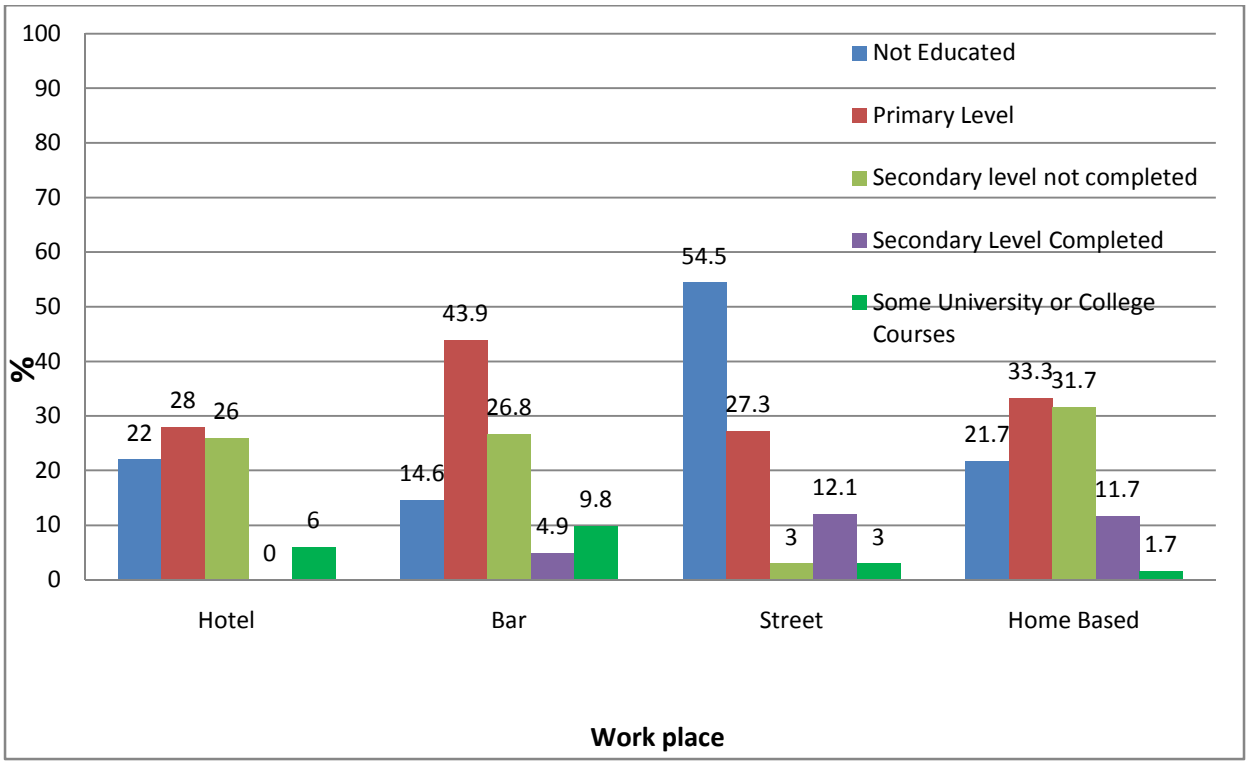
Respondents were also asked about their monthly income from sex work and their income level vary based on their work place, from those working in Hotels, 8.5% get less than 500 birr per month, 17.0% get between 500-1000 birr per month, 40.4% get between 1000-2000 birr per month and the rest 34.4% get above 2000 birr from sex work. From those working in Bars, 2.6% get less than 500 birr, 43.6% get between 500-1000 birr, 30.8% get between 1000-2000 birr and the remaining 23.1% get above 2000 birr. From those working in Home Based, 15.6% get less than 500 birr, 46.9% get between 500-1000 Birr, 34.4% get between 1000-2000 birr and 3.1% get above 2000 birr. From those working in Street, 14.0% get less than 500 birr, 57.9% gets between 500-1000 birr, 28.1% get 1000-2000 birr and 0.0% gets above 2000 birr.

The average monthly income from sex work is 1401, sex workers getting the minimum from sex work is 100 Birr and the maximum is birr 4000.This data shows as those venue based FSWs get much more monthly income than those who operate on street and home based establishments.

Characteristics of Respondents by Educational Status

Based on the respondents educational characteristics, 26.1% of respondents are not educated, 33.2% are attended primary level education, 23.9% are not completed the secondary level, 12.0% completed primary level and the remaining 4.9% attended some university or college level courses. When we look at respondents place of work, from those working in Hotels, 22.0% are not educated, 28.0% are attended primary level, 26.0% are attended some secondary level courses but not completed, 18.0% completed

secondary level and the rest 6.0% attended some university and college courses. From those working in Bars, 14.6% are not educated, 43.9% are attended up to primary level, 26.8% are attended some secondary level courses but not completed, 4.9% completed up to secondary level courses and the remaining 9.8% attended some university or college courses. From those working in Streets/Red Lights, 54.5% are not educated, 27.3% attended some primary level courses, 3.0% are attended secondary level but not completed, 12.1% are completed secondary level courses and the remaining 3.0% attended some university or college courses. From those working in Home based establishments, 21.7% are not educated, 33.3% are attended up to primary level, 31.7% are attended some secondary level courses but not completed, 11.7% are completed secondary level and the remaining 1.7% are attended some college or university courses.



Graph One: Characteristics of Respondents by Educational Status of FSWs.

Table 4.3: Marital Status, Age of Sex Workers at first marriage

Marital Status	Age Category By Year	Frequency	Percentage (%)
1	Never Married	80	43.5
2	Married Now	8	4.3
3	Divorced	74	40.2
4	Widowed	22	12
Those married, Age at first marriage			
1	Below 15 years	8	7.7
2	Between 15-18 years	60	57.7
3	Above 18 years	36	34.6
Age at first sex			
1	Below 15 years	23	12.7
2	Between 15-18 years	119	65.7
3	Above 18 years	39	21.5
Feeling and Experience of First Sexual Intercourse			
1	Raped/violence	54	29.4
2	Male partner pressure	18	9.8
3	Alcohol intoxication	65	35.3
4	By will/love	28	15.2
5	Other	19	10.3
First Sexual Partner			
1	Boy Friend	79	42.9
2	Husband	74	40.2
3	Paying Clients	31	16.8
4	Other	0	0

As indicated in the table above, large numbers of the respondents are never married (80%), followed by divorced 74 (40.2%) and widowed 22 (12%).Based on age of sexual debut 119 (65.7%) claimed they were between the age of 15-18 years, 39 (21.5%) were above 18 years and the remaining 23 (12.7%) were below 15 years. Significant number of female sex workers were experienced their first sex by rape or abduction 54 (29.4%), 18 (9.8%) did it due to male partner pressure, 65(35.3%) expresses they did it because they were intoxicated, 28(15.2) did it willingly and the remaining 19 (10.3%) gave other reason. Majority of sex workers dis they first sexual intercourse with their boyfriend 79(42.9%), 74(40.2%) did it with their husband, 31(16.8%) did it with their paying clients.

