ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
DEPARTMENT OF COMMUNITY HEALTH

Assessment of status of commercial sex in females selling local beverage, their risk perception towards HIV infection and condom use in towns of Gojjam

BY TENAW BAWOKE (BSc, PUBLIC HEALTH)

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR MASTER OF PUBLIC HEALTH DEGREE

JULY 2007

ADDIS ABABA, ETHIOPIA

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A Thesis submitted to the School of Graduate Studies, Addis Ababa University in partial fulfillment of the requirement for Master of Public Health degree

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ACKNOWLEDGEMENT

I want to use this opportunity to pass my deepest appreciation to my advisor Dr. Mulugeta Betre for his concerned and mentoring advice from the very start to the conclusion of this work.

I am also extremely indebted to Professor Ahmed Ali for his help during selection and settlement of the research title and objectives.

Again I want to pass my gratitude to Ato Abere Mihretie, director of Anti Malaria Association and all the staff of the Association for their sincere cooperation during data collection and other procedures of the research.

It is also my pleasure to acknowledge my data collection supervisor Ato Mekonnen Aderaw, all the study participants and all of them who have played their own roles in the study.

Finally, I sincerely want to acknowledge the Department of Community Health for funding my research thesis and all the staff of Department of Community Health of Addis Ababa University Medical Faculty for all the help to enable me to do this work.

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ABBREVIATIONS

1. **AAU -** Addis Ababa University
2. **AAUMF -** Addis Ababa University Medical Faculty
3. **ABC –** Abstinence, Be faith full and use Condoms Consistently
4. **AIDS -** Aquired Immuno Deficiency Syndrome
5. **AMA -** Anti Malaria Association
6. **ANC -** Antenatal Care
7. **AOR –** Adjusted Odds Ratio
8. **ART -** Anti-retroviral Therapy
9. **BSS -** Behavioral Surveillance Survey
10. **CBHW –** Community Based Health Workers
11. **CI –** Confidence Interval
12. **COR –** Crude Odds Ratio
13. **CSW** - Commercial Sex Worker
14. **DCH -** Department of Community Health
15. **DPCD -** Disease Prevention and Control Department
16. **EPHA -** Ethiopian Public Health Association
17. **FCSW -** Female Commercial Sex Workers
18. **FGD -** Focus Group Discussion
19. **FMOH -** Federal Ministry of Health
20. **FSW -** Female Sex Workers
21. **HAPCO -** HIV/AIDS Prevention and Control Office
22. **HBFSW -** Home Based Female Sex Workers
23. **HIV -** Human Immunodeficiency Virus
24. **IGA -** Income Generative Activities
25. **KAP –** Knowledge, Attitude and Practice
26. **LBSF -** Local Beverage Selling Females

27. **NGO –** Non Governmental Organization
28. **OR –** Odds Ratio
29. **PLWHA -** People Living with HIV/AIDS
30. **SNNPR -** Southern Nations' Nationalities and Peoples Region
31. **SPSS –** Statistical Package for Social Scientists
32. **SRS -** Simple Random Sampling
33. **STD -** Sexually Transmitted Disease
34. **UN -** United Nations
35. **UNAIDS –** Joint United Nations HIV/AIDS Program
36. **USA -** United States of America
37. **VCT -** Voluntary Counseling and Testing

ABSTRACT

Background (problem statement): - Selling local beverages like Araki, Teji and Tella by females is of back long and widely practiced activity in Ethiopia in general and in most towns of Gojjam in particular. And some of these females are practicing commercial sex with their beverage customers most of whom are farmers presumably with low awareness level towards HIV/AIDS compared to urban people. It is assumed that commercial sexual transaction between these females and farmers play significant role for the steadily growing rate of HIV transmission to the rural area.

Objective: To assess the status of commercial sex among local beverage selling females and to identify their risk perception towards HIV/AIDS and condom use in selected Gojjam towns.

Methods: a cross sectional survey assisted by focus group discussion (FGD) was conducted on 354 randomly selected local beverage sellers in Debre Markos, Dembecha and Finote Selam towns from March 3 – March 10, 2007. A pre-coded, pre-tested and structured questionnaire was used for the quantitative method and FGD was conducted in the three towns for the qualitative method.

