

**Assessment of socio-cultural risks in relation to HIV transmission
in pastoralist community of Surma woreda,
SNNPR, Ethiopia**

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Declaration

I, the undersigned, declare that this is my original work, has never been presented in this or any other University and that all the source materials used for the thesis have been duly acknowledged.

Name _____

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Date of submission _____

This thesis has been submitted for examination with my approval as a University advisor;

Name _____

Signature _____

Date _____

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ABRREVATIONS

AIDS	Acquired Immune Deficiency syndrome
ARV	Antiretroviral
ASAL	Arid and Semi-Arid Land
BCC	Behavioral Change Communication
BSS	Behavioral Surveillance Survey
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
MOH	Ministry of Health
NACP	National AIDS Control Program
PLWHS	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
STI	Sexual Transmitted Infection
UNAIDS	Joint United Nations program on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
SNNPR	South Nations Nationalities Peoples Region

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ABSTRACT

Background: The magnitude and depth of HIV/AIDS impacts in sub-Saharan Africa are staggering. Over 36 million individuals are currently living with HIV/AIDS, 95% of whom are from developing countries. In the past, rates of HIV/AIDS in urban populations were greater than in rural areas; more recently, improved and expanded surveillance has shown that HIV prevalence in rural areas is lower than anticipated. Nevertheless, the differences in infection levels between rural and urban areas will be narrowed over time. The absolute number of HIV-infected persons in rural areas may equal or surpass the number in urban areas. In Ethiopia most of the studies on HIV/AIDS focused on urban centers; however, on the other hand, evidence has shown that the prevalence of HIV infection is increasing rapidly in rural areas.

Pastoralists are among the marginalized people with diverse cultures, and these cultural practices have been cited to be fueling HIV transmission in pastoralist areas. Surma is pastoralist woreda found in Bench Maji zone (SNNPR), 750km from Addis Ababa. Different socio-cultural practices are predominantly performed in the community which may facilitate HIV in the community.

Objective: This study aimed to identify socio-cultural risk factors for the transmission of HIV infection in pastoral communities of Surma woreda, SNNPR.

Methods: A cross-sectional study was conducted using quantitative method involving 447 study participants in the age range of 15-49 who are residing 18 kebeles in Surma woreda. A qualitative method was also applied involving elders, influential peoples, traditional healers and community leaders. The study was conducted from Dec 2005 to Feb 2006, in surma woreda, Bench Maji zone, SNNPR.

Results: The result of the study was based on 416 respondents who adequately responded to the questionnaire interview. Findings revealed over 88.2% of the study population were illiterate and 41.9% of married males involved causal sex during the post natal period of their wives. Over fifty two percent of respondents never heard about HIV/AIDS. 90.4% and 90.1 % of the respondents had been pierced skin and body tattooing respectively.

According to the graded risk practices score, 70.4% of participants were among the high risk while 29.6% were at low risk category. Their awareness and knowledge about HIV/AIDS was less. In addition, the identified socio-cultural practices (skin piercing, body tattooing, tooth extraction, hair shaving, traditional surgery and cultural rituals) were found to fuel the transmission among the study population. Their sexual behavior also had a grave consequence for the wide spread of HIV/AIDS. The awareness towards VCT and willingness to undergo VCT was also low.

Conclusions: The nearly created linkage, which is starting sex some of the surma people with non-endogenous people, will make the identified socio-cultural practices to play a considerable role in the transmission of HIV spread. In addition lower status of awareness and knowledge about HIV/AIDS, as well as dreadfully high illiteracy level made the study population at critical level for HIV spread. The liberal sexual practices with the recently amplifying level of alcoholism made horrible the probability of HIV spread in the community.

Recommendation: Multidisciplinary survey teams urgently need to raise local awareness and knowledge of HIV/AIDS using culturally appropriate methods, and reduce high-risk behaviors to prevent the spread of HIV.

1. BACKGROUND

The Global epidemic of the Human Immunodeficiency Virus / Acquired Immune Deficiency syndrome (HIV/AIDS) is the greatest threat to human health and development (1). The magnitude and depth of HIV/AIDS impacts in sub-Saharan Africa are staggering. Over 36 million individuals are currently living with HIV/AIDS, 95% of whom are from developing countries (2). In the past, rates of HIV/AIDS in urban populations were greater than in rural areas, although there was little difference in HIV infection rates between urban and rural infection rates in some countries (3).

More recently, improved and expanded surveillance has shown that HIV prevalence in rural areas is lower than anticipated. Nevertheless, the differences in infection levels between rural and urban areas narrowed over time. The absolute numbers of HIV infected persons in rural areas may equal or surpass the number in urban areas (4). In Ethiopia most of the studies on HIV/AIDS focused on urban centers, however, evidence on the other hand, has shown that the prevalence of HIV infection is increasing rapidly in rural areas too (5).

These facts suggest that it is very important to identify possible roots of entry and spread of HIV to the remotely situated communities. Giving due emphasis to the context, will have paramount importance to limiting the spread of the infection to the rural areas (6). Less work has been done on the role of cultural competence in the delivery of effective HIV/AIDS prevention programs. Current prevention methods often fail to address the cultural and social contexts of their target populations. Failure to consider the social and cultural ecology of the community will bring about program failure, due to poor utilization, which makes the reference to the importance of cultural sensitivity, cultural relevance, and \ or cultural competence in the delivery of prevention services and care.

Because culture shapes and influences the way people think about gender, sexuality health, and illness, a program's ability to deliver services in a culturally competent manner has serious implications for access to and quality of prevention services and care (7).

Culture should be taken into account at various levels:

- **as context** – an environment in which HIV/AIDS communication and prevention education takes place;
- **as content** – local cultural values and resources that can influence prevention education; culturally appropriate content of sensitization messages is mandatory for them to be well understood and received
- and as a **method** that enable peoples' participation, which helps to ensure that HIV/AIDS prevention and care is embedded in local cultural contexts in a stimulating and accessible way.

The low lands are best by problems of poorly developed infrastructure and communications, low population densities, and highly variable and uncertain rainfall. The back bone of the economies of these areas is, and is likely to remain in the future, extensive livestock herding. Generally, in Ethiopia pastoralist specialization may not be confined to a particular ethnic group, but rather be an adaptive feature of any group living under conditions which make extensive livestock keeping ,an effective way of utilizing natural vegetation . Because of their remoteness and distance from major population centers, infrastructure and communication are generally poorly developed. Long distance to market on poor roads impose constraints to the development of commerce and the availability and cost of grains produced in the highlands .These distances also make pastoral societies especially vulnerable to breaks in communication(8).

Ethiopia is the country with rich diversity of people and culture. Surma is one of the various ethnic groups, where cultural practices are predominately preformed and traditional forms of rules are strongly functional. They reside in the remote southwestern area of the country edging with Sudan. It is 750 Km far from Addis Ababa, the Capital city of Ethiopia. The name “suri” is a self-name used by all three groups. Neighboring tribes also refer to all three groups – Tirma, chai, Baale – as “suri” or “surma” people; the latter label apparently has some derogatory connotations, since it also refers to some type of “black lowland ant”.

Although cattle are the main source of income for the suri, they also mine gold from the tributaries of the Akobo River. A major problem for the suri is their hostile relationship with the neighboring Bume (Nyangatom), who are heavily armed because of their connections with the Southern Sudanese People’s Liberation Army (SPLA), a rebel group operating in the border area between Sudan and Ethiopia. The area inhabited by the suri is among the least developed ones in Ethiopia, because of inaccessibility, central government in the past had little control over it. They may be estimated roughly at around 60,000. The resent census made by the Ethiopian government did not cover all areas because on the inaccessibility of most of the villages.

The suri societies have a traditional practice known in certain ways. A women or girl without a lip-plate may be subject to a series of sanctions, mockery, and alienation by the community. The suri groups as patriarchal societies predominantly seem to favor members of the male sex. The attitude towards female is indicative of the women’s position in various aspects of life.

Maidenhood

Suri societies seem quite liberal towards girls during their maidenhood. Girls may be said to have complete sexual freedom in their pre-marital stage. This means that suri girls can have love affairs before they are engaged to someone. If the two men love a girl equally, they try to win the girl

through the stick fight known as donga, a fight carried out with the help of long and strong sticks. Even though a suri girl is not discouraged from having sex before marriage, she is strictly forbidden to conceive a child. In case she is pregnant, she has to immediately report the case to her parents and relatives and reveal the man who has made her pregnant. Her relatives may take all the property of the subject; even kill him unless he escapes. The case may also be settled peacefully, however, if her lover sends elderly people to negotiate for him. In that case, he will be obliged to pay the amount of bride wealth requested by her family, and he may be allowed to marry her. If the suspect runs away to save his life, and another man falls in love with the pregnant woman, he may marry her; the actual bride wealth in such instance, however, is smaller than usual. When the illegitimate child is born, the man is expected to raise it like his own son or daughter. Unlike in some other societies, an illegitimate child among the suri is well taken care of.

To avoid pregnancy during the pre-marital stage, girls make use of the menstruation period cycle. Since sexual intercourse is not a secret matter among the suri, girls are oriented and taught how to calculate and use the safest time to make love. Usually the elder girls have the obligation to teach younger ones. Pre-marital pregnancy apparently is a relatively rare phenomenon in suri society. Contrary to many other Ethiopian societies, virginity among the suri is also apparently of lesser importance.

The traditional system of the suri suggests that the time of marriage for girls be after the attainment of puberty.

Wifhood

With respect to earlier stages of the cycle, i.e during maidenhood, the suri seem to have a rather liberal attitude towards women; women are observed enjoying some freedom. But there are other times when traditions speak of rigidity withdrawing the same right at the subsequent stage. Pre and

post-marital periods are critical in this sense. In suri societies no woman enjoys freedom of extra-marital sexual relations. The women, under customary law, are supposed to be within the limit imposed by wedlock. The tradition totally disapproves extra-marital sex relationship and this applies only to women. As long as they can afford the bride wealth, men can have more wives. For a suri man keeping more than one wife is an indication of superior social and economic status.

With regard to the form of marriage, the suri are thus predominantly monogamous, combined with polygyny when economic resources permit; no polyandry is allowed however. Suri couples do not usually share a bed. This is because it is believed that men who frequently spend the night with their wives would become weak during a stick fight, the *donga*. It is assumed that sharing a bed with a woman makes a man just as weak as his female counterpart.