FSWs were also asked about for how long they stayed in Dessie Town, for how many years they have been engaged in Sex Work Business or years to stay in sex work. In terms of years stayed in Dessie town,8(4.5%) of sex workers stayed in Dessie for less than one year, 70(39.5%) stayed between 1-5 years, 57 (32.2%) stayed between 5-10 years and the rest 42(23.7%) stayed above 10 years. From responded FSWs, 11(6.4%) of sex workers engaged in Sex Work for less than 1 year, 101(58.4%) stayed between

1-5 year, 56 (32.4%) stayed between 5-10 years and 5(2.9%) stayed above ten year, 14(7.7%) sex workers expect as they will stay in sex work for less than one year, 13(7.1%) expect as they will stay above one year and 156(85.2%) don't know how long they will stay in sex work business which shows us as many sex workers do may stay longer in the business. .

Table 4.4: Work condition before sex work and possible reasons to engage into sex work

Work condition before sex work		Frequency	Percentage (%)
1	Domestic workers	45	24.5
2	Waitress in Café or Bars	79	42.9
3	Daily labourers	26	14.1
4	Other	34	18.5
Possible reasons and factors to be engaged into sex work			
1	Due to difficult working situations	51	28.5
2	Divorced from marriage	43	24
3	School drop out	17	9.5
4	Parental death and lack of support	23	12.8
5	To support family	45	25.1

Respondents were also asked what they were doing before engaging into sex work, 24.5% of sex workers were domestic helpers/workers, 42.9% were waitress in Café or Bars, 14.1% were daily labourers and 18.5% were doing other business.

Respondents were also asked why they engaged into sex work business and 28.5% of respondents said they engaged into sex work because of very harsh and difficult working conditions, 24.0% were said because they divorced from marriage, 9.5% said because they dropped out from school, 12.8 % said because their parent (either one or two of them) died and lack of support pushed them to engage in to sex work and the remaining 25.1% said they engaged into sex work to support family and cope with poverty.

During the FGD, respondents were asked how they started and what factors pushed them to be engaged into sex work. Different respondents were answered the question from their own experiences, feelings, thoughts and opinions. The responses reinforce the answers collected through questionnaire administered individually.

Respondent one said, "While I was attending school, my mother died, I tried all my best to support myself and little siblings working as waitress but the income I obtain from it was not sufficient let alone my dependants but my basic needs and decided to work in

bars and hotels which I started to gain much more money every day. I continued working in this business and found it the only viable option for me".

Respondent two said, "I was married and respected lady in the village, but repeated conflict with my husband forced me to opt for divorce and the only choice to give bread for my children was to work as a sex worker and making business from it to help myself and my children"

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The third respondent said, "when my husband died I was trying to support myself and my children working as daily labourer which the work is very difficult, laborious and for longer time in the reverse the income from it is very minimal and I decided to open my own local beer house and started making sex for business alongside with selling local beer".

The fourth respondent said, "I started the business just due to peer pressure, observing them as they are able to afford for cosmetics, jewellery and fulfil their financial needs and wanted to make huge amount of money as others do".

4.2 Patterns of Clients, Partners and Sexual Action/Behaviour

FSWswere also asked about patterns of sexual action and number of partners. From total respondents 38(20.8%) have less than five partners per a week, 109(59.6%) have between 5-10 clients per a week, 27(14.8%) have between 10-15 clients per a week and 9(4.9%) have above 15 clients per a week. Among those sex workers working in Hotels, 5(10.2 %) have less than five partners per a week, 28(57.1%) have 5-10 clients per a week, 12(24.5%) have 10-15 clients per a week and 4(8.2%) have more than 15 clients per a week, from those working in Bars, 9.8 % have less than five clients per week, 70.7% have between 5-10 clients per a week, 14.6% have 10-15 clients per a week and 4.9 % of clients have above 15 clients per a week.

As indicated in the finding, sex workers working in Hotel have contact with multiple partners thanHome based establishmentsand the Average number of clients visiting a sex worker per week is 8. With the Average number of sexual action per a week per sex worker is 9.

Commonly/ most frequently visiting clients

According to the response from the participants the common clients of FSW in Dessie town are trader/business men (29%) followed by long truck drivers (54%) and daily labourers (44%).

FGD participants were also asked the on the type of clients and their response substantiate the qualitative data. One respondent particularly suggested “everybody except priest’ to show the diversity and dynamics of their clients. Long truck drivers, daily labourers, traders, government and NGO workers were frequently mentioned during the discussion referring to them as common types of clients.

4.3 Knowledge, Awareness and Understanding of Sex Workers about HIV and STI.

4.3.1 Knowledge about common signs and symptoms of STI (Sexually Transmitted Infection)

In order to assess FSWs knowledge and attitude about STI, the seven common signs and symptoms of STI were listed and respondents were asked to make Tick (√) mark on the listed common signs and symptoms which they believe as it will be related with STI and the finding shows as 97(52.7%) of sex workers responded as genital ulcer can be possible sign of STI, 78 (42.4%) consider as Genital Discharge can be possible sign of STI, 93(50.5%) consider as burning sensation during urination can be due to STI, 62 (35.3%) identified as itching around the genital area can be possible sign of STI and 65(35.3%) consider as offensive discharge can be due to STI and 62(33.7%) feel as Scrotal Swelling in male can be due to STI.

The finding shows as there are no sex workers who listed or marked more than one signs and symptoms of STI as which shows their knowledge about common signs and symptoms STI is limited and may not seek medical attention when they develop such signs and symptoms. In relative terms those sex workers working in Hotels and Bars have better understanding than those sex workers making their business in the street and home based establishments.