Results: Fifty nine percent of the studied local beverage selling females (LBSFs) were older than 35 years and all of them were above 15 yeas old at the time of interview. About 46 % of the respondents were illiterates. More than one-forth of the females studied were married before 10 years old, 76 % of them before 18 years old and most (72.3 %) females had no knowledge and consent of their first marriage.

Out of the studied 354 LBSFs, 38.7 % (n=137) have ever practiced commercial sex work (CSW) of which 28.5 % (n=39 of the 137 ever practicing CSWs) have interrupted it at the time of interview and 27.7 % (n=98) are still practicing.

Educational status before local beverage selling, duration of engagement in local beverage selling, age and lack of additional means of income other than local beverage selling have positive significant associations with engagement to commercial sex work.

Family, marriage and other socio-economic factors before being engaged in local beverage selling are found to be statistically significant factors for commercial sexual engagement.

Ninety nine percent of the study participants and especially 100 % of the FSW participants have knowledge of HIV/AIDS. Sixty five percent of the respondents have described all the three basic programmatically important prevention methods (Abstinence, Be faithful and use Condoms consistently).

Thirty eight percent of the participants have comprehensive knowledge about HIV/AIDS. But 39.6 % of them had at least one misconception (incorrect belief) about HIV transmission.

Twenty nine percent of the interviewed females have ever been tested for HIV of which 88 % have taken their results.

About 43 % of the studied females have moderate/high and 55.8 % have nil/low risk perception towards HIV infection based on their past risk behaviors.

Eighty eight percent of the studied LBSFs (100 % of FSWs) and 63 % of them have knowledge of male condoms and have ever used it respectively. And 65.8 % of the FSWs who have ever used male condoms have used it during their recent sexual contact with their

paying clients. With in 30 days prior to the day of interview, about half of the commercial sex practicing LBSFs studied have used condoms persistently.

Conclusion and recommendation: several family, marriage and other socio-economic related factors before being engaged in local beverage selling are observed playing significant roles for LBSFs to start commercial sex work. And there is high level of unprotected commercial sexual transaction between these CSWs and farmers and other rural community members aggravating the speed of dissemination of HIV infection to the rural Ethiopia. These situations need due attention and rapid remedial intervention by joint efforts of the local government, civil societies and the community itself.

1. INTRODUCTION

1.1. Background

Selling local beverages like Arakie, Teji and Tella is of back long history and widely practiced activity in most towns of Ethiopia in general and in Gojjam in particular. Most of the females selling these local beverages in their own home are not in union with husbands except some of them have regular partners to whom they are called "Kimit/Wushima".

Since most of these females are non-married, divorced or widowed and they sell local alcohol day and night to their male customers, some of them are observed practicing sex for money too. Even if there are no notable studies conducted on these females showing their role in the spread of HIV/AIDS to the rural part of Ethiopia, it is assumed that they are playing significant role for the steadily growing rate of HIV prevalence in the rural part of the country where 85% of our community resides.

1.2. Problem Statement

HIV prevalence of Ethiopia in 2005 was 3.5% (10.5 % for urban and 1.9 % for rural areas). The urban epidemic appeared to have stabilized between 1996 and 2000 and showed a slow and gradual decline since 2001. However; unlike the urban areas, the prevalence in rural Ethiopia increases continuously from 1990/1 to 1999, peaked from 1999 to 2001 and showed a relative stabilization following this peak [(1)]**.**

When we see the number of new HIV infections, it has been greater for urban areas than rural areas of Ethiopia until 1994 EC; beginning 1995, the number of new infections in rural areas surpassed that of the urban areas until 2001 [(1)]. This is partly because the awareness level and attitudinal changes towards HIV/AIDS are low in the rural areas compared to the towns of the country due to lack of access to education and other awareness programs compared to people in the towns.