An extremely important aspect of suri marriage is the payment of bride wealth. Bride wealth is given and taken as part of tradition, and no marriage takes place without the payment of bride wealth. This traditional practice makes suri marriage an expensive affair. The implication of the payment of bride wealth on the life and well-being of suri women is tremendous. Since the payment of bride wealth and the lip-plate custom have a strong social and cultural nexus, a girl without a plate means, a girl devoid of her basic right to have a husband. In addition, she may be subject to mockery or alienation by the community for failing to bring the bride wealth to her parents.

Inheritance and succession

Suri women are not entitled to inherit either father's or their husband's wealth. When a woman's husband dies, her wealth, her daughter(s) as well as she herself are transferred to her eldest brother-in-law. Daughters are inherited, for they are considered sources of income when they grow up. In these societies women are, therefore, deprived of their right over the property of their parents as well as their own. Inheritance is chiefly the prerogative of men. Since the suri are patrilineal, patterns of

inheritance are gender stratified. Females do not have equal rights to the access resources of their family. Females in suri society are themselves considered commodities and subject to inheritance.

Economic activity

As stated above, pastoral horticulture forms the basic economy among the suri. Commenting on the Mursi in particular, Turton (1971:867) says: “Despite their dependence on cultivation ... the system of values and outlook of the Mursi is that of a pastoral people”. The same applies to the ethnic groups together forming the suri, i.e the Tirma, Chai, and Baale, although cattle is less common among the latter because part of their country is infested by tsetse flies. They do not believe in surplus, or at least they are not conscious about it. Paradoxically, they do believe, that one can never have enough cattle. This is because for them cattle constitutes more than a means of subsistence, they are the ultimate store of value and status symbols.

In suri economic life, women contribute a great deal. They shoulder the bulk of the responsibilities associated with children and the household child rearing, food preparation, and care of the domicile. They are also responsible for growing food or cultivation. Men’s participation in such takes is almost nil. Suri men generally involve in extra-domestic work tasks, e.g looking after the cattle plus additional activities such as hunting and gold-mining. In fact, suri men seem to spend most of their time relaxing and gossiping. Their indolent nature is attributed to the excessive use of **geso**, a kind of locally prepared liquor.

Traditional believes

In suri societies, as in many other societies, there are specialists, **K’ayi**, who are believed to be helpful in adverse circumstances. They are believed by most people to have links with the

supernatural world. The involvement of women in this aspect of traditional belief among the suri is not restrained; the right of being **K'ayi** is rather equally open to both men and women.

The same is true for people forecasting the future by reading the intestine of a slaughtered ox. They foretell when and in what direction cattle raiders from neighboring ethnic groups will come, drought, or any other danger that the society is supposed to face in the future (9).

It Bordered with Bero woreda North and North West, Dizi woreda East, Sudan West and South. They are purely sedentary pastoralists in Bench Maji zone. They are among the least developed community in the country with poorly constructed road, minimal infrastructures and greatly separated with other part of the zone community for marketing.

The Surma live primarily on a diet of milk and blood, seasonally supplemented by maize and millet. An arrow is shot quarter of an inch into the jugular vein of the young heifer to obtain just enough blood to fill a calabash. The animal never killed; instead the wound is sutured with a compress of wet mud. Young boys drink blood to grow and men to gain strength (10).

According to the data from woreda Administrative council the population is expected to be around 55,300. There is one nearly built Health center which is not fully functioned for the reason of the people not used it; instead they use traditional healers for their health problems. It is not also central for the people. There is one boarding school at kibish which serves elementary (cycle one) students. There is “Surma rehabilitation project” involved in health, agriculture and water development activities run by Ethiopia Evangelical Church Mekanyesuse South West Betel in collaboration with concerned governmental organizations. The office of the project is at Tulgit 18 km before kibish.

The project leaders are Protestants, and they side by side of the project activities, expands their religion in the area .Surma people who are around tulgit are almost become their followers and

changed their traditional religion to Christian. Some of the surma peoples also start to restrict themselves from the usual social norms like drinking local alcohol, premarital sex, extramarital sex, skin piercing and body tattooing and the like.

Dimma is one of the neighboring woreda of Gambela region found along the road to surma, which Surma people use to exchange gold and other goods with non-suri community. It is known by economic center as it serves for the nearby woredas to exchange different goods including gold. Traditional Gold mining is produced in the adjoining woredas (Surma, Bero, Dizi and Dimma). There is Sudan refugee camp at the edge of Dimma , which has an input for the market by bringing their rations of oil and wheat to the market. Due to its warm exchange nature it attracts different people from different part of the country. Sex workers are largely present. The trade of local alcohol (Areki) is highly practiced in this area, which brought from other part of the country. This local alcohol also distributes to the farthest rural part of the near by woredas including surma.

This study, therefore, meant to assess factors contributing to the spread of HIV in the remotely situated communities of Surma woreda, SNNPR. Furthermore, the study attempted to explore the socio-cultural attributes, which put the communities at augmented risk of contracting HIV infection. The outcome of this study would provide baseline information related to the possible roots of HIV spread in the Surma woreda to local and regional planners for designing appropriate control programs. It also helps policy makers to devise feasible strategy for evidence based decision in such complex and resource scarce part of the country.

2. LIETRATURE REVIEW

The AIDS epidemic is exceptional, it is required an exceptional response that remains flexible, creative, energetic and vigilant (11). At the beginning of the 21st century, AIDS is the number one cause of death in Africa and forth globally. Emerging just 20 years ago, few would have predicted the current state of the epidemic, particularly in sub-Saharan Africa. That over 30% of adults would be living with HIV/AIDS in any country was unthinkable. Yet this is the current situation in four countries, at least one out of five adult are living with HIV/AIDS and in an additional six sub-Saharan countries, one out of ten adult is HIV positive (12).

HIV/AIDS was initially perceived mainly as a health problem; today both the short-and long term social and economic development impact of HIV/AIDS are increasingly recognized, leading development agencies to regard the AIDS pandemic as an important cross-sectional development issue (13).

Sub-Saharan Africa has the world's highest prevalence and faces the greatest demographic impact. In the worst affected countries of eastern and southern Africa, if current infection rates continue and there is no large-scale treatment programme, up to 60% of today's 15-year-olds will not reach their 60th birthday. The stark differences in access to antiretroviral treatment are reflected in mortality rates. In low- and middle-income countries, such rates among 15-49 year olds are now up to 20 times greater than death rates for people living with HIV in industrialized countries (14).

Assuming that each HIV/AIDS cases directly influences the live of four individuals, the disease is affecting a total of more than 150 million people. Sub-Saharan Africa is the region most affected, where HIV/AIDS is now that areas leading cause of adult morbidity and mortality. Most, if not all,

of the 25 million people in sub-Saharan Africa who are living with HIV/AIDS will have died by the year 2020, in addition to the 13.7 million Africans already claimed by the epidemic (2).

HIV was first detected in Ethiopia in 1984 in stored sera. The first two AIDS cases were reported to the federal ministry of health Ministry of Health (MOH) in 1986. HIV/AIDS surveillance activities began in 1989 and since then HIV epidemic appears to have steadily increased in Ethiopia. There are many cultural factors that promote the spread of disease. Known risk factors including the presence of sexually transmitted infections (STIs), multi-sexual partner, and harmful traditional practices such as female genital mutilation, uvelectomy, blood letting, skin cutting, and piercing practices (15).

The 2003 estimate of People Living with HIV/AIDS (PLWHS) is 1.5 million. If it continues unchecked, HIV/AIDS will alter the trajectory of the country's development by retarding growth, weakening human capital, discouraging investment, exacerbating poverty and inequality, and leaving the next generation increasingly vulnerable to the impact of the epidemic. For this reason, HIV/AIDS cannot be viewed as merely one among many competing priorities in the nation's development. Investing adequately in the HIV/AIDS prevention is now a precondition for virtually all other development investment to succeed. Ethiopia future depends on addressing the epidemic forcefully and fast (16).

The role of the African culture, values and practices in relation to the fight against HIV/AIDS constantly came in to discussions. It was said that the African society is closely woven to culture and traditions, which influence people's daily life in attitudes and behavior. Within the African culture context, decision made and actions taken are significant to the person. Culture is the glue that binds members of communities together (2). Traditional influences may be stronger within rural areas, where village chiefs and traditional healers seem to have greater authority (17).

Identifying the underlying sociological factor that contributes to the spread of this disease will be a positive step forward in leading on effective HIV/AIDS intervention campaign “Although it is unrealistic to expect to alter the underlying socioeconomic context quickly, understanding its nature and influences on local pattern of sexual behavior should aid development of more relevant and, therefore more effective HIV prevention strategies.” (2)

In the past, rate of HIV/AIDS in urban populations were greater than in rural areas, although that gap is narrowing. No longer can HIV/AIDS be regarded as mainly an urban-centered disease. Two out of every three Africans live in rural areas. Since the mid-1980s, rural communities in eastern and central Africa have been increasingly affected by HIV/AIDS (18). Most of the few reports available discuss impact in terms of HIV/AIDS spreading within pastoral communities (19).

PASTORAL LIVELIHOOD

Groups who live on the margins of society exist in every country, although they differ from place to place. One among the group of the society is the pastoral community. Over the past decade, HIV has emerged as one of the lead threats to the productive sectors of the economy (20). Pastoralism is the production systems in which 50% or more of gross household revenue comes directly or indirectly from livestock or livestock related activities (4).

Three broad categories of pastoralist practice were identified, urban pastoralism, Sedentarised pastoralism and Nomadic pastoralism. Sedentarised and urbanized pastoralism have both sprung from the nomadic pastoralism in response to challenges pastoralist communities. Africa is a home to about 50% of the estimated 30-40 million paternalists worldwide, despite the perceived low potential of Arid and Semi-Arid Land (ASAL) areas, they account for 59% of all domestic ruminants in Africa (20).