4.3.2 Knowledge about HIV and Prevention methods

When we look at FSWs knowledge about HIV and Prevention Methods, it is found that as many sex workers have good understanding and knowledge about HIV, almost all of them 184(100%) heard about HIV before, from those responded 126 (70%) believe as HIV can be prevented through abstinence, 68(37%) believe as HIV can be prevented by being faithful for one tested negative partner and 159(86.9%) believe as consistent and correct use of condom can prevent HIV. It is also found that 110(60.5%) believe as

healthy looking person can have HIV and they don't judge any person by physical appearance whether to have HIV or not in his blood.

The finding shows as regardless of their place of work, all sex workers involved in this study have heard about HIV previously, it also shows as those sex workers working in Hotels and Bars know better about prevention methods than those sex workers working in home based establishments and streets.

4.3.3 Source of Information about HIV and Sexually Transmitted Infection

The finding from this study indicates that Radio and Television are the common source of information about HIV and STI forFSWs in Dessie town(70%). Ofcourse, other alternative sources of sources information were also indicated involving health workers (50%), peer educators (27%) and..... An attempt was made to segregate sex workers based on their media preference. Large number of FSWs who operate in hotels and bars (i.e. 80% and 70 % respectively) indicated Television and Radio as preferred and common source of STI and HIV related information.

FGD participants also explained as they also obtain information about HIV from MULU HIV Prevention program implemented by Beza Posterity Community Based organization through peer-to-peer education session, from print Medias and community mobilization campaigns.

4.4 Patterns of HIV Testing and Counselling

FSWs HIV testing and counselling practice were also assessed, 146(79.3%) of Sex Workers tested for HIV, among from those tested, the frequency of testing practice vary and 107(73.8%) tested every three month, 27(18.6%) tested every six month, 2(1.4%) tested every year and the remaining 9(6.2%) tested only once in life. When we look at the testing trend based on their location of work, from those working in Hotels, 29(70.7%) tested every three month,9(22.0%) tested every six month, none tested every year and the remaining 3(7.3%) tested only once in life. From those working in Bars, 25(78.1%) tested every three month, 4(12.5%) tested every six month, 2(62.0%) tested every year and the remaining 1(3.1%) tested only once in life. From those working in home based establishments, 13(59.1%) tested every three month,6(27.3%) tested every six month, none tested every year and the remaining 3(13.6%) tested only once in life and from those working streets, 40(80.0%) tested every three month,10(16.0%) tested every six month, none tested every year and the remaining 2(4.0%) tested only once in life. From those tested to HIV, 89(61%) tested in Health Centre, 37(25.3%) tested in outreach HIV counselling and testing campaign and 20(13.7%) in other places. From those not tested to HIV, 1(2.6%) explained as service unavailability for not being tested, 30(76.9 %) explained as they don't want to test being afraid of positive for HIV, 3(7.7%) not tested because they don't believe with its relevance and the remaining 4(10.3%) do not Know as they have to be tested for HIV

Through Focus Group Discussion, Respondents were also asked about their testing practice for HIV, five respondents said “as they are tested before and they check their status every three months”. Four of them responded as “they have been tested once in their life” and of course no sex workers responded as they have never been tested.

4.5 Participation in HIV Prevention Program

Respondents were also asked about if they have participated in any HIV prevention program previously and 73(39.9%) of respondents participated in HIV prevention program by different community based organizations like Beza and Family Guidance Association Peer to Peer HIV prevention program. Their participation also varies based on their place of work and among from those sex workers working in hotels, 21(42.9%), in Bars 9(22.0%), in red lights/streets 12(36.4%) and in home based establishments 31(51.7%) participated in HIV prevention program.

4.6 Condom Use Pattern

Respondent were asked on their condom using behaviour, and146(79.3%) explained as they use condom correctly and consistently with paying clients and regular non-paying partners. Many of FSWs use condom correctly and from the respondents. 60(32.6%) of sex workers explained as there is no occasion when they have not used condom in the last six months, 19(31.7%) reported as they use condom with all paying clients in the last six months, 43(71.7%) reported as they use condom with their non-paying partners in the last six months, 75(41.0%) reported as there was a condition not used condom in last year and 112(61.2%) reported as they experienced condom tear off during intercourse.

The findings from the FGD further strengthen the data collected quantitatively. Participants unanimously indicated as they value condom as lifesaving instruments. One participant suggested “Condom is my saviour! No condom, No business!” Comments from other FGD participants further validated her argument. They indicated as they are even very cautious to go out with intoxicated clients due to fear of condom resistance behaviour. Condom breakage is rarely reported and FSWs indicated as they often check expiry date. Moreover, the bargaining skills and techniques of FSWs with condom resistant customers is very diversified: some attempt to convince their clients; others advise them to marry while some of them return client’s money and leave the room. Shouting on an event of violation and forceful sexual advance without condom was also reported.

4.7 Patterns of Alcohol, Chat/Katt and Shisha Use among Sex Workers

It was also possible to assess risky behaviours (Alcohol, Shisah, and Chat/Kat use pattern) of Sex Workers which may increase their level of risk for HIV, 117(63.6%) of sex workers responded as they drink alcohol every day, 50(27.2%) as they drink alcohol occasionally once or more per a week and 17(9.2%) have never used alcohol in their

life. Their chat/katt utilization also were assessed and 96(52.2%) respondents answered as they will chew chat every day, 60(32.6%) once or more per a week, 28(15.2%) never chewed chat/katt, Their shisha usage also was assessed and 32(17.9%) use shisha every day, 52(29.1%) use shisha once or more per a week and 95(53.1%) never used shisha at all.

Respondents were also asked as whether their behaviour and work could make them at risk for HIV,

Some of the respondents answered as they will be at risk unless and otherwise they exit out from this life, one of them said, as far as “I take care, I will not be at risk”. Other respondents said, “Through time, I believe as I will be at risk of acquiring HIV because I practice sex with many clients and partners”.