Home-based commercial sex by local beverage sellers in small towns is one of the main meanes of rapid transmission of HIV/AIDS in the rural Ethiopia. Home based female sex workers (HBFSWs) in the rural areas have low educational level and have low practice of risk reduction towards HIV infection compared to their street and bar based town counterparts. The second round HIV/AIDS Behavioral Surveillance Survey (BSS) of Ethiopia in 2006, revealed that 69.3 % of FSWs in Bahir Dar town are illiterates (the highest proportion compared to other towns of Ethiopia included in that study) [(2)]**.** The condition is similar from observations in the towns of Debre Markos, Dembecha and Finote Selam (towns where this study focuses) if not worse than Bahir Dar. As any rural area of the country, farmers and other community members of Gojjam used to drink local beverage and pass the night with females selling sex for money in small towns. These females may be one-time sexual clients or regular partners (Kimit or wushima) to the visiting males. Anti-Malaria Association (AMA), a local NGO and the respective Women Affairs offices of the three towns under study have listed more than 100 females selling local beverage in their own houses in each town**.** It is in view of these problems that this study is planned with the following rationale/significance of the study.

1.3. Significance of the study

The study is assumed to have significance to program planners and implementers on HIV/AIDS in Gojjam in particular and the nation in general at least for the following reasons;

1. Providing information on the status of commercial sex among females selling local beverages so that relatively high risk segment of the community can be pointed out for intervention purposes.

2. Identification of the associated risk factors to practice commercial sex among these females so that program planners and implementers will focus on the alleviation of those factors leading females to commercial sexual engagement.
3. Appreciation of their KAP and risk perception towards HIV/AIDS and condom use so that base line information on KAP can be obtained for the evaluation of awareness raising programs to be conducted in the study area.

2. LITERATURE REVIEW

2.1. Sexual behavior and condom use status of commercial sex workers in relation to risk to HIV infection

Prostitution is an old world profession. Its legal status has different features in different countries, even if it is widely practiced around our globe whether legal or illegal [(3)].

In 1994, the United Nations (UN) adopted a convention stating that prostitution is incompatible with human dignity, requiring all signing parties to punish pimps (those who facilitate or serve as brokers and recruit females for prostitution) and brothel owners [(4)]. Eighty nine countries ratified this convention. But USA, Germany and Netherlands didn't participate [(4)]. Even if there is different legal status for home and bar/hotel based sex work, street based prostitution is illegal all over the world with the exception of Wales, Australia and New Zealand [(4)]. In some Muslim countries prostitution carries the death penalty and at the other end they are tax paying and unionized professionals in Netherlands [(4)].

In South Africa, it is a crime to be a sex worker. But still there are a lot of sex workers which are highly vulnerable to HIV/AIDS and violence (physical and sexual) as they are scared, hide themselves and don't have access to information since they are illegal and don't report to police during violence; rather they try to be far from them [(5)].

Generally prostitution has different legal statuses at different countries and there are also a lot of restrictions for those countries that legalized prostitution. For instance, most countries limited minimum age of sex workers being 18 years (except Netherlands); again, in Nevada, the sex workers should be tested for STDs and HIV every week and month respectively [(4)].

The prevalence of FSWs in Sub Sahara African countries as studied by R. Lyeral et al in 2005, in capital cities is 0.7 - 4.3% and it is 0.4 - 4.3% in other towns [(5)]. According to a study in Panama City in 2001, 99% of the FSWs use condoms [(6)]. But still they are vulnerable to HIV infection, which is due to seldom use of condoms with their regular partner, rape (client objection to use condoms after wearing out cloths) by their paying clients and alcohol consumption and intoxication. Only 25% of FSWs in Panama City use condoms with their regular partners. This is because they trust their partners; they are economically dependant on them while no paying clients and they fear the stigma for no regular male partner [(6)]. In another study in India on FSWs [(7)];

- The mean age for HBFSWs during interview was 26 years
- The mean age during first sex was 15.1 years
- The mean age during first commercial sex was 22-23 years and
- The mean duration of commercial sex work was 4.21 years.

A study conducted by Fitch K. in 2003 in Argentina indicated that the average number of commercial sexual contacts of commercial sex workers per week was 14.5 and 81.9 % of the FSWs used condoms consistently during 30 days prior to the day of interview [(8)].

Even if not articulated clearly both in the penal and civil codes of the Ethiopian existing constitution, female prostitution has a long history in the country with three main distinct types (street based, home/brothel based and bar/hotel based) depending on the place of sexual practice and where FSWs solicit their paying clients [(2)].