The pastoral areas of Ethiopia are generally endowed with enormous economic potentials, although these is yet undeveloped (21). Pastoralist communities are becoming integrated in to the mainstreaming economic system. Where as previously they produced only for subsistence and limited batter needs, pastoralist today is producing more and more for the market. More importantly the HIV/AIDS is links to the market, often through urbanized kin, are the basis for the establishment of social links that may culminate in sexual contact. Monitoring data with in pastoral districts indicates HIV prevalence 5.56 (2003) from who had gone to health centers for other medical complaint and anti-natal care (20).

DHS in 17 African countries shows that about one-third of married women are co-wives. Example in Tanzania, Uganda, Kenya and Zambia (28%, 34%, 23%, and 18%) of women are in a polygamous union respectively. The norm regulating widow's re-marriage and sexual behavior may affect infection risks of both men and women (22)

According to the Kenya, Demographic Health Survey (DHS) of 2003, that rate of HIV awareness among the reproductive group in society was approaching 100%. However, field data collected from households for this study found that among the pastoral communities enumerated, the awareness rate is only at 79.5%. There was a wide disparity in awareness rate across districts. Wajir 83.7%, Marsabit 62.1%, and Naiad 90.4%. The lower than national average and the disparities across districts can be attributed in part to center- periphery models of information flow (20).

Ethiopia DHS 2000 result shows that knowledge of AIDS is very high, with women some what less likely to have heard of the infection than men (85% and 96%, respectively). In addition, three in four women and nine in ten men behave there is a way to avoid getting AIDS. At the same study knowledge of AIDS in Afar region were 67% and 89.7% for women and men respectively (14).

Among the married pastoralist 26.7% had polygamous marriage and 17.7% were able to name all three major HIV preventive methods. The three most common misconceptions were that HIV could be contracted by eating uncooked egg from chicken that had swallowed a condom 92.3%, by eating raw meat prepared by a person infected with HIV 66.4% and mosquito bites 54.2%. These misconceptions lowered the comprehensive knowledge level of the respondent. Only 11.7% of male and 9.1% of female pastoralist were considered to have comprehensive knowledge. Most pastoralists 84.6% had heard of male condoms. Of those who were aware that male condoms existed, considerable proportions 87.9% knew where they could obtain male condoms. Only 13.5% of pastoralists were aware of the existence of female condoms (23).

On average the pastoralist had been 17.4 years old, at sexual debut. Amongst those who were sexually active, 22.6% of pastoralists reported having had more than one sexual partner during the previous 12 months. Amongst the respondent who was married, 15.7% of pastoralists reported having extra marital sex during the previous 12 months

The qualitative study result of BSS shows that almost 50% of pastoralist (discussant and interviewees) had basic knowledge of HIV prevention. The most frequently method modes of transmission were sexual intercourse and the use of contaminated sharps (23). Another feature of the HIV/AIDS epidemic is that its impact may be observed only when the epidemic reaches the mortality stage of AIDS, with people dying in large numbers. It is therefore important to design measures that allow the prediction of the impact of the epidemic in the future as well as in the present (24).

3. OBJECTIVES

General objective

To identify the socio-cultural risk factors related to transmission of HIV among the pastoralist community of Surma woreda, SNNPR.

Specific objectives

- To determine the awareness and knowledge of the Surma population about HIV/AIDS and its transmission.
- To identify the socio-cultural factors that exacerbates the risk of HIV/AIDS transmission among the study population
- To indicate sexual behaviors that increase the risk of HIV transmission among the study population.
- To indicate level of the awareness about VCT and willingness to use the service.

4. Methodology

Study area

The study was conducted in Bench maji zone, Surma woreda, which is one of the 104 woredas in SNNPR.

Study design

This was a descriptive cross-sectional study with the purpose of finding out the various community risks and socio-cultural factors that exacerbate the transmission of HIV/AIDS. The study employed both quantitative and qualitative methods. Quantitative data was collected with a structured questionnaire. Data on socio-cultural profile of the study population were collected using Qualitative approach.

Study population

All adults of both sexes, whose ages were 15-49 and currently living in the woreda, were enrolled for quantitative study and influential peoples and community leaders, as well as community representatives, were participated in the qualitative part of the study.

Sample size determination

The study unit were selected from the source population .The proportion of those with high-risk practice such as extra marital sex 15.7% for pastoral populations were used to calculate sample size based on single population proportion: - (20).

Expected prevalence (p) = 15.7%

$Z_{\alpha/2}$ = reliable coefficient (1.96), corresponding the 95% confidence interval

Margin of error (d) = 5%

Design effect = 2

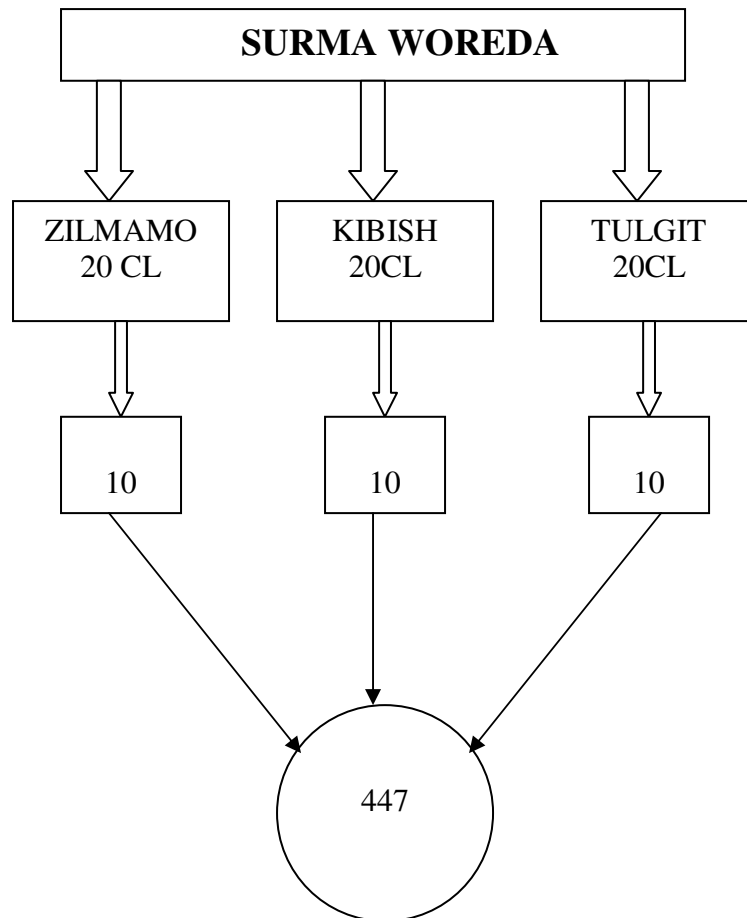
Non response rate = 10 %

The sample size determination- using estimator of single population proportion was: -

$$n = \frac{(z\alpha/2)^2 p (1-p)}{d^2} = \frac{(1.96)^2 \times (0.157 \times 0.843)}{(0.05)^2} = 203$$

Then $203 \times 2 = 406 + 10\%$ (non-response rate) = 447

Sampling procedure and Technique



Due to scattered settlement of the population, it was difficult to reach all kebeles in the woreda. But, based on accessibility and their populated settlements, three geographically known areas were selected for the study. The total study population was allocated to each group proportionally. Then twenty representative cluster points from each group of cluster were identified through discussion

with community leaders and elders. From twenty clusters ten sub-clusters were selected randomly and the number of household were allocating for each sub-clusters.

Each cluster data collection was started with the one closest to the point in the direction randomly decided by throwing a pencil. With the proximity of the beginning, the allocated numbers of households were enrolled in the study. Then, from each selected households an individual, irrespective of sex, in the age range of 15 – 49 were selected with lottery method.

VARIABLES: - Independent- socio-demographic factors (age, sex, marital status, mobility, income status, awareness and Knowledge about HIV/AIDS and VCT)

- Dependent- Risk practices (premarital sex, extra marital sex, skin piercing, body tattooing, wife-inheritance and tooth extraction)

DATA COLLECTION PROCRDURES

For the quantitative household survey, a closed-ended structured questionnaire was used. This was administered to the respondents using trained enumerators who are of 10th grade students'. They also can speak both surma and Amharic languages. Standard questionnaires were used to develop the questionnaire and the necessary adoption was made in order to address important variables of the study, and it was pre-tested on 30 individuals with similar set-up.

The qualitative part of the study: - FGD and in- depth interview before the survey were conducted in order to generate more detail information about socio - cultural risks, which could have a role in the transmission of HIV (skin piercing, body tattooing, wife-inheritance, tooth extraction, traditional surgery). A semi-structured interview guide containing questions to explore socio- cultural risks in

relation to HIV transmission designed in English and translated in to Amharic was used by the principal investigator to conduct the FGD and key informants' interview.

FGD: - There were 6 FGD groups with eight FGD discussants. Effort was made to make the group homogeneous in terms of sex, because both sexes are not allowed to discuss sexual issues together due to the cultural reason. The principal investigator with the help of translator moderated the FGD and in-depth interview. Non-probability purposeful sampling was employed to select potential participants; this was made possible by snow ball sampling technique, where the community leaders suggest the name of the individual who could be relevant source of information. Probing questions approach were arranged to introduce new ideas and tape was used to record the discussion.

Individual in-depth interview: - Individual informants from the study community were interviewed using in-depth interview technique to generate detailed information for some sensitive issues on sexuality and general background information about the community. The investigator conducted the interview based on the prepared guideline with the help of translator. The main idea was written and all interviews were recorded by tape recorder. The interviews were continued until information redundancy is observed.

The questionnaires for both study methods were made by selecting and adopting relevant and standard questions from UNAIDS, John Hopkins Blooming school, HIV/AIDS program evaluation, Kenya impact of HIV/AIDS in pastoralist communities study questionnaires, and from thesis research papers submitted to Department of community health, Addis Ababa University (20,25,26,27).

OPERATIONAL DEFINITION

1. Culture – The complex whole includes, knowledge, beliefs, art, moral, law custom and any other capabilities acquired by man as a member of a society.
2. Social - norm – A role or standard of behavior defined by a shared expectations of two or more people regarding what behaviors is to be considered socially acceptable
3. Socio-cultural risks – adverse out come for traditional practices that may contribute to the transmission and spread of HIV/AIDS.(Polygamous, Wife-inheritance, skin piercing ,body tattooing, surgery done by traditional healers etc)
4. Pastoralist- People who are primarily rising and depending on livestock and their products as their source of food and income
5. Risk practices- any activities or practices performed individually and\or publicly, which they have an a role in the transmission of HIV/AIDS
6. Knowledge about HIV/AIDS -respondents were considered to be knowledgeable about HIV/AIDS, if they identified at least one from transmission and\or prevention methods of HIV/AIDS
7. SAGINE - is an art form that allows young men to take part in competition of strength and masculinity, earn honor among their peers and win the hands of girls in marriage without serious risk of death.
8. MOON TIME PLAY - it is a custom ceremony prepared by girls at the time of harvesting to play with their friends of both sexes and to publicize the lip pierced girls after two years .