4.8 Extent of Gender Based Violence among Female Sex Workers

Table 4.5: Gender Based Violence

Description	Violence	By Work Place				Percentage
		Hotel	Bar	Home Based	Street	
Physical Violence	Yes	39(78.0%)	27(65.9%)	19(57.6%)	36(60.0%)	121(65.8%)
	No	11(22.0%)	14(34.1%)	14(42.4%)	24(40.0%)	63(34.2%)
Sexual Violence	Yes	43(86.0%)	33(80.5%)	21(63.6%)	35(58.3%)	132(71.7%)
	No	7(14.0%)	8(19.5%)	12(36.4%)	25(41.7%)	52(28.3%)
Emotional Violence	Yes	47(94.0%)	39(95.1%)	26(78.8%)	46(76.7%)	158(85.9%)
	No	3(6.0%)	2(4.9%)	7(21.2%)	14(23.3%)	26(14.1%)

Respondent sex workers were also asked about their experience if they faced any form of Gender Based Violence, 121(65.8%) of respondents reported as they faced physical violence, 132(71.7%) sexual violence and 158(85.9%) emotional violence. Magnitude of violence also varies based on where they work and from those working in Hotels, 39(78.0%)of respondents reported as they faced physical violence, 43(86.0%) sexual violence and 47(94.0%) emotional violence, in Bars, 27(65.9%) of respondents reported as they faced physical violence, 33(80.5%) sexual violence and 39(95.1%) emotional violence, In streets, 36(60.0%) of respondents reported as they faced physical violence, 35(58.3%) sexual violence and 46(76.7%) emotional violence and in home based establishments, , 19(57.6%) of respondents reported as they faced physical violence, 21(63.6%) sexual violence and 26(78.8%) emotional violence.

Table 4.6: Commonest Type of Violence

Ser.No	Commonest form of Violence Faced	Frequency	Percentage
1	Slapping	69	57%
2	Intimidation and Knife Threatening	43	35.5%
3	Out of will sexual action	37	28%
4	Forced not to use condom	43	32.6%
5	Forced unusual sexual action	63	47.7%

From those sex workers facing gender based violence, 69(57.0%) said slapping is common type of physical violence they faced, 43(35.5%) intimidation or threatening through knife, 37(28.0%) said rape, 43(32.6%) said forced not to use condom and the remaining 63(47.7%) said forced for unusual sexual action/position.

Respondents were also asked if they have ever been faced any kind of violence either from their clients or regular partners, all of the respondents answered as they have faced different kinds of violence by different clients and it is not easy to mention all in this short time. The extent of violence could be from insulting, slapping to intimidating through knives and guns like pestle.

Respondents were also asked what measures they have taken while they face violence and four respondents said as they reported the case to police officers but police officers ignored our case and left the issues to resolve by our own, one of the respondent said "when I report the case to police officers, the officer himself asked me to spent the night with him and left him in the middle of the road", the other respondent said "I get satisfactory response from police officers making the person who intimidate me to be in custody for the night".

Responsive actions of Sex Workers when they face violence

Sex workers responsive action when they face Gender Based Violence were also assessed and 125(70.2%) of respondents said they were reporting and will report the case to police officers, 8(4.5%) said take the case to the courts, 14(7.9%) said take a case to women affair offices, 7(3.9%) said will negotiate with perpetuators of the violence and the remaining 24(13.5%) said as they will do nothing and will not report the case for any one.
From those reported the case to concerned officials, their level of satisfaction were also assessed and 53(36.3%) said we have highly satisfied with the response, 60(41.1%) said partially satisfied, 21(14.4%) said not satisfied and the remaining 12(8.2%) said we are disappointed with the response.
Those who do not reported while they face gender based violence were also asked for their reasons and 5(14.7%) said not reported because they do not get legal services, 9(26.5%) said because do not get response from police officers, 3(8.8%) said because don't get response from women affairs office, 7(20.6%) said don't know where to report.

Respondents were also asked their belief about the importance of Female Sex Workers Association, majority of sex workers 127(69.0%) believes that it will be important if they can be organized as an association.

Chapter Five

Discussions

Dessie is one of the corridor towns in the North East part of Ethiopia. The town is a transitional town to the north corridor. Since Dessie is in the middle of the north corridor and serve as a hub, many traders, travellers and tourists spent their night in the town which attracts many sex workers. The purpose of this study is to assess behavioural, structural and biomedical risk factors of HIV transmission among female sex workers in Dessie town. This study will help to identify the situations and risk factors of HIV transmission among female sex workers and to design evidence based comprehensive interventions.

The study was conducted in Dessie town during the period November 1st, 2013 to May 5, 2014. One hundred eighty four sex workers involved in this study. The data was collected by structured questionnaire and Focus Group Discussion using interview method. The questionnaire was checked by experts and pre-tested prior of the data collection. In this study there was a set of questionnaire consisting of fifty questions related to socio- demographic factors, risk factors increase HIV infection among Female Sex Workers, condom use pattern and sexual behaviour and gender based violence.

5.1 Socio- Demographic Characteristics

Study shows that, the youngest respondent was 18 years old and the oldest was 40 years old, the average year was 25 years. Most of the respondents were belonging to the age group of 20-30 years. Majority of respondents were orthodox Christians followed by Muslims (46.7% and 30.4%) respectively. Based on ethnicity majority of respondents were from Amahara ethnic group followed by Oromo (65.2% and 14.1%) respectively. Based on their educational status 33.2 % attended primary level, 26.1% not educated at all, 23.9% attended secondary level but not completed and 12% completed secondary level and the remaining 9(4.9%) attended some university or college courses. As indicated, 26.1% of female sex workers are not educated at all with no capacity to read or write. Their educational status even varies based on their place of work as Sex Workers working in Hotel and Bars are much better educated than sex workers working in street and home based establishments.

Majority of FSW's 70 (39.1%) family income fails between 200-500 birr (10-25 USD) per month, 51 (28.5%) of FSWs family income fails between 500-1000 Birr (25-50 USD), 35(16.6%) of FSWs family income reaches above 1000 birr (above 50 USD) per month and 23(12.8%) of FSWs family income is below 200 birr (Less than 10 USD) per month. As it is clearly stated majority of Sex Workers' family income is very low which

indicates as they are from poor family and engaged in to sex work in order to support themselves and their family.

In this study it is found that as majority of sex workers obtain monthly earning between 500-1000 birr (25-50USD) with the average income from sex work is 1401 birr ($70) per month. The average monthly earning is almost similar with the finding of other studyon Commercial Sex Worker conducted in Bahi Dar, Addis Ababa, Adama and Mekelle which is nearly ($73) per month(Woldemariam G. and Annabel E.CSW Survey, 2009).

In this study, majority of sex workers are not married (43.5%) and (40.2%) are divorced and nearly 65.7% of sex workers experienced their first sex between the age of 15-18 years with the average age of 17 years. This shows that as many sex workers experience sexual intercourse at early age.