Even though there is deficit of studies specifically on HBFSWs living in rural towns of Ethiopia like LBSFs, there are some studies generally on FSWs especially in big towns like Addiss Ababa, Nazareth and Bahir Dar by different institutions and individuals.

One study in Dabat, Kola Diba and Chuahig towns (North-West of Ethiopia) in 2002 showed that the level of knowledge of FSWs about HIV/AIDS was 97.2 % and about

condom was 96.2 %. But 32.5 % of them have ever used condoms out of which only 12.8 % use it consistently. Among their partners who object to use condoms, 81 % were farmers and a higher condom use rate was observed as the educational status increases [9].

Another country wide study in 2006 on FSWs; 61%, 30%, 96% and 86% of whom were aged 20 – 29 yeas old, less than 20 years old, never married and Orthodox Christians respectively; showed also that 12 % of the respondents have performed unprotected sex 12 weeks prior to the study. According to this study, older (greater than 30 years) FSWs had more unprotected sex than their younger (20 – 30 years old) counterparts and education has not resulted in any difference on unprotected sexual experiences [10].

Relatively comprehensive and nation wide Behavioral Surveillance Surveys (BSS) on HIV/AIDS have been conducted in Ethiopia in 2002 (round one) and in 2006 (round two) by FMOH, AAU, HAPCO and EPHA in collaboration with other organizations. Seven towns (Addis Ababa, Bahir Dar, Dire Dawa, Nazareth, Awassa, Gambella and Liben-Borena) were included for the round one study and three big towns (Addis Ababa, Nazareth and Bahir Dar) were assessed for the second round BSS. Both round one and two BSS studies have assessed the socio-demographic, KAP, risk perception and other related variables of FSWs and the result is reviewed from the recent one (round two) as follows [2, 13].

There are three types of female commercial sex workers (FCSWs) in our country:

- ✓ Hotel/bar based – 49.6%
- ✓ Home based – 37.9%
- ✓ Street based – 15.2%

The mean age of female sex workers (FSWs) at the time of interview was 25.1 years of which 57.7 % had attended school with high illiteracy rate at Bahir Dar town (69.3 %). Regarding their marital status, 36.5 % of the FSWs have ever been married and most respondents (88.9 %) have married before 20. Regarding previous residence, 23.3 %, 46.3 % and 28 % of the respondents were living in the same town, came from other town and came from rural area respectively. Concerning income generating activities (IGAs), only 17.3 % of the respondents

were engaged in other IGAs in addition to commercial sex and 32 % of them were also found to support their families (children, mother, father or other extended family members) [(2)].

About ninety four percent of the FSWs interviewed have heard of HIV/AIDS of which 80.8 % knew people died of the disease (10.3 % said it was close relative, 28.7 % said it was a close friend). From the respondents, 75.9 % of them identified all the three basic programmatically important HIV preventive methods (Abstinence = 87 %, Being faithful = 81.7 % and use Condoms consistently = 89.2 %) but still there was a very high misconception (at least one) concerning the mode of transmission and means of prevention of HIV/AIDS (89.7 %). Some of the misconceptions drawn during the study were mosquito could transmit HIV (49.5 %), meal sharing could transmit HIV (11.1 %), eating raw egg of a hen that feeds on used condoms could transmit HIV (39 %) and eating raw meat handled by HIV positives could transmit HIV (54.9 %). Generally, misconception concerning HIV/AIDS during the study was two times more among the illiterates than their literate counterparts [(2)].

Eighty nine percent of the respondents started sexual practice at age less than 19 years and 46.2 % started it at age less than 16 years. The main reasons explained by FSWs to start commercial sex were, financial problem (41 %), death of parents (12.1 %), disagreement with family (21.8 %) and desire to be FSW (10.4 %) [(2)].

More than 68 % of FSWs reported having had one or more paying clients in the previous seven days while 12.1 % of them reported that they had never practiced commercial sex in the same time and the rest 11.4 % of them didn't remember the number of clients they had sex with. About 35 % of the FSWs reported that they have non-paying sexual partner [(2)].