DATA ANALYSIS

Quantitative data analysis was made based on the 416 complete responses, which made the response rate 93.1%, excluding 31 incomplete and inconsistently filled questionnaires from 447 calculated sample size.

Quantitative data was entered using statistical package Epi-6 software and exported to SPSS version 11 and analyzed. Descriptive statistic was used to summarize the frequency and distribution of the variables across different categories. These are presented through tables, to summarize the data. Analytical statistics to test the association between independent variables and dependent variables odds ratio at 95% confidence interval was done. The qualitative study comprises a total of 6 FGD. There were 3 male and 3 female, married and unmarried groups of FGD discussants above the age of 18. There were also 3 in-depth interviews. The interviews and discussions were conducted in local language facilitated by a translator who speaks both Amharic and the Surma language. This has made the participants to interact actively in the discussion and to express their ideas without reservation.

Qualitative data was analyzed manually through the process of summarizing, categorizing and direct quoting.

Ethical consideration

Before the fieldwork, ethical clearance was obtained from The Ethical Committee of the Faculty of Medicine of Addis Ababa University. Then the concerned officials from regional level were communicated through formal letter from Department of Community Health, Faculty of Medicine, and Addis Ababa University. Official permission and supportive letter was secured from the regional

and local authorities. Informed consent was obtained prior to the individual's interview and the respondents were participated based on their willingness. The participants were assured that they would not face any problem and, privacy and confidentiality was maintained throughout the study period.

Dissemination of results

The final result report of this study will be available for the population of the study area, for decision makers and interested bodies of the study area through the zonal HAPCO and the zonal administration office. To other regional and national decision makers and interested bodies the result will be made available at the department of community health, faculty of medicine of Addis Ababa University. Efforts will be made to communicate the final result to the wider readers through publishing.

5. RESULTS

5.1 socio-demographic profiles of the study subjects

Of the total 416 respondents, 269 (64.7%) were males and 147 (35.3%) were females. 143 (34.4%) of the respondents don't know their age. From the respondents who know their age 52 (12.5%) and 51(12.3%) were in the age range of 40-44 and 15-19 years (Table 1) The dominant ethnic group were Tirma 198 (47.6%) followed by Chi 166 (39.9%) and 52 from Balize.72(17.3%) of the respondents were Christian while 344(82.2%) were local believers. Concerning to marital status, 312 (75.0%) were married, while 100 (24.0%) and 4 (1.0%) were single and widowed. The educational status of the study subjects 367 (88.3%) were illiterate (unable to read and write) while the rest 49 (11.8%) were literate.

Table 1- Socio -demographic background of the study subjects in Surma woreda,
SNNPR, January 2006. (n = 416)

Variables		Number	Percentage
Sex	Male	269	64.7
	Female	147	35.3
Age	15-19	51	12.2
	20-24	40	9.6
	25-29	47	11.3
	30-34	22	5.3
	35-39	39	9.4
	40-44	52	12.5
	45-49	22	5.3
	Don't know	143	34.4
Ethnicity	Tirma	198	47.6
	Chi	166	39.9
	Balize	52	12.5
Religion	Traditional (local) believers	344	82.7
	Christian	72	17.3
Marital status	Married	312	75.0
	Single	100	24.0
	Widowed	4	1.0
Educational status	Illiterate	367	88.2
	Read and write	17	4.1
	Grade 1-6	27	6.5
	Grade 7-10	5	1.2

5.2 Mobility and participants' sexual experience

A total of 321 (77.3%) study subjects reported that they have temporarily changed their original residence over the last five years. Usually, surma's mobility differs according to the reason which triggers the mobility. If the mobility is for search of grazing land for their cattle, one of the family members responsible for herding would move with the cattle with in the wereda where grazing land is available. If it is due to the conflict of enemies, all the family members would move towards enemy free areas in the woreda temporarily. When the condition settles, they return back to their permanent residence. The last case is the only condition which all members of the community move.

Other reason for movement is as trader to exchange materials to and from the neighboring weredas. Which may have an implication for making an interaction with non-indigenous people including sexual relation, in turn may play as a bridge for the transmission of STI. Reason of the study population who were temporarily changed their permanent residence were 206 (64.8%) as pastoralist, moving in search of grazing lands for their cattle, 87 (27.2%) due to conflict and 25 (7.9%) as trader. In relation to reported duration of stay out of their permanent residence, 136 (42.6%) were more than a year, 92 (28.2%) were 3-6 months, 54 (16.9%) and 37 (11.6%) were less than three months and 6-12 months respectively (Table 2).

The respondents were asked for spending night for the last three months in the location other than their house hold while they are available in their permanent residence. 200 (36.3%) respondents had spent the night as pastoralist, 143 (25.9%) due to conflict and 116 (21.1%) were spent night to pass the night with co-wife\friends . The frequent area for spending the night in location other than home were 278 (86.3%) with in the territory of Surma woreda, while the rest 44 (13.7%) were with in the urban and sub-urban centers of the neighboring woredas.

Respondent practice of sex during their last night spent out of home were assessed and 152 (57.6%) of the respondents were engaged either casual sex or their co-wife\friends.

Table 2 Mobility pattern of respondents and their risk sexual practices Surma woreda,

SNNPR, January 2006.

VARIABLES	NUMBER	PERCENTAGE
Temporary change of residence area over the last five years (n = 415)		
Yes	321	77.3
No	94	22.7
Reasons for temporary change of residence over the last five years (n=318)		
As pastoralist	206	64.8
Due to conflict	87	27.4
As trader	25	7.9
Ever spent nights out of home over the last three months (n=416)		
Yes	262	63.0
No	154	37.0
Reasons for night spent over the last three months		
Looking after cattle	200	36.3
Due to conflict	143	25.9
To get co-wife\friends	116	21.1
As a trader	92	16.7
Frequent area of night spent (n= 322)		
With in rural & urban territory of surma	278	86.3
Urban & sub-urban centers of neighboring woredas	44	13.7
Ever engaged in sex during recent night spent out of home (n=264)		
Yes	152	57.6
No	112	42.4

5.3 Marriage, postpartum abstinence and extra-marital sex practices.

97 (94.1%) of female respondents reported that their marriage were arranged with family permission, and, the remaining 6 (5.8%) were abducted. Out of the total 213 married males, 118(55.3%) were in polygamous relationship (Table 3).

Regarding to the practice of postpartum abstinence, out of 103 married mothers 77 (74.8%) reported that they practiced sexual abstinence after they gave birth. The duration of postpartum abstinence ranges from 2 months up to more than 6 months. However, most married male respondents reported that they did not have sex with the delivered wife but, not complete abstinence. From 213 married male respondents 172 (96.1%) of male partners reported that they usually did not abstain from having sex when their wives gave birth, rather they mentioned options of sexual experiences, the rest 41(19.2%) abstain 2 to 6 months .Among non-abstained husbands 100 (58.1%) had co-wives and the rest 72 (41.9%) involved in casual sex.

In relation to wife inheritance, 378 of the respondents heard about wife-inheritance and, 316 (83.6%) reported that it is a common practice in the woreda (Table 3).

Qualitative result on Socio-cultural norms linked to marriage, sexual practices and risk of HIV \ AIDS

Pre-marital sex

All discussants of both sexes are agreed that premarital sex is free to unmarried girls with both engaged and bachelor males. Most of males and females started sex at the age of middle puberty. Most discussant believed that both sexes have pre-marital sexual freedom until marriage but pregnancy before marriage is socially condemned. If it happens, it may result in assassination of the one whom impregnate the girl unless managed with the traditional way of social rules with the parents of the girl. One of the discussants said: *“The main reason why girls perform per-marital sex*

is to bring high pride price for her parents all the way through competition between males who want her for marriage". Some discussant said parents also encourage girls to have relation with males in order to urge her towards marriage if they consider she is late for. They thought that if the girl did not marry on time, she might remain single and the parents would not get the pride price. Most girls knew the natural method of family planning which prevents them from pre-marital pregnancy. It is not usual to have sex with non-indigenous people for both sexes, especially for females.

Some discussants stated that, due to trading across the woreda like Dimma (woreda of Gambela region) and working at the gold mining area at the neighboring woredas, some person of both sexes started to have sex with non-indigenous people, especially after alcohol intake. The other point which most of the discussant raised is that, the alarming increase trade of local alcohol (Areki) in most parts of the woreda, which would facilitate the pre-marital sex even with non-surma people. Mostly a girl can have one boy friend before marriage that may or may not marry her. However, in addition, if she is interested to have one who is famous with local cultural games like Sagine, she can have more.

Marriage, wife-inheritance, abduction and polygamy

All discussants believed that marriage is basically based on the capacity to pay the bride price. Most males are married at the age above twenty years, which he can earn cattle for bride price. Females are married at late puberty. Most marriages are arranged by family consent. There are different marriages styles in surma community. Of which all the discussant agreed on is polygamy. It is considered as very indispensable matter to build extended family. This in turn is also believed to make them famous and popular in the community. One male discussant said that: *"If you have no extended family, you will be always under your opponent"*. For such reason, most male discussants believed that having many wives is essential, as far as one can pay the bride price.

It is believed that extended family is the only option to live safe and sound in surma community. Females also support polygamy too. One female discussant said that: *“It is good to have many wives to my husband, because we will help each other in works and we will have many children, of which daughters will bring us cattle through bride price and boys will keep the cattle”*.

The other form of marriage is wife- inheritance: -. The reason for this practice is to grow-up one's brother's children as well as to look after the properties of the deceased. The younger brother, who may be married or single, is accountable to inherit the older brother's wife. Most of the discussant said that they did not consider HIV as a problem regarding to wife- inheritance, because they thought that it is not prevailing in the area.