In this study, it is also identified as majority of sex workers were engaged in other business and paid work before initiating commercial sex work and majority of sex workers were waitress in café and restaurant and domestic workers (42.9% and 24.5% respectively). This finding is almost similar with the other survey conducted in the four big towns of Addis Ababa, Adama, Mekelle and Bahir Dar which indicated as 44% worked as domestic worker and 21% as waitress in Café and Restaurant(Woldemariam G. and Annabel E.CSW Survey, 2009).

There are multiple reasonsfor sex workers to be engaged in to sex work, according to this study most of the reasons revolve around socioeconomic factors,51(28.5%) of sex workers engaged into sex work due to difficult working situations combined with minimal return, 43(24%) engaged because they divorced from marriage, 45 (25.1%) to support their family, 23 (12.8%) due to parental death and lack of support and the remaining 17(9.5%) reasoned because of school dropout. This finding is almost similar with other studies conducted in Bahir Dar, Addis Ababa, Adama and Mekelle which shows as the vast majority of sex workers (85%, n=2050) initiated sex work following a negative event such as escaping abusive domestic work 39% and divorce 29% following with school dropout which is 28% (Woldemariam G. and Annabel E.CSW Survey, 2009).

Sex workers have multiple partners from each walk of life, 59.6% have 5-10 clients per week and 55.9% have between 5-10 times sexual action per a week with different clients with an average of 9 times sexual action per a week. This study also identified as most frequently visiting clients of sex workers are traders/business men (29.3%) followed by tourists and long truck drivers which is 23.9% and 16.8% respectively.

5.2 Knowledge, Attitude and Practice of Sex Workers about STI and HIV

5.2.1 Knowledge about common signs and symptoms of STI

Respondents knowledge about common signs and symptoms of STI were assessed, only 97(52.7%) of female sex workers know that as Genital Ulcer can be sign and symptom of STI, 78(42.4%) of respondents know that as Viginal Discharge/Urethral Discharge can be sign of STI, 93(50.3%) knew that as burning sensation during urination can be possible sigh of STI, 62(33.7%) knew that as itching sensation can be sign of STI, 65(35.3%) knew that as offensive discharge can be possible sign of STI. The survey conducted in four big towns (Addis Ababa, Adama, Mekelle and Bahir Dar) also show that as female sex workers are less knowledgeable about common signs and symptoms of STI, nearly 44% could not even name any symptoms and only 28% could name three or more symptoms (Woldemariam G. and Annabel E.CSW Survey, 2009). In general, Female Sex Workers knowledge about common signs and symptoms are limited which need further consideration of targeted education and raise level of awareness to increase the demand for treatment seeking behaviour.

5.2.2 Knowledge about HIV and HIV Prevention Methods

All sex workers have heard about HIV and there is no respondents said not heard about HIV. In relation to knowledge about prevention methods 126(70%) of respondents believe that as HIV can be prevented by abstinence but 54(30,4%) do not believe that as HIV can be prevented by abstinence, 68(37%) believe that as being faithful to one HIV negative partner can prevent HIV whereas 116(63%) do not believe as being faithful to one partner cannot prevent HIV, 159(86.9%) of respondents believe as consistent and correct use of condom can prevent HIV but 24(13.1) do not believe that as consistent and correct use of condom can prevent HIV.110 (60.1%) of respondents believe that healthy looking person can have HIV but 73(39.9%) believe that as there is no HIV in healthy looking person.

But it is also found that as there is misconception of HIV transmission, only 19.1% believe that as HIV cannot be transmitted by mosquito bite and some sex workers still believe that HIV can be transmitted by eating together of sharing latrine in commonThe study conducted in Addis Ababa, Mekelle, Bahir Dar and Adama also shows that a high proportion of sex workers knew that one can get HIV by having unprotected sex (95%) and that correct and consistent use of condom protect from HIV transmission (94%) (Woldemariam G. and Annabel E.CSW Survey, 2009).

5.2.3 Source of Information about HIV and Sexually Transmitted Infection

Source of information matters about the knowledge and awareness of Female Sex Workers about HIV and other STI, from this study it is found that 128(69.9%) of respondents obtain information from Radio and Television, 66(36.1%) from posters and fliers, 92(50.3%) from health workers, 27(14.8%) from peers and the remaining 57(31.15%) obtain from other source.

5.3 HIV Testing and Counselling Practice among FSWs

Knowing one's status about HIV will help to take care of not being infected or considering additional care and treatment if tested positive. From the study it is identified as majority of sex workers have been tested at least one times which is very encouraging, 146(79.3%) of sex workers have been tested at least one times, only 38(20.7%) of them are not tested for HIV. From those tested, 107(73.8%) checked their status every months, 27(18.6%) checked every six month, 2(1.4%) checked every year and 9(6.2%) tested only one times in their life. Majority of sex workers 89(61%) of them are tested in the health centre, 37(25.3%) are tested in VCT campaign/tent and the rest 20(13.7%) tested in other places. Majority of sex workers tested for HIV 142(44.6%) know their result/status but 41(22.4%) do not know their status though tested for HIV. From those sex workers not tested for HIV 30(76.9%) said that they are not tested because they afraid to be positive for HIV, 4(10.3%) do not know as they have to be tested for HIV. In the survey conducted on commercial sex workers in Addis Ababa, Bahir Dar, Mekelle and Adama, it is shown that as most of FSWs are received HIV testing and counselling at least one time before (70%) (Woldemariam G. and Annabel E.CSW Survey, 2009).

In this study it is found that significant number of sex workers (60.1%) did not participated in any HIV prevention program in the community, but majority of 73(39.9%) sex workers participated in HIV prevention program. The finding indicated that those sex workers working in street and home based establishments are not participated in HIV prevention program as compared to sex workers working in Hotels and Bars.

5.4 Condom Use Pattern

Majority of sex workers 146(79.3%) reported as they use condom correctly and consistently but 38(20.7%) responded as they do not use condom correctly and consistently. Based on their place of work, sex workers working in home based establishments and streets do not use condom correctly and consistently than those sex workers working in Hotels and Bars. Only 60(32.6%) of sex workers reported as there is occasion not used condom in the last six month. It is also identified that from those respondent, 43(71.7%) of sex workers use condom with non-paying partners whereas

17(28.3%) not used condom with their non-paying partners.112 (61.2%) faced condom tear off/break previously but 71(38.8%) reported as they have never experienced condom tear off in their sex business.