Concerning their knowledge about male condoms, 99.2 % of the respondents have ever used condoms and almost all of them have heard of it. Ninety eight percent (97.6 % for home based sex workers) of the FSWs interviewed had used male condoms during their recent sex with paying clients (45.3 % decided to use condoms themselves 41.5 % of the occasions were done by joint decision) and 93.3 % of them used it consistently during the commercial sexual practice for the last 30 days from the time of interview. About 70.2 % of them have also

reported that they consistently used condoms for the last 12 months (both with paying clients and non paying partners). However, 21.7 % of the FSWs reported that they had not used a condom the last time they had sex with their non-paying partners [(2)].

About forty nine percent of the respondents believe that they can get a confidential HIV test in their community. About twenty eight percent of them have ever been tested for HIV of which 97.3 % have taken their results and 67 % of them have been tested with in the last 12 months and 17.9 % of them with in the past two years from the time of study [(2)].

Concerning exposure to interventions, even if there is low coverage of radio, television and printed media in the country as a whole, since the study was done in selected towns, 69.3 %, 47.5 % and 17 % of the respondents respectively had listened to radio, watched TV and read messages about HIV/AIDS during the last 12 months from the time of interview [(2)].

Exposure to media about HIV/AIDS was significantly and positively associated with knowledge of the three basic preventive methods and lack of misconception. Similarly education, exposure to media and personal risk perceptions were seen associated to condom use. As far as their risk perception is concerned, 27.9 %, 6.3 % and 16.2 % of the female sex workers could not rank their chance of contracting HIV, perceived their chances of contracting HIV to be high and moderate respectively; a further 17.9 % said there was a low chance and the rest 30.6 % thought there was no chance that they could be infected with HIV [(2)].

Reasons for their perceptions were:

- 82.7 % of FSWs with no/low risk perception said they always used condoms.
- Most FWSs with moderate/high risk perception said they had multiple sexual partners; condom had broken and had done sex with out condoms.

According to another study conducted in Addis Ababa in 1990 on FSWs, 52.2 % of the respondents said that they have practiced CSW for less than two years, 16.3 % of them for two to four years and the rest 14.5 % for longer than four years from date of interview. Concerning their educational status, 48.85 % and 33.9 % of them were illiterates and grades 1-6 respectively. And 15 % of the interviewees were married during the interview. Regarding their sexual practice, 55.4 % of them had less than or equal to one sexual partner, 29.9 % of them had 2-3 and the rest 14.7 % had 4-9 paying clients with in one week prior to the day of interview [(11)].

Another study was also conducted in 1990 on FSWs living in Addis Ababa which revealed that 7.1% of females of Addis Ababa aged 15-49 years were CSWs of which 3.6%, 50.7%, 43.9% and 1.8% respectively are married, never married, divorced and widowed and 2.3%, 29.9%, 56.8% and 15.8% respectively are illiterates, those who can read and write, primary school completed and high school completed at the time of the study. Concerning their condom use status, 2.9%, 56% and 41.45 of them were regular, occasional and non-condom users respectively [**(12)**].

2.2. The existing situation of HIV/AIDS

Our world has passed more than two decades during which HIV/AIDS is a global multi-faceted problem. According to The "report on Global AIDS, 2006" prepared by UNAIDS, there are about 40 million (34-64 million) people living with the virus of which 37 million are adults and the rest three million are children**.** This report has also added that about 5 million people are newly infected in a year (2005) and three million are died during the same year. Sub-Saharan Africa takes the lion's share of PLWHA with more than two-third (25 million) of burden of the world [**(14)**].

Ethiopia is one of the top hard hit African countries concerning the epidemic of HIV/AIDS. According to the 2006 AIDS in Ethiopia report prepared by Federal Ministry of Health, Ethiopia, the national prevalence rate of HIV is 3.5% (urban= 10.5%, rural= 1.9%, male= 3% and female= 4%) with about 1.32 million PLWHA**.** But there are global reports that indicate more than three million people are living with the virus in Ethiopia**.** The unadjusted/crude HIV prevalence rate among the antenatal care (ANC) attendant mothers sampled in 2005 is 5.3 % [1, 3]**.** UNAIDS has reported in 2003 that the prevalence rate of HIV among FSWs attending health centers in Addis Ababa, Ethiopia in 1998 was 73.7 %[14, 17]**.**