The other mode of marriage which is not common in the community is abduction. It sometimes occurred with the agreement of both sexes if the parents are not voluntary to allow the marriage. Most discussant agreed that most of the abduction performed, if the relatives had blood shade as compensation, instead of taking retribution.

Regarding to the post delivery abstinence, all married male discussants stated that usually wouldn't have sex at the time of post delivery period of their wives, but they do have alternatives, like to have sex with co-wives, unmarried regular partner and casual sex. Females' discussants also shared the reality of the aforementioned practice.

Table -3 Marriages, postpartum abstinence and risk of extra-marital sexual Practices.

Surma woreda, SNNPR, January, 2006.

Variables	Frequency	Percentage
Marital status (n=416)		
Ever married	316	76.0
Never married	100	24.0
Marriage modalities(n=213males)		
polygamous	118	55.3
Monogamous	95	44.6
Types of marriage arrangement(n=103)		
Family consent	97	94.1
Abduction	6	5.8
Duration of mothers postpartum abstinence(n=77)		
> 2 months	8	10.4
2-6 months	41	53.2
> 6 months	28	36.4
Husbands' practice of sexual abstinence during wife postpartum period(n=213)		
Yes	41	19.2
No	172	80.8
Husbands' sexual option during postpartum period (n=172)		
Co-wife	100	58.1
Causal sex	72	41.9

5.4 Traditional rituals “Sagine” and “MOON TIME PLAY” and participants experience during the Ceremony

The study attempts to investigate the experience of study participants in specific cultural rituals such as “sagine” and “moon time play” and their role on promoting casual sex. Sagine is two types: Among both the surma and mursi a single - combat sport of physical skill, known as donga (stick fighting), has evolved in to something of an art form that allows young men to take part in competitions of strength and masculinity, earn honor among their peers and win the hands of girls in marriage without serious risk of death.

Surrounded by cheering spectators, the duelist – swathed in protective clothing-measures up to each other in specially prepared clearings. Each contestant is armed with a hard wood pole, carved in to a phallus shape at the tip, about six feet in length and weighing just under two pounds. In the attacking position, this pole is gripped at its base with both hands, the left above the right, to give maximum swing and leverage. Each player lands as many blows as possible upon his adversary, the object of the exercise being to knock him down and completely eliminate him from the game. Sever injuries are often inflicted, but the referee usually intervenes before a fatal blow is delivered.

If a fighter kills his opponent, he and his family are banished from the village, his property is confiscated and if he or his family has a daughter she may be given to the victim’s relatives as compensation. Selected from the two warrior age grades, players are generally unmarried men between sixteen and thirty-two years old and represent local “team”. Often as many as fifty people will compete, and all of them get the chance to fight at least once. At the end of every bout, however, the loser must accept his defeat gracefully and withdraw while the winner goes on to face another

winner. In this way the field eventually narrows down to just two surviving contestants, one of whom will emerge not only as the victor of the last bout but also of the contest as a whole. The winner is borne away on a platform of poles to a group of girls waiting to the side of the arena who decided among themselves which of them will ask for his hand in marriage. Taking part in the donga stick fight is considered to be more important than winning it. Thus even if he was knocked out early in the contest, a brave and determined duelist will still be heaped with honor. He will marry in the usual way – that is by choosing his own wife to be and offering her father the required bride price for her hand (10).

The other type of the game is carried out to separate the winner, if two males want one girl to marry. The one who wins the fight will be able to marry the girl. This game is also organized and judged by community leaders of the area. It is an occasion when friends get chance to meet each other and can do whatever they like. Others who need friend or casual sex also use this occasion. Because of its recognized and popular game in the community all community members are allowed to attend regardless of age and sex, which create a favorable condition for casual sex.

Of the study subjects 396 (95.2%) of the respondents were attend during the “sagine” play. The respondent commonest practice during the cultural play (Sagine) were watching passively 275 (70.0%), searching age mate of different sex 87(22.1%), while 31 (7.9%) of the respondents replied that they attend the ceremony to search of opposite sex for their temporal sexual desire on the time.

The frequency of organizing the “SAGINE” ranges from one to more than eight times in three months (Table 4).

Discussants of both sexes deeply discussed upon “SAGINE” and “MOON TIME PLAY”. All male discussants supposed that being famous is the only way in surma to live unaffected and respected by any of the community member. The discussant stated that “SAGINE” is a mass stick game which would be judged by elders. The game is accomplished in group of families performed by males only.

The girls of Surma are celebrating their own special day. The traditional annual ceremony prepared during the time of harvesting by girls (sede). It is called moon time play. In the evening they will gather at the playing field for singing, dancing, laughing which is practiced in surma. The girls are free from their regular daily routines work. The moon time play gives the girls a chance to entertain themselves in private, without interference from their parents or male relatives. The female discussants said, “*We prepare this occasion to play each other with our boy friends and to publicize the lip pierced girls who were pierced two years back*”. They stated that this is the most appropriate time to get boy friends and to enjoy with them. It is a night time play, and any interested person can participate regardless of marital status. Mostly youngsters are the main participants. After play or during play, if two couples agree each other, they can have a sex hiding themselves from their relatives.

Traditional Cultural practices, and risk of HIV/AIDS transmission

Tooth extraction

It is one of the common traditional practices in surma .Children at the age of six to seven are to be extracted two front lower teeth .For the community professed that it would be difficult to get opening to feed the children if they are critically ill. Females are totally extracted four front lower teeth, two during child hood and two before lip piercing at puberty for the preparation of marriage.

Both male and female discussants told about the procedure that it is done in mass with a single metal pin- pointed material by the traditional healer known by the community.

Skin piercing

The Surma and the Mursi are part of the small remaining group of people anywhere in the world whose women still wear lip plates and, these have a function that is almost purely symbolic. There are several theories as to why the use of lip plates was first adopted: perhaps to discourage slaves looking for unblemished girls; or perhaps to prevent evil from entering the body by the way of the mouth (since people believe that evil penetrates the body through its orifices), or to indicate the number of cattle required by the wearer's family for her hand in marriage. Today it is the third of these theories that is the one seen in practical use. In her early twenties a woman's lower lip will be pierced and then progressively stretched over the period of a year-the size of the lip plate determining the size of the bride price (10).

It is extremely familiar practice in surma community. It is a practice done for both sexes. Males are pierced only their ears with thorn while females both ears and lower lip with pinpointed and both sided sharpen small knife. Lip piercing is one of the most perilous practices for HIV spread. Female discussant, who is expert in skin piercing, told that: *“Skin piercing is done to make the girls to be beautiful and bring high bride price to her parents. She stated the procedure, when the girls are considered they are at the age of marriage ,most of them prepared themselves for marriage, She also added that if the girls were not prepared at the considered age of marriage, parents push them to prepare themselves for marriage by having their lip pierced”*.

The main sign of marriage preparation is lip piercing. All the girls who are standing by for lip piercing gather at some place and pierced in mass with a small both side sharpened knife. After being pierced their lip, small rounded material made of wood or metal will be inserted in the hole. The hole will be increased gradually by inserting different sized material date-to-date until reaches the desired size. It can be enlarged to the size to put large plate of clay. All the discussant of both sex agreed that the larger the hole of the lip results the high bride price would be.

Body tattooing

It is the traditional practice performed for both sexes, for the reason to decorate the tattooed surface of the body painting with different colors made from soil. It is mostly done at the upper arm, chest and abdominal surface of the body. One discussant told about tattooing: *“It is must in surma community, for it is one of our identification. If a man dies without tattooing, his skin should be cut by blade before buried .It is also used to stimulate sexual desire when touching and sensing the rough part of the body”*. Regarding to body tattooing female discussant also said, *“If a female is not decorated, males are not interested to play with such girls. Some males even discourage them by asking, if they are not surma girls. Why you are different from others? So having body tattooing is important to be accepted by males too”*. All discussant agreed on the performance that it is done in mass by a person who had the experience, using blade and thorn. Picking up the skin with the help of thorn and cut by blade with different designs. They use one blade for many people and until it become blunt.

Bone setting

Another traditional practice done in the community is traditional bone setting. It is a practice which takes place during bone fracture due to stick fight and war. With the use of both side sharpened small knife. The practitioner incises the skin and underline muscle until he gets the fractured part of the bone. Then he removes the fragmented part of the bone and aligns the bone in to the natural

position, and closes as it was before incision .Medications made of different part of plants applied on top of the skin and tied with supportive sticks. Most discussant said that these people saved a lot of people's lives with the application of such skills. The practitioner also stated the practice would be performed in mass in the occasions of mass stick fight like sagine and during war with people at the border of Sudan.

Hair shaving

The surma hair shaving style is the most popular type of practice. It is done by the family member who had the experience to do so. They frequently have their hair shaved with different styles. They also used one blade for many people. One discussant said about their utilization of blade in community "*We never dispose blade unless it is dull*".

Table-4 Traditional ritual “SAGINE” and participants experience during the ceremony
in Surma woreda, SNNPR, January 2006.

Variables	Number	Percentage
Ever presence during “SAGINE” (n= 269)		
Yes	396	95.2
No	20	4.8
Reported participants of “SAGINE” (n= 396)		
All members of the community	380	95.9
Unmarried youngsters	16	4.0
Respondents trained during “SAGINE” (n=393)		
Watching passively	275	70.0
Searching age mate opposite sex	87	22.1
Sometimes for sex	31	7.9
Frequency of organizing “SAGINE” over three months		
One to three times	68	17.4
Four to eight times	169	43.3
More than eight times	153	39.2

5.5 Knowledge about HIV/AIDS transmission, prevention methods and Awareness about VCT

Perception of the study community about HIV/AIDS

Even though they knew the disease by the name of “KANGAY” in local language, which means a disease came from monkeys; both female and male discussants said that they considered HIV/AIDS as it is not there in surma. Some of the discussants suspect that the disease might be introduced to Surma through the government employees, the local people who had a contact with non-surma people due to treading, X-solders and those who are working at gold mining in surma terrain and neighboring weredas with other people who came from different parts of the country.