The same study conducted in Addis Ababa, Bahir Dar, Mekelle and Adama also shows that as condom use by commercial sex workers was reportedly high with paying clients, but relatively low with regular partners(Woldemariam G. and Annabel E.CSW Survey, 2009). More than 99% of respondents used a condom with their most recent commercial clients and the finding is consistent with other studies of sex workers in Ethiopia (DKT, 2008)

Additionally, the study conducted in Assosa also shows that as 77% of respondents reported as they use condom always with their paying clients but is less with non-paying partner.

5.5 Risky behaviours for HIV and other STIs

From this study, majority of Sex Workers 117(63.6%) consume alcohol every day, 50(27.2%) consume alcohol once per a week and only few of them 17(9.2%) have never drink alchol. Majority of sex workers 96(52.2%) chew chat/katt every day, 60(32.6%) chew chatt/katt once or more per a week and only 28(15.2%) of them never chewed chatt/katt. Majority of sex workers do not use Shisha, only 32(17.9%) use Shisha on daily basis.

5.6 Extent of Gender Based Violence among Female Sex Workers and Responsive Actions

Majority or almost all of respondent sex workers have faced at least one or more form of Gender Based Violence. 121 (65.8%) faced physical violence, 132(71.7%) faced sexual violence, 158(85.9%) faced emotional violence. Slapping is the commonest form of physical violence 69(57%), from those facing physical violence 43(35.5%) faced intimidation and knife threatening, 37(28%) sexual action out of will (rape), 43(32.6%) forced not to use condom and 63 (47.7%) forced to unusual sexual action or position like oral sex and mal position. Majority of sex workers, who faced violence, 125(70.2%) reported their case of for police officers, 8(4.5%) took the case to the court, 14(7.9%) reported to women affairs, 7(3.9%) negotiated with perpetuator and 24(13.5%) not reported for any one. Those reported the case; their satisfaction varies from being highly satisfied to being disappointed with the response of reported officer/agency. From those not reported their case, 10(29.4%) believe that they are not reported because there is no justice at all, 9(26.5%) said they don't expect appropriate response from police officers, 5(14.7%) believe that as it is not easy to get legal service.

Female sex workers were also asked their believe about being organized and establishing associations 127(69%) of sex workers believe that as they will be benefiting if they can be organized and if there is Female Sex Workers association.

Chapter Six

Conclusion and Recommendation

6.1 Conclusion

- Commercial sex works or prostitution exists in Dessie Town and quite many young women from different ethnic group and religious affiliation are involved in this trade as a means of survival.

- Many young women are led into sex work due to adverse socio-economic and demographic factors that make them especially vulnerable to prostitution. Most notable of these are parental/spouse death, divorce, unemployment or difficult working situations, school dropout and lack of financial support for themselves and their dependents.
- Knowledge and Awareness about HIV/AIDS among sex workers was high, including awareness about the various protective options.
- Knowledge and awareness about other Sexually Transmitted Infection is limited among Female Sex Workers.
- Most sex workers were engaged in risky sexual behaviour through unprotected sex and multiple sexual relationships. Many sex workers have multiple sexual contacts with multiple partners so as frequent sexual action combined with unprotected sex will increase risk of being infected by HIV. So, sex workers are at high risk of being infected with HIV.
- Although many sex workers sought to protect themselves by using condoms, economic, psychosocial and behavioural factors among sex workers prevented consistent and sustainable use of condoms.
- Sex workers perceived that they are at a high risk and vulnerable to HIV/AIDS infection and were aware of risk reduction options. However, risky behaviour that permitted continued disease transmission still persisted among sex workers and their clients including excessive and frequent use of alcohol, not using condom correctly and consistently particularly with their non-paying regular partners and other factors.
- All of the sex workers participated in this study have faced gender based violence; it can be physical, emotional or sexual violence.

6.2 Recommendations

- The practice of prostitution is integral to the problem of the spread of STI and HIV/AIDS. Therefore, HIV and sexually transmitted infection prevention programs need to address the special needs of sex workers that drive them into risky behaviour when they are well aware of the potential risks involved.
- Sex workers' clients are men from all walks of life and are part of the general public. They are thus also at risk being infected by HIV/AIDS. There is a need to study factors that motivate these men to visit prostitutes. There is also a need to establish the knowledge, attitude and sexual behaviour of the clients related to STI and HIV/AIDS in order to come up with appropriate interventions.
- It is also necessary to provide services that address the factors undermining condom use, such as alcohol and other substance use. Sex workers with harmful alcohol use have a higher risk of HIV infection and therefore a greater need for support. Alcohol adversely affects decision-making, and the skills to negotiate condom use and use them correctly. It is possible that a reduction in alcohol use among sex workers and clients would reduce the prevalence of unprotected sex, sexual violence, HIV and other STIs.

- There is a need to incorporate efforts geared towards income generating activities in interventions among sex workers. This will, in the first instance, raise their bargaining power while negotiating for safer sex with clients. Ultimately, this will provide them with alternative income to sex work if they opt to abandon the sex trade.
- Many sex workers cannot fully benefit from the educational programs about HIV/AIDS since they are either illiterate or semi-literate or unreached. Therefore, STI and HIV/AIDS interventions among sex workers should include adult and functional literacy to improve the benefit of the target population and those areas not reached through community education need to be identified and targeted for further Information Education and Communication.

- Condoms have been observed to play a big role in reducing the risk of HIV infection among sex workers. There is a need to increase awareness on the importance of correct and consistent condom use among sex workers and their clients. There is also a need to introduce and emphasize the female condom, which does not require the cooperation of the clients since many have been reported to be reserved about using them.
- The role of peer educators as a vital human resource in passing on information and education about STD and HIV/AIDS needs to be exploited and expanded. Many sex workers are in constant contact with their peers and freely pass on information to one another, which they deem necessary for their survival.
- Comprehensive, accessible, acceptable, sustainable, high-quality, user-friendly HIV prevention program must be scaled up and adapted to different local contexts and individual needs. Essential actions include: actions to address structural barriers, including policies, legislation, and customary practices that prevent access and

utilization of appropriate HIV prevention, treatment, and care and support; policies and programmes to ensure freedom from violence, abuse, and discrimination;

- information for sex workers and their clients and others involved in the sex industry; reliable and affordable access to commodities, including high-quality male and female condoms, water-based lubricants, and contraceptives, access to voluntary HIV testing and counselling, with treatment, effective social support and care and for sex workers who test positive for HIV; access to high-quality primary health care, TB management, sexual and reproductive health services, especially sexually transmitted infection management and prevention of mother-to-child transmission; access to alcohol and drug-related harm reduction programmes.