Some pocket studies show that the Amhara regional state is the most strongly hit region by the HIV epidemic. According to the "AIDS in Ethiopia" report prepared by FMOH of Ethiopia, Bahir Dar town is the leading town in the prevalence of HIV (20.2 %) among the ANC service users compared to other selected towns of the country for that specific sentinel survey [15]. When we see some exemplary results in Gojjam area concerning the prevalence of HIV among ANC service users in 2005, Mertolemariam (East Gojjam) is 2.8 % and Dangilla is 4.5 % respectively [1]**.**

Even if not well studied, commercial sexual transaction between farmers and local beverage sellers who practice commercial sex is usual and risky for the dissemination of HIV infection to the rural Ethiopia from general observations. These females are usually less educated and the farmers who are their usual sexual clients are too.

All these facts lead the Principal Investigator to plan for this research project with research questions:

1. What is the magnitude of commercial sex among LBSFs of towns of Gojjam?

2. What determinant factors are responsible to lead LBSFs practice commercial sex in towns of Gojjam?
3. What is the knowledge, attitude and risk perception of LBSFs towards HIV infection and condom use in towns of Gojjam?

3. OBJECTIVES

3.1. General objective

- To assess the status of commercial sex among local beverage selling females and to identify their risk perception towards HIV/AIDS and condom use in selected woreda towns of East and West Gojjam zones of the Amhara National Regional State.

3.2. Specific objectives - To:

- Identify the magnitude of commercial sexual practice among local beverage selling females of selected Gojjam towns
- Describe socio-economic background differences between local beverage selling females who practice and who do not practice commercial sex in selected Gojjam towns.
- Determine the knowledge, attitude and risk perception towards HIV/AIDS of the local beverage selling females in selected Gojjam towns.
- Determine the KAP on condom use status of the local beverage selling females in selected Gojjam towns.

4. METHODS

4.1. Study design

Both quantitative and qualitative methods are applied.

Quantitative design - this was a descriptive cross-sectional survey conducted in randomly selected LBSFs in three towns of East and West Gojjam zone of Amhara National Regional State using a pre-tested and structured questionnaire. The study was conducted from March 3-20, 2007 and an internal comparison was done between those who practiced commercial sex and those who didn't.

Qualitative part: - to substantiate and supplement the quantitative study, six focus group discussions (FGDs) was conducted among selected LBSFs in the three towns (one among sex workers and the other among non-sex workers per town) based on established guideline.

4.2. Study area background

East and West Gojjam zones are two of the zones of the Amhara National Regional State representing more than five million people. The three specifically selected towns (Debre Markos, Dembecha and Finote Selam) are the administrative towns of Gozamen, Dembecha and Jabi-Tehnan woredas/districts; respectively, located about 300, 345 and 380 kms North-West of Addis Ababa on the road taking from Addis Ababa City to Bahir Dar town. These towns represent the three agro-ecological zones (Dega/cold zone, Wayna dega/high land zone and Kolla/low land zone) corresponding respectively to Debre markos, Dembecha and Finote Selam. Farmers and other males with different socio-economic background in the three Woredas/districts used to sell their cereals and other agricultural products especially during market days like Saturday and Wednesday and drink local beverages like Tella and Arakie. During these days it is not unusual to see large number of farmers presumably with low awareness level on HIV/AIDS and condom use to pass the night with home based female sex workers (HBFSWs) purchasing sex for money.

4.3. Reference population -constitutes all LBSFs in East and West Gojjam.

4.4. Source population - all local beverage selling females in the towns of Debre Markos, Dembecha and Finote Selam.

4.5. Study population or sample - 354 LBSFs randomly selected by lottery method from the three study towns.

Inclusion criteria - all LBSFs living in the three towns currently not married and/or not living in union with husband.

Exclusion criteria - married LBSFs and those who were seriously sick and incapable of responding for the interview.