From all respondents 195(47.4%) heard about HIV/AIDS and 216 (52.6%) have never heard. Among those who have heard about HIV/AIDS, 183 (44.4%) believed that people can protect themselves from the infection of AIDS. Among 387 of the respondents, in regarding to the transmission of HIV/AIDS, 169 (43.7%) were reported that multiple sexual practices are the means of transmission. While 86 (23.9%) mentioned mother to child and unsafe injection utilization, the rest 25.9% and 28.7% of the respondents were reported sharing sharp objects in different occasions of traditional practices and having sexual contact with bar ladies could transmit the disease respectively. On the other hand, there were misconceptions about ways of HIV transmissions, 32 (9.8%) of respondents replied mosquito's bite and sharing food and utensils with AIDS patients could transmit the virus.

Of the respondents, 71(17.0%), 57 (13.7%), 52 (12.5%), 28 (6.7%) and 8(1.9%) reported that avoiding multiple sexual practices, abstinence, using condom, becoming faithful to one's sexual partner and avoiding unsafe injection are among prevention and control methods respectively.

As to the source of information about HIV/AIDS, 142(31.7%) reported they got from health institutions, 99 (22%) from friends and neighbors, 75 (16.7%) from NGO, and the rest 41 (9.1%), 23 (5.1%), 9 (2%) were from radio and television, posters and leaflets and news paper correspondingly. Concerning the awareness of VCT from 411 respondents, only 88 (21.4%) reported that they heard about VCT and from 415 respondents 94 (22.7%) were willing to be tested for HIV/AIDS (Table 5).

Attitude of the participants in the promotion of preventive measures

Some discussants of both groups never heard about HIV/AIDS as well as VCT and condom. Some who heard about AIDS and condom said using condom in surma community is very thorny because of elevated need for children. Regarding the test for HIV/AIDS, some are willing to be tested. However, most of the discussants agreed if the result becomes positive, it will be very hard to live in the society. One discussant said *“It is better to isolate the person to protect others”*.

The woreda council members expressed during in-depth interview, the juncture of local alcohol sale which becomes trendy practice in short period changes our essential cultural performance like prohibition of women extra marital sex after marriage and, sex with non-indigenous people. The social – norms are being altered after alcoholism. This recently being practiced condition would create a grave circumstance with the context of surma liberal sexual practice and, open the opportunity for the introduction of sexual transmitted diseases including HIV/AIDS.

Table 5 Knowledge of study participants about HIV/AIDS, transmission, prevention and VCT awareness, in Surma woreda, SNNPR, January 2006.

VARIABLES	NUMBER	PERCENTAGE
Ever heard about AIDS (n= 411)		
Yes	195	47.4
No	216	52.6
Know any one infected\died of HIV/AIDS (n=410)		
Yes	61	14.9
No	349	85.1
Knowledge of HIV/AIDS transmission and prevention methods (n= 412)		
Yes	183	44.4
No	229	55.6
Knowledge of transmission at least one (n= 416)		
Multiple sexual practices	169	43.7
Sex with prostitutes	98	28.7
Sharing sharps in different occasions	90	25.9
Mother to child during (pregnancy & breast feeding)	86	23.9
Un safe injections	86	24.
Mosquito bite	32	9.8
Sharing food and utensils	32	10.0

Table 5 Cont...

VARIABLES	NUMBER	PERCENTAGE
Knowledge of prevention at least one (n= 412)*		
Avoid multiple sexual partner	71	17.0
Abstinence	57	13.7
Use condom	52	12.5
Faithful sexual partner	28	6.7
Avoiding sharing sharps	8	1.9
Source of information about AIDS (n= 450)*		
Health institution	142	31.7
Friends and neighbors	99	22.0
Ngo	75	16.7
Radio and TV	41	9.1
Poster and leaflet	23	5.1
News paper	9	2.0
Ever heard about VCT(n=411)		
Yes	88	21.4
No	323	78.6
Willingness to be tested for HIV/AIDS (n=415)		
Yes	94	22.7
No	321	77.3

5.6 Risk practice determinants

Risk practices were assessed through different factors, and binary logistic regression analysis was used to control the effect of confounding variables in order to measure the risk on the study population. Socio-demographic and some variables were entered against dependent variable (Table 6). The risk practice were graded taking the responses from quantitative survey of (premarital sex, extramarital sex, sex at last night spent other than their permanent residence, skin piercing and body tattooing, as considering each practices as having equal risk). Result showed that males are more involved in risk practices than females though it is not statistically significant [Adjusted OR (95% CI)=3.54(0.34, 37.09)]

In relation to educational status, illiterates take part in risk practices more than literates, and it is also statistically significant [Adjusted OR (95% CI) =3.47(1.16, 10.36)].

Concerning marital status in relation to risk practice, people who are in polygamy are most likely involved in risk practices and it is also statistically significant [Adjusted OR (95% CI) = 4.55(2.40,8.60)] .The risk practice is not related with the state of hearing about HIV/AIDS and willingness to be tested for HIV/AIDS. However, it has significant relation with the general knowledge about HIV/AIDS [Adjusted OR (95% CI) = 0.38(0.17, 0.87)] (Table 6).

Table-6 Comparison of risk practice by socio-demographic background, Surma woreda,
SNNPR January 2006.

Variables	Risk practice	95% CI	
		Crude	Adjusted
Sex			
Male	184	1.3(0.84,2.07)	3.54(0.34,37.09)
Female	109	1	1
Literacy status			
Illiterate	367	2.74(1.29,5.82)	3.47(1.16,10.36)
Literate	49	1	1
Marital Status			
Polygamous	146	4.34(2.37,7.97)	4.55(2.40,8.60)
Monogamous	63	1	1
Ever head about HIV/AIDS			
No	216	1.25(0.83,1.87)	1.25(0.56,2.81)
Yes	195	1	1
Willingness to be tested HIV/AIDS			
No	321	1.63(0.98,2.69)	1.56(0.70,3.48)
Yes	94	1	1
Knowledge about HIV/AIDS			
poor	288	0.95(0.63,1.46)	0.38(0.17,0.87)
Good	128	1	1

6. Discussion

This chapter is devoted to deeper analysis of the findings with regard to the study objectives. Even though there is an immense lack of information regarding to factors facilitate the spread of HIV infection in isolated population. Especially pastoralists who are at very remotely situated portion of the country. This study tried to uncover the risk practices which are in favor of spreading HIV/AIDS in Surma population of the SNNPR.

The basic demographic characteristic of the study population was 269 (64.7%) male and 147 (35.3%) female.

Regarding to the marital status 316 was married and 100 were unmarried. Among the married 213 were male and 103 female. From 213 married males 118 (55.3%) were reported that they are in polygamous union. Comparing this survey with study done in south omo of the agro-pastoralist community 44.2%, it can be said that it is high (24). The result is also very high comparing with BSS 2002 survey result whose polygamy status of the pastoralist community was 17.4% (21). The result difference between this study and the previous ones is due to their zeal to have as many children as they can, since children are sources of respect, security and wealth in the society. That is the reason why they marry many women and giving birth is also the means for women's to have social reputation and reverence. The polygamy by it self may not be a risk for HIV transmission, as far as the relationship between the spouses is restricted. What makes polygamy risky in surma is that, the social-norms that permit extramarital sex for males with unmarried girls. This occasion might not have a problem previously, but the recently creates events, involvement of both sexes in trading and gold mining opens an opportunity to make contact with non-surma people, which this contact starts to extend to the extent to have sexual relation. This relation serves as a bridge to the introduction of sexual transmitted diseases including HIV in to the surma.

Dimma is the known site, which serves as an economical center, for the nearby woredas as well as people from different part of the country including Addis Ababa for market exchange of different goods including gold. This situation attracts much sex workers to the area which facilitates the contamination of the people with STDS. This reality amplifies the risk of polygamy in surma with the previously stated of sex with non-endogenous peoples.

Abduction is not widely practiced style of marriage in the community. Among 103 married women 5.8% were abducted. It seems a bit higher from the result (2.3%) of the study conducted in Hammer but it is lesser from DHS 2000 result which was 15% in rural community. Abduction is undesirable practice in surma community. Since females are the most economic resources for their parents through bride price, the act of abduction is severely prohibited amongst the Suri community but it may be acceptable if it is occurred to recompense blood shade. During FGD, both male and female discussants were seriously replied supporting the aforesaid idea. Though the abduction rate is low and unacceptable practice in the community, 5.8% abduction rate will have a role in the spread of HIV, as stated above an opportunity is created for the introduction of the HIV infection to the surma people.

Regarding to wife-inheritance 92.2% of the respondents were aware of the practice. 83% of the above mentioned respondents were reported as it is a common practice in surma. This result was strengthened during qualitative study in which most of both groups of the discussant agreed up on that it is a necessary practice, for it enables them to bring up the children and to protect the prosperity and the diseased man's wife from intrusion of non- family member since she is thought to be the treasure of that family. As it stated it is widely practice in surma community, with the reason

of contamination of non-surma people, it will have a considerable role in the spread of HIV, since the status of sero-prevalence of the diseased person is not known.

Skin piercing and Body tattooing were among the most mandatory cultural practices in Surma community. Among 415 respondents 376 (90.6%) had pierced skin, of which 58.8% and 31.8% were males and females respectively. On the other hand, 375 (90.1%) had body tattooing; of them 57.5% are males and 32.7% females. These practices were an age old practices in the area. Such practices are done as a social value. Skin piercing is done for any person in Surma but the way and body part to be pierced for females is more sever than males. Females pierce their lips to beautify themselves. Even though the magnitude of skin piercing in the transmission of HIV was not detected yet, its role may not be negligible. Body tattooing also appeared to have considerable role for HIV transmission. The way the performances done, made the practices risky due to the utilization of blood contaminated material for many people at a time. So the risky probability is high. Nevertheless Skin piercing and body tattooing practiced are old aged, the previous sexual network were closed (with in the endogenous people only) which way of infection introduction to the area were null. As the FGD discussant stated above the opportunity of acquiring the infection in the community, which in turn brings these practices as a tool for the transmission of HIV.

Tooth extraction is also the common cultural practice widely done in Surma people. All children at the age of 6-7 were expected to have their tooth extracted. Females at puberty age are forced to extract two additional teeth.

As other cultural practices, tooth extraction is also done in mass with the same material at a time. So the probability of infection seemed very high. Moreover females pass double risk time.