- Sex workers are often victimized by violence, including gender-based violence, perpetrated by clients. Violence is associated with unprotected sex and heightened risk of HIV transmission. All people selling sex must be protected from violence, coercion and other forms of abuse, and be ensured of their rights to legal assistance and access to judicial and extra-judicial mechanisms. Actions to protect sex workers should include addressing clients' misuse of alcohol and consequent violence towards sex workers.
- Protection and legal service providers need to be responsive for all reported cases in a way which encourage sex workers to feel confident and protected.

- Specific education campaigns must be developed with and for clients, who can be reached not only in sex work settings but in other occupational and recreational environments. Successful service delivery strategies for clients include those focusing on truck drivers; heavy transport; business travellers; daily labourers, NGO workers, migrant workers and uniformed peoples.

- In devising strategies to reach sex worker clients, programme planners should engage sex workers, who can help identify settings where sex work occurs.

- Reaching the spouses and regular partners of clients is also important to effective HIV prevention. Prevention strategies should use sexual and reproductive health services as an entry point for HIV prevention, counselling, testing and referral services for further partner counselling and education.

- Building capacity in sex-worker networks and communities is part of a fundamental commitment to the protection, promotion and respect of the human rights of sex workers. Capacity-building includes provision of adequate funding and training for sex-worker groups to develop and sustain organizational strength and expertise to effectively communicate and share good practices with each other and externally.

- Partnerships at national, local and community levels should be strengthened to remove the barriers that sex workers face to service access and enjoyment of their human rights.
- At the community level, culturally sensitive advocacy and appropriate education efforts should be directed towards opinion leaders and law enforcement authorities

to increase support for, and the success of, HIV interventions focused on sex workers.

- Partnerships with sex workers and sex work community organizations, health professionals, technical advisors, partners, families, and communities, will facilitate meaningful participation of Sex Workers.

- All adult sex workers have the right to determine whether to remain in or leave sex work. A comprehensive package of services to facilitate expanding choices should include: meaningful alternative employment and livelihood opportunities—jobs, education for life, including literacy classes and vocational and skills training

APPENDIX A

Questionnaire

Assessment of Risk Factors (Behavioral, Structural and Biomedical) of HIV AIDS Transmission among Female Sex Workers in Dessie Town.

This questionnaire is prepared for only for Master of Social Work thesis program purpose only. The questionnaire is prepared to assess risk factors on HIV/AIDS transmission among female sex workers in Dessie Town. Your response and any information you will give us will be confidential at any stage by the entire individual who involved in this research. Therefore, we need your cooperation, consent and honest answers for all questions.

I) Socio Demographic Characteristics			
No.	**Questions**	**Coding Categories**	**Skip To**
Q1.	How old are you?	_____Years	
Q2.	Place of Work	1. Hotel 2. Bar 3. Home Based Establishments 4. On the street/ Red Lights/Moon Lights	
Q3	Educational Status	1. No schooling 2. Primary 3. Incomplete Secondary 4. Completed Secondary 5. Some College and University Courses	
Q4	Religion	1. Muslim 2. Orthodox 3. Other Christian 4. No Religion or Don't want to talk 5. Other(Specify)----------	
Q5	Ethnicity	1. Amhara 2. Oromo 3. Tigrie 4. Other(Specify)----------	
Q6	How much your parents/family earn		

	per month?	1. Below 200ETB 2. 200-500ETB 3. 500-1000ETB 4. Above 1000 ETB	
Q7	How old were you at your first sexual intercourse?	_____Years	
Q8	Marital Status	1. Never Married 2. Currently Married 3. Divorced/Separated 4. Widowed	
Q9	If married, how old were you at your first marriage?	_____Years	
Q10	For how long you lived in Dessie Town?	_____	
Q11	What were you doing before engaging into sex work?	1. Domestic Worker/ Home Assistant 2. Waitress in Hotels, Restaurant or Cafeteria 3. Daily Laborer 4. Other_____	
Q12	Why you engaged in to Sex Work?	1. Escaping abusive work 2. Following a divorce 3. Following school drop out 4. Following death of parents 5. Need to support Family	
Q13	How much do you get from sex work monthly	_____ETB	
Q14	Who was your first sexual partner?	1. Boyfriends/Fellow Students 2. Husband /Fiancé 3. Paying Client 4. 4.Othe	
Q15	How was your first sexual experience?	1. Coercion including insistence 2. Physical Force 3. Man/Boy insisted /would not take 'no' or an answer 4. Physical Force Used 5. Partner Hit/Beat you to have sex 6. Drugs/Alcohol were used to obtain sex	

Q18	How many clients do you have per a week?	_____	
Q17	How many times you have had sex with in the last week?	_____	
Q18	Total number of years worked as a sex worker	_____	
Q19	How long you are planning to stay in sex working practice	1. Less than one year 2. More than a year 3. I don't know	
Q20	Occupation of your most frequent clients?	1. Government Workers 2. Uniformed/ Police, Soldiers 3. Businessmen 4. Truck Drivers 5. Tourists/Foreigners 6. NGO Workers 7. Others 8. I don't know	
	II Knowledge, Attitude and Awareness about HIV and other STIs		
Q21	Can you tell me some signs and symptoms of STI?	1. Genital Ulcers/ Sores 2. Discourage 3. Burning Paid During Urination 4. Itching 5. Foul Smelling Discharge 6. Swelling in the Groin Area 7. Abdominal Pain	
Q22	Can you tell me what you know about HIV/AIDS?		
Q22.1	Have heard of about HIV/AIDS	1. Yes 2. No	
Q22.2	Do you think,Abstinence can reduce risk of HIV Transmission?	1. Yes 2. No	
Q22.3	Do you think, Having sex with one faithful, uninfected partner can reduce risk of HIV transmission?	1. Yes 2. No	
Q22.4	Do you think Using condom can reduce risk of HIV transmission?	1. Yes 2. No	
Q22.5	Do you think A health looking person can have HIV?	1. Yes 2. No	