4.6. Sample size determination

The sample size was determined using the formula for single proportion.

$$\mathbf{n = \frac{p\,(1-p)\,(z_{\alpha/2})^2}{d^2}}$$

Where; n = sample size (number of samples)

p = proportion of female sex workers during the 2002 HIV/AIDS BSS study at Bahir Dar town who practiced sex with out condom at the last commercial sex that perceived themselves with low or no risk of HIV infection (0.35)

α = level of significance (0.05)

z = standard deviation at standard normal curve of 95% CI

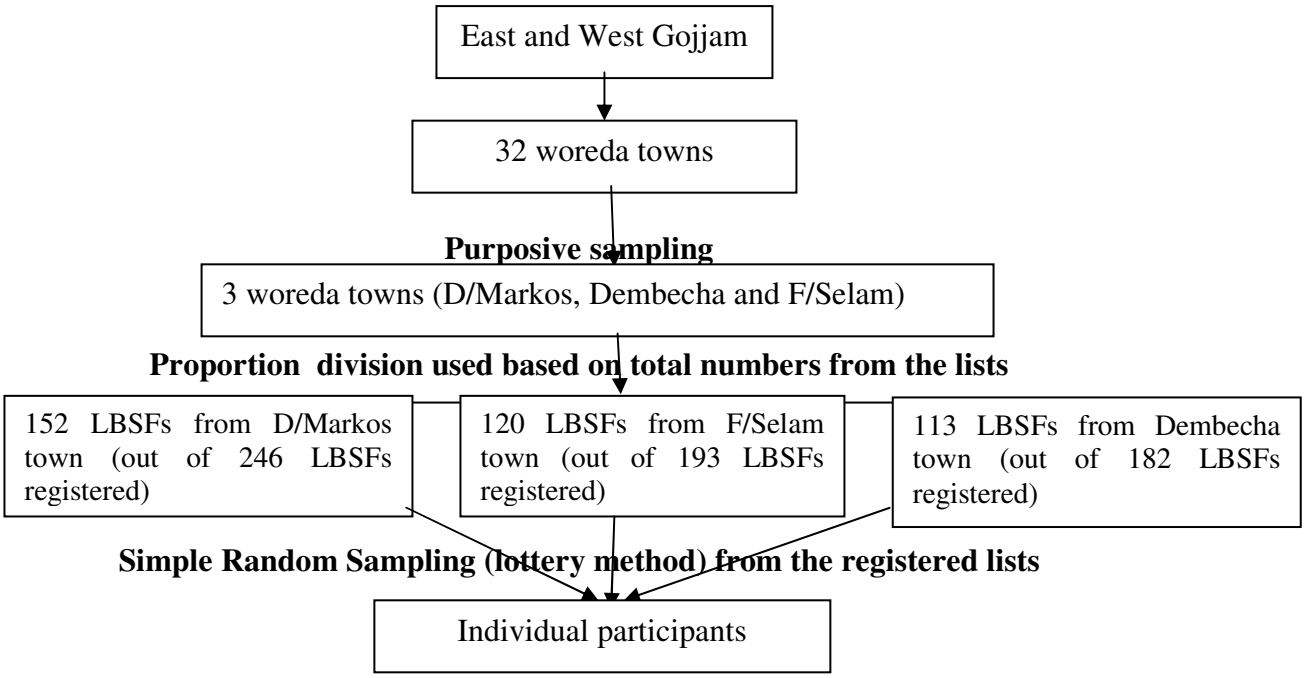
d = absolute precision (maximum tolerable error) which is 5 %

$$n = \frac{(0.35)(0.65)(1.96)^2}{(0.05)^2} = \frac{0.87}{0.0025} = 350$$

Finally, 10% contingency (350 x 10% = 35) has been added on the sample size 350 to make total sample size 385. Then the number of participants were divided in to three towns proportionally based on the number of LBSFs registered under each town.

4.7. Sampling procedure

Fig 1: Sampling frame work



a. Selection of the three towns

Purposive/non-probability sampling method was applied to select the three towns out of the 32 Woreda towns of East and west Gojjam zones. This method was applied due to the following reasons:

i. The selected towns can reasonably represent all the 32 towns of Gojjam as they represent the three agro-ecological zones. Thus people in different socio-economic status of the reference population can be represented as socio-economic status of people is determined by the agro-ecological situation in all zones of Gojjam.

ii. The local beverage selling transaction is also more or less dependent with the agro-ecological situation of the towns (Tella is common in low lands and Arakie in high lands) and both low land and high land towns of Gojjam are represented by the selected three towns for this study.
iii. Out of the 32 woreda towns of Gojjam, LBSFs in the above mentioned towns are well registered by AMA and women affairs offices of the respective towns for awareness raising and income generating activities.

b. Selection of individual study units

The study units are LBSFs achieving the inclusion criteria and they were selected applying the simple random sampling (SRS) or lottery method using their lists as a sampling frame.