Traditional surgery is also a common practice in Surma. It is done by well known traditional healers of the community. A person who would be fractured due to war, conflict and any other circumstance will get help from practitioners. The procedure is done with a special knife made locally for this purpose only.

During FGD discussion male discussants replied that due to the existence of fighting and conflict the presence of traditional healers is highly advantageous to protect injured people from severe health complications and disabilities. However, in the occasion of massive involvement in the conflict it is expected to have a risk of blood contamination. The above mentioned cultural practices had been there for long time, and they might not have created serious problems due to the quite isolation of the people from the rest of the world. On the other hand, these days, the environment is being changed in different aspects of the community. This in turn makes the cultural practices more suitable for HIV/AIDS transmission.

Especially those people who are traders 25(7.9%) will have a considerable role in the transmission of HIV in the area. They may have a sexual contact with people who are working in the bar at Dimma. This area is known for the exchange of gold from the surrounding weredas. As a result of this Dimma become commercial center. The opening of bars has attracted sex workers to the area. Those traders from surma will have a chance to have sex with this people and contaminate the surma ladies due to the permitted free premarital and extra marital sexual practices. Then the spread will be aggravated by other innocent people who are living with the existing cultural practice. Though the number of people who serves as a bridge is few, it will have a great role in the transmission of the infection.

Awareness and Knowledge of HIV/AIDS

Awareness about HIV/AIDS of the study population was 47.4% of which 30.9% and 16.5% were male and female respectively. The result was lower than the study carried out in south omo community which was 73.8% (26). More over this result was by far lower than the results; over 95% of pastoralists were aware, BSS 2002 survey. Where as the general population awareness were 96% and 85% for males and females respectively (CSA 2001). The other study result in Kenya about HIV/AIDS awareness shows 79.5% among pastoralist community which is better than the study population of Surma. The result of the study about HIV/AIDS awareness showed very less, which could amplify the consequence risk of cultural practices. It could be due to the low health coverage or minimal activities carried out concerning HIV/AIDS. Despite the high illiteracy status of the study population 47.4% of respondents were aware about HIV/AIDS. This might be the implication Mekanyesuse religious leaders effort, which they may disseminate information of HIV/AIDS to their followers at their worshipping programs. As the religious organization has a responsibility to combat HIV/AIDS in order to protect their followers.

Preventive methods

Knowledge of the study population about HIV/AIDS prevention and transmission methods was assessed. 183 (44.4%) of the respondent mentioned that people can prevent themselves from HIV. Among the respondents only 15 (3.6%) were able to name all the three major HIV preventive methods, while BSS 2002 survey were 17.7% which indicates huge gap with surma result. Of the respondents 71 (17.1%) were identified avoiding multiple sexual partner is among the priority methods of prevention where as 13.7% and 12.5% mentioned abstinence and using condom as prevention methods respectively. Despite the cultural practices which allow multiple sexual practices, 17.1% of the respondents mentioned avoiding multiple sexual partners as a method of

HIV/AIDS prevention. This may be due to the religious education; people who are changed to protestant religion may start to change their previous behavior of such practices. All the parameters used to measure knowledge about HIV prevention shows very low comparing to previously done surveys of pastoralists. It implies that the possibility of HIV spread risk is higher, because it is known that knowledge is one of the factors for HIV prevention and, it needs great consideration.

28.4% of the participants were reported that they know at least one means of HIV transmission. However, when weighed against the previous study in Hammer community which was 83.8%, the knowledge of the surma community is highly deflated. The CSA 2001 indicated that the rural population had less knowledge of the preventive methods. In addition, BSS 2001 result mentioned that less than 25% of pastoralists knew the three prevention methods which correlate with this survey. The huge gap of the results indicate that there were barriers which could be low literacy status, the cultural impact, limited infrastructures like schools and health facilities as well as minimal attention given to the area about HIV/AIDS prevention and controlling programs. The comprehensive knowledge was analyzed by grading all the knowledge questions about HIV/AIDS, and giving equal points for each question. The mean was used as cut off point to separates poor and good level; of knowledge. The result were 288 (69.2%), 128(30.8%) poor and good knowledge respectively. This dreadfully low knowledge level needs serious consideration.

Surma have liberal sexual norms and practices that is a privilege for both sexes before marriage. Having multiple sexual partners during premarital period is a practice not publicly denounced in surma society though girls would be considered “bad” if they have multiple sexual partners publicly. Boys publicly declare that they have multiple sexual partners without any fear of intimidation. Men

can have girlfriends that they visit regularly or more wives. However married women are strictly forbidden to have extra marital sexual relations (28).

Among currently married pastoralist, 264 (89.2%) reported that they were sexually active before marriage. This result is somewhat similar with the BSS 2002 survey that revealed 81.2% of pastoralists had premarital sex. This confirmed that the study population is culturally free for premarital sex. Among married women 30.9% reported that virginity at a time of marriage is not useful and it should not be kept up to marriage. This approves that the tradition is strongly supports premarital sexual practices. This lofty level of premarital sexual practice and the performance of risky cultural practices of the study population need a significant consideration in the era of HIV/AIDS.

Even though, Surma males need to marry many wives to have extended family, it is not easy in surma society because of the amount of wealth needed for bride price. He has to pay up to 30 cattle and one AK-47 rifle to the family of his fiancé. From 213 married males 118 (55.3%) were in polygamous union. Comparing with the South omo result 44.2% it is higher. Moreover BSS 2002 result of pastoralist was 26.7% which is lower than the result of surma. The risk practice determinant's table also shows polygamy is 5.41 times riskier than monogamy. This idea was raised during FGD and most of the discussant were agreed that polygamy is necessary for the family to be respected by the community because having extended family would enable them to be winner in most ritual practices like sagine.

Extra marital sexual practice is socially acceptable in surma community. Among married males 72 (41.9%) had involved casual sex, 100(58.1%) of husbands encountered either co-wives or non-marital regular partners. Comparing with the result of South omo study (41.5% causal sex and 61.2% encountered either non-marital or co-wife sex) it was nearly similar. From the view of the above result, it needs crucial measure. Premarital and extramarital sexual practices with the resent context of surma, which sexual relation is already linked with external community of which high acquiring probability of infection, they will result a devastating problem of the community unless appropriate intervention applied.

Regarding to cultural ritual's "SAGINE" and "MOON TIME PLAY" were the main events which facilitate causal sex. 94.1% of the respondents reported they were present during sagine play. This cultural plays are in favor of those people who are in need of causal sex and for friends of opposite sex since the plays are well recognized and allowed to attend irrespective of gender and age by the communities. Both groups of FGD discussants confirmed that most friends of opposite sexes used this opportunity to meet each other to do whatever they like.

The moon time play is also among the one which facilitate sexual contact for both sexes.

The other cultural practice popularly done in surma society was hair shaving style. Most FGD discussant of both sexes agreed on that it is their identity and frequently performed in mass with one blade for many peoples. The practice is not considered as it can facilitate HIV transmission.

Willingness to VCT in the study population was 22.7% which is very low from the BSS 2002 result of 77%.The variation could be due to high illiteracy status , low health coverage and weak HIV\AID related programs in Surma woreda .

STRENGTH AND LIMITATIONS

The study design is appropriate to answer the study question of socio-cultural risk factors in relation to HIV transmission in Surma woreda. The investigator relied on combination of study methods. As socio-cultural factors related to HIV transmission, can't be investigated thoroughly using only quantitative survey. For this reason, most information was collected by qualitative method. However, the household survey was conducted to generate baseline data on socio-demographic background and behavioral data of the study population. Addressing the very marginalized and disadvantaged segment of the community could be considered as strength.

One of the limitations of the study was the language barrier between the informants and the investigator. Despite the attempts to recruit the best possible translator available in the area, valuable information and expressions of qualitative part of the study might have been lost since the informants' response relayed on to the investigator through the translator.

Limitation in getting similar studies on pastoralist societies with in the topic of interest in the country and lack of references has constrained the study to compare with.

6 CONCLUSION

Bearing in mind the limitation of the study and considering the remotely situated pastoralist community, it is possible to conclude:

1. Lower Awareness and knowledge about HIV/AIDS in addition to high level of illiteracy status facilitates different way of transmission of the infection would put the community in a severe problem.
2. Socio-cultural practices (skin piercing, body tattooing, wife-inheritance, tooth extraction hair having and traditional surgery), in the study community will have a grave consequences with the recently linkage of sexual relation with non-endogenous people who had multiple sexual exposure, putting participants at elevated exposure and infection level.
3. Marriage and sexual behaviors such as Polygamy, pre-marital sexual practice, extra-marital sexual practice are in high status which defiantly favors the spread of HIV infection in the community.
4. Specific cultural rituals like “SAGINE” and “MOON TIME PLAY” as they facilitate casual sex, they will accelerate the spread of HIV infection in the community.
5. Awareness about VCT and willingness to be tested are at lower status.

8. RECOMENDATION

The following recommendations are forwarded based on the finding of the study:

1. The conservative nature of the pastoralist communities calls for culturally sensitive approaches to be adopted in addressing the HIV/AIDS awareness. However , efforts should ultimately be promoted towards extensive health education on HIV/AIDS
2. In support to the awareness effort, the involvement of culturally and socially influential people will have paramount importance in the campaign .This will ensure the local people to feel easy during IEC.
3. Health education can be disseminated at social gatherings and during cultural rituals, giving emphasis on the traditional practices which facilitate high-risk practices.
4. No data on the sero-prevalence of pastoralist communities in the region. There fore sero-prevalence study of the pastoralist community should be conducted.
5. Taking in to account the deep rooted cultural and traditional practices, the involvement of the community at the planning level of the intervention programs is mandatory.