Q23	Which of the following conditions do you think can transmit and can't transmit HIV?	1. Shaking hands 2. Toilets 3. Sharing Food 4. Sexual Intercourse 5. Kissing 6. Mosquito Bite 7. MTCT 8. Breast Milk	
Q24	From which source do you get information about HIV/AIDS?	1. Radio or Television 2. Reading Materials, Leaflets, Broachers, Posters.....etc 3. Health Service Provider 4. Teachers 5. Friends 6. Others	
	III Pattern of HIV Testing and Health Service Utilization		
Q25	Have you ever tested for HIV?	1. Yes 2. No	1→26.1 2→26.2
Q26.1	How frequent you have checked your status?	1. Every three months, 2. Every six months 3. Every Year 4. Only one times in life	
Q26.2	Why you have not been tested for HIV?	1. Lack of access for test service 2. Fear of being positive for HIV 3. I don't believe with its relevance 4. I don't know as I have to be tested 5. Other reason	
Q26.3	If Q26.2 is tested, Where you have been tested?	1. In health center or Clinic 2. In mobile HTC test service 3. Other place, please specify_____	
Q27	Did you know your status?	----------	
Q28	Have you ever attended any HIV prevention programme?	1. Yes 2. No	2→Q30

Q29	If yes, please describe what kind of HIV Prevention programme you attended and where you attended it?		
	III Condom Use Pattern		
Q30	Do you use condom always?	1. Yes 2. No	
Q31	Is there any condition you have not used condom while making sex in the last six months?	1. Yes 2. No	2→33
Q32	If yes, with whom	Non-paying partner_____. Paying Client _____	
Q33	Did you use condom at last sex with paying client?	1. Yes 2. No	
Q33.1	Is there any time you have not used condom with paying clients in the last 12 month?	1. Yes 2. No	
Q34	Did you use Condom at last sex with non-paying partners?	1. Yes 2. No	
Q35	Is there any condition where condom is tear-off during sexual intercourse in the last one year?	1. Yes 2. No	
	IV Alchol, Kchat and Shisha Use Patterns		
Q36	Alcohol use in the past month.	1. Every day 2. More than once a week 3. Less than once a week 4. Never Used	
Q37	Khat Use?	1. Every day 2. More than once a week 3. Less than once a week 4. Never Used	
Q38	Shisha or Other Drug Use	1. Every Day 2. More than once a week 3. Less than once a week 4. Never used	
	V Violence and Discrimination		

Q39	Have you ever faced physical violence from your clients or partners?	1. Yes 2. No	2→Q41
Q40	If yes, What type of physical violence you faced either from your regular paying or nonpaying partner?	1. Slapping or Thrown Something to hurt 2. Pushing or Shoving 3. Threatened to use or actually used a gun, knife or other weapon 4. Hit with a fist, tied up or blind folded	
	Sexual Violence		
Q41	Have you ever faced sexual violence from your clients or partners?	1. Yes 2. No	2→Q43
Q42	If yes, what type of sexual violence you faced	1. Physically forced to have sex against your will for sex 2. Offered much more money not to use condom for sex 3. Forced to do something humiliating or different sexual position against your will 4. Other type of sexual violence	
	Emotional Violence		
Q43	Have you ever faced emotional violence from your client or partner?	1. Yes 2. No	2→45
Q44	If yes, what type of emotional violence you faced.	1. Being insulted or made to feel bad about oneself. 2. Being humiliated or belittled in front of others 3. Being intimidated or scared on purpose	
Q45	What do you do for any form of violence you faced by your partner or client?	1. I reported the case for police officers 2. I took the case to the court 3. I took the case to Women Affairs 4. Personally negotiated with the perpetuator 5. Not revealed to any one	1→46 1,3,4 and 5→47

Q46	If you reported the case to any of the above, what was your feeling about the response?	1. I am highly satisfied with the response 2. I am fairly satisfied 3. I am not satisfied at all 4. I was offended	
Q47	If not revealed or reported, what was the reason not to take any action	1. Legal service not easily accessible 2. Police officers do not respond properly 3. Women Affairs don't respond properly 4. No fair judgment can be obtained 5. I don't know for whom I should report	
Q48	Is there Female Sex Workers Association working to promote human rights in the Town?	1. Yes 2. No	
Q49	If no, do you think it will be helpful for you if FSWs association/societies established?	1. Yes 2. No	
Q50	If you think that it is helpful, what kind of support you expect from the association?		

I would like to thank you for your time and patient to respond all the research questions.

Thank You Very Much!

Name of Interviewer_____ Respondent No_____

Date _____

Signature of Interviewer_____

Focus Group Discussion Questionnaire

Date _____ **Region_____**

Time_____ **Town Place._____**

Name of Interviewer_____

1) Can you tell me the possible reasons why you are engaged in Sex Work?

_____
_____
_____
_____

2) Who are most of your clients by their work type?

_____
_____
_____
_____
____

3) From which source you get information about HIV/AIDS and STI?

_____
_____
_____
_____
_____

4) What do you think about importance of using condom?

_____
_____
_____
_____

5) What precautions you take before using a condom?

_____
_____
_____
_____

6) How often you used condoms?

_____
_____
_____
_____

7)Have you heard of any problems in relation to using condoms?

_____
_____
_____
_____

8) Have you faced condom tear-off (burst) while making sex?

_____
_____
_____
_____

9) What you will do with clients who refused to use condom?

_____
_____
_____
_____

10) Have you ever thought that your present sexual behavior might lead to getting infected by HIV in the future?

_____
_____
_____
_____
_____

11) Have you ever sought for HIV/AIDS counseling and testing from anywhere?

_____
_____
_____
_____
_____

12) Do you feel that using condom can serve as a practical protective option against HIV/AIDS?

_____
_____
_____
_____

13) Have you ever faced any form of Violence from your client or partner?

_____
_____
_____
_____

14) What did you do when you face violence?

_____
_____
_____
_____

Thank You Very Much for Your Time and Information

Name of Discussant_____

Group Number_____

Date and Time_____**&**_____

Annex II

Work Plan and Budget Break Dawn

Ser.No	Activity Description	Period/Time	Estimated Budget in ETB	Remark
1	Ethical Clearance and Approval	Octo.1-5,2013	____	
2	Questionnaire Translation into Amharic, Duplication	Nov.7-10,2013	5500.00	
3	Recruitment and Training of Research Assistant/Interviewer	Nov.11-15,2013	5000.00	
4	Data Collection	Nov.15-30,2013	7000.00	
4	Data Verification and Entering to the Soft Ware (SPSS)	Dec.1-10,2013	3000.00	
5	Data Analysis and Tabulation	Dec 10-25,2013	_____	
6	Finding Discussion and Presentation	Dec.30,2013		
7	Recommendations	Jan.1-5,2013		
9	Finalization, Printing Hard Copy and Submission	April.5-15,2013	500.00	
Total Budget of the Research			**21000.00**	

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