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Annexes

I. Questionnaires

004 interviewer code: ____/____, Name _____,

Sign _____, Date _____

005. Checked by supervisor, Name _____, Sign _____ Date _____

Section one Background characteristics

No	Question & Filters	Coding categories	Skip to
101	Record sex of respondent	Male Female	1 2
102	Age of respondent	Age in complete year ----- Don't know ----- No response -----	88 99
103	What is your religion	Christian Muslim Traditional believers -----	1 2 3
104	To which ethnic group do you belong	Tirma Chi Baele	1 2 3
105	Have you ever attend school	Yes No	1 2
			107
106	What is the highest level of schooling	read and write grade 1-6 grade 7-10 grade 11-12 Above 12+	1 2 3 4 5
107	Your/family in-come	No of live stock ----- Other income month based in birr ----- Don't know ----- 88	
108	Did you have drinking alcohol in the last four week	Yes No	1 2
			201
109	If yes to 108 how often did you have drinks contains alcohol in the last 4 week?	At least once a day At least once a week Less than once a week	1 2 3

Section tow mobility questions

No	Question & Filters	Coding categories		Skip to
201	For how long have you been in the present area/community?	Less than 1 year Less than five years More than five years	1 2 3	
202	Have you ever changed/ away from your area?	yes No	1 2	206
203	Why did you have to change/away from your resident area?	As pastoralist As mobile trader As military force Other specify _____	1 2 3	
204	If yes to Q 202, for hoe long have you been away from your decedent area	Less than 3 month 2.3-6 month 3.6-12 month More than one year	1 2 3 4	
205	If yes to Q 203, where is your frequent area of stay/spent?	Rural & urban surma territory Urban sub-urban centers of neighboring woredas other specify _____	1 2	
206	Have you ever spent (night) in location other than your home for the last 3 months?	Yes No	1 2	301
207	If yes to Q 206, why did you sleep/passé?	As pastoralist As mobile trader Due to cultural plays To pass with co-wife Other specify -----	Y 1 1 1 1	N 2 2 2 2
208	If yes to Q 206, with whom did you pass?	Just alone Some one (causal) Regular partner No response _____ 99 Others _____	Y 1 1 1	N 2 2 2
209	If yes to Q 206, have you engaged in sexual activity during your last night spent?	Yes No	1 2	
210	Have you had skin piercing?	Yes No	1 2	
211	If yes how long?	Less than 6 month 6month-1year 1year-5years 5years-10years	1 2 3 4	
212	Have you had body tattooing?	Yes No	1 2	
213	If yes how long?	Less than 6 month 6month-1year 1year-5years 5years-10years	1 2 3 4	

Section - three marital status and sexual history

No	Question & Filters	Coding categories	Skip to
301	Have you been married?	yes No	1 2 303
302	If yes to Q 301, Age at first marriage	Age in full years ____/____ Do not know ____ 88 Not response ____ 99	
303	Are you currently married/living with sexual partner	currently, living with spouse currently married, living with other sexual partner Not married, not living with sexual partner Not married, not living with sexual partner Married but spouse died	1 2 3 4 5
304	FEMALE How was your first marriage	With family permission Self consent By abduction No response _____ Other (specify)	1 2 3 99
305	FEMALE Was your virgin during 1 st marriage?	yes No No response _____	1 2 99
306	What is your perception about virginity?	Should be kept till marriage Should not be kept till marriage(not important) No response _____ other specify _____	1 2 99
307	MALE Do you have another wife/sexual partner? FEMALE Does your husband/partner have other wife/wives?	yes No No response _____ Other (specify)	1 2 99 310
308	If yes to Q 307, how many wife/wives do/does you / he have?	_____	
309	If yes to Q 307, what could be the reason to have additional wife/ sexual partner? Circle more than one	Cultural reasons To get/more children For economic benefit One partner doesn't satisfy No response _____ other (specify)	1 2 3 4 99

No	Question & Filers	Coding categories	Skip to
310	Do you think polygamy / more than one sexual partner has health risk?	Yes No	1 2 312
311	If yes to Q 310, what are the health risks associated with it?	STI including HIV/AIDS Psycho- social problem Do not now _____ other specify	1 2 88
312	<u>FEMALE</u> Have you ever practices postpartum Abstinence? <u>MALE</u> Have you ever practices postpartum Abstinence when your wife gives birth?	Yes No	1 2 315
313	<u>FEMALE</u> If yes to Q 312, for how long do you abstain?	<2 months 2-6 months >6 months	1 2 3
314	If no to Q 312, what alternative does your husband has? MALE what alternative do you have?	co-wife causal partner other specify -----	1 2
315	Have you heard of wife inheritance?	yes No	1 2 318
316	If yes to Q 315, is it common in your area?	yes No	1 2
317	If yes to Q 316, do you know any one inherited?	Yes No	1 2
318	Are you circumcised?	Yes No	1 2

Section four – sexuality and Traditional practices

No	Question & Filters	Coding categories	Skip to
401	Have you ever had sexual intercourse?	yes No	1 2 403
402	If yes to Q 401 , age at first sexual commencement	Age in full years ____/____ Do not know ____ Not response ____	88 99
403	Are you currently married?	Yes No	1 2 405
404	If yes to Q 403, have you had pre-marital sexual intercourse?	Yes No	1 2
405	MALE Have you ever had sexual intercourse with prostitute?	yes No No response _____	1 2 99
406	Have you ever attained traditional play “DONGA”	Yes No	1 2
407	If yes to Q 406, who are participants of the traditional play	All members of the community Unmarried youngsters Married youngsters No response _____	1 2 3 99
408	If yes to Q 406, what is the EXPERIENCE of participants during DONGA	Passive attendance Search of age mate Some times sexual contact	1 2 3
409	If yes to Q406, what is the frequency of the organizing DONDA in three months?	One – three times Four- eight times More than eight times	1 2 3

Section -five HIV/AIDS knowledge, Attitude and practice

No	Question & Filters	Coding categories			Skip to
501	Did you have any one of the following in the last six months	Urethral discharge (men)	Y 1	N 2	
		Vaginal discharge (women)	1	2	
		Genital ulcers	1	2	
		Don't know		88	
502	Whom do you discuss health issues with? (check all that apply)	Husband/wife	Y 1	N 2	
		Friend of the same sex	1	2	
		Health workers	1	2	
		Traditional healers	1	2	
		Others specify ----- -----			
503	Have you ever heard about HIV/AIDS	Yes		1	
		No		2	
504	If yes to Q 503 , from where did you get the information?(circle more than one)	Mass media (radio, TV)	Y 1	N 2	
		News paper (magazine)	1	2	
		Pamphlet(poster)	1	2	
		Health workers	1	2	
		NGO's	1	2	
		Friends/ neighbor's	1	2	
		If other specify _____ _____			
505	Do you know any one infected/died of HIV/AIDS?	Yes		1	
		No		2	
506	What are the sign/symptoms of HIV/AIDS?	Chronic weight loss	Y 1	N 2	
		Fever > 1 month	1	2	
		Diarrhea of 1 month	1	2	
		Chronic cough (TB)	1	2	
		Skin lesion	1	2	
		I don't know _____		88	
507	In what way HIV/AIDS transmit?(circle more than one)	Mother to child	Y 1	N 2	
		Delivery and breast feeding	1	2	
		Multiple sexual contact	1	2	
		Un safe injection	1	2	
		Sharing sharps(blade, etc)	1	2	
		Mosquito bite	1	2	
		Sex with prostitute	1	2	
		Sharing food and utensils			
508	Can people protect them selves from getting HIV/AIDS?	Yes		1	
		No		2	

No	Question & Filters	Coding categories		Skip to
509	If yes to Q 508, how can people protect them selves from getting HIV/AIDS?	No sex at all Avoid multiple sexual relation ship Having single faithful partner Avoid unsafe injection Use condom Don't know _____	1 2 3 4 5 88	
510	Have you ever hared about condom?	Yes No	1 2	
511	If yes to Q 510, from where did you hared?	Mass media (radio, TV) News paper (magazine) Pamphlet (poster) Health worker NGO's Friends /neighbors	Y 1 1 1 1 1 1 2	N 2 2 2 2 2 2 2
512	Have you ever see condom?	Yes No	1 2	
513	If yes to Q 512, from where can you get condom?	Health institute NGO's Friends Don't know	Y 1 1 1 1	N 2 2 2 2 2
514	What do you think, if it is made available in your vicinity?	I don't care I will try I will never use No response -----	1 2 3 99	
515	Have you ever heard about VCT?	Yes No	1 2	
516	Would you volunteer to be tested for HIV/AIDS?	Yes No	1 2	

A. General Perceptions of the Study Community about HIV /AIDS

Probe!

- . What is the current health Problem in your area?
- . Could you list them according to order of importance?
- . What about HIV/AIDS? What about its transmission and prevention?
- . Whom do you think are most at risk of acquiring the disease?
- . Which age group, what type of workers? Why?

Method of discussion- free discussion and matrix

B. What high-risk social and cultural practices in your area do favors the spread of HIV?

Probe.!

- . Risk behavioral practices related to marriage and sexuality
- . What about premarital, practices
- . What about multiple sexual practices, sex with non indigenous individuals
- . What about polygamy, widow inheritance, abduction
- . What about post-partum abstinences in your area?
- . What does the male do during prolonged abstinence period?
- . Traditional healer's role in the community
- . What about Circumcision
- . What about skin piercing
- . What about body tattooing
- . What about traditional surgery (bone setters?)

Method of discussion- free discussion and matrix

C. What other socio-cultural practices do exist, do you think that is risk to HIV infection?

Probe!-

- . How do you see'' Donga''?
- . What about mass circumcisions and FGM?
- . What about sharing Knife, razor blades?

Method of discussion- free discussion and matrix

D. How do you consider the mobility of the adults to the rural and urban areas?

Probe!-

- . What about market trips?
- . What dose the adults commonly practices during nightttime at towns?

Method of discussion- free discussion and matrix

E. What possible preventive methods do you think important in your community?

Probe!-

- . What about health education?
- . What other preventive methods do you know?
- . What about condom promotion?
- . How is the willingness of the community about condom promotion program?
- . How about VCT
- . What other alternatives do you recommend?

Method of discussion- Free discussion and matrix

Annex III Consent form

Socio-cultural risks in relation to HIV transmission in Surma wereda SNNPR.

Introduction: - My name is _____ I am working for _____

. We are interviewing people here in _____ (name of site) about socio-cultural risks in relation to HIV transmission. I am going to ask you some questions that are very important for the program planners in HIV/AIDS controlling activities to plan improved intervention. Your name will not be written in this form and the information you give will be kept confidential. Unless you are will to participate in this study you are not obliged to participate. If you don't want to answer all or some of the questions, you do have the right to do so; however your willingness to answer all of the questions would be appreciated.

Would you like to participate in this study?

Yes _____ Continue interviewing

No _____ thank the participant and go to the next household.

Thank all participants at end.