4.8. Data collection procedure

a. Quantitative part

The following procedures have been applied during data collection:

a) Structured questionnaire was prepared in English, translated to Amharic and back to English. And data collectors and a supervisor were selected from each town and trained on data collection and supervision for two consecutive days by the principal investigator.
b) Pre-testing of the questionnaire was conducted in Amanuel (another woreda/district town in Gojjam area) and amendments have been made to the questionnaire based on experiences obtained from the pre-test.
c) The data collectors have divided the study participants among geographically feasible catchments, have taken informed consents and have conducted data collection process for four consecutive days per town (totally for 12 consecutive days, March 3-15, 2007). The supervisor and principal investigator have followed the day-to-day processes of data collection.

b. Qualitative part

Two types of FGD guidelines were prepared, one for those who practice commercial sex and the other for those not practicing commercial sex. Then 60 FGD participants (10 from those who practice commercial sex and 10 from not per town) were selected from LBSFs who have

participated during the quantitative study. The principal investigator and the supervisor have facilitated the FGD in accordance with the prepared guidelines. In such a way both FGDs, among those who practice commercial sex and among not, have been conducted for half day for each team taking three consecutive days totally (one at morning and the other at the after noon per town).

4.9. Terminologies and operational definitions

a) **Arakie** - a local beverage prepared from cereals and leaves of a plant called "Gesho (*RHAMNUS prrinoides*)" by evaporation process.

b) **Commercial Sex/prostitution** - a sexual relationship where money was paid for sex .

1. **Home based** - soliciting clients at the sex worker's own home.
2. **Bar based** - soliciting clients in bars/hotels.
3. **Street based** - soliciting clients at street and road sides.

c) **Comprehensive knowledge about HIV/AIDS (UNAIDS indicator)** – respondents were considered to have comprehensive knowledge about HIV/AIDS if they were both knowledgeable about the three HIV/AIDS prevention methods and had no incorrect believes about HIV transmission.

d) **Dega** – a cold climatic zone above 2,200 meter above see level.

e) **Female sex worker** – a female who sells sex for money.

f) **Kimit/Wushima** - relatively regular sexual partner (not legal wife) with out daily payment.

g) **Kolla** – a low land climatic zone below 1,500 meter above see level.

h) **Knowledge about HIV prevention** – respondents were considered to be knowledgeable about HIV prevention if they correctly identified the three main ways to prevent HIV transmission: abstinence, being faith full to one uninfected partner and condom use.

i) **Local Beverage** - a type of beverage which is produced locally without factory processing.

j) **Local Beverage Selling Female** - Females who are selling local beverages like Arakie and Tella in rented houses to their customers.

k) **National indicator of Knowledge about HIV/AIDS** – People are considered knowledgeable about HIV/AIDS if they have an acceptable response to five questions assessing knowledge. The questions were "Can HIV be transmitted with mosquito bite?", "Can a person get HIV by sharing a meal with some one who is infected?", "Do you think that a healthy looking person can be HIV positive?", "Can people protect themselves from HIV by using a condom correctly every time they have sex?", and "Can people protect themselves from HIV by having one uninfected faith full sex partner?".

l) **No misconception (no wrong belief) about HIV/AIDS transmission** – respondents were considered to have no incorrect belief about HIV/AIDS transmission if they correctly rejected statements expressing the two most common local misconceptions about HIV "eating raw meat prepared by an HIV infected person transmits the virus" and "eating uncooked egg laid by a chicken that has swallowed a used condom transmits HIV infection", and a healthy looking person doesn't have HIV infection" (UNAIDS recommended).

m) **Paying Client** - Sexual partner of a female sex worker who paid money in exchange for sex.

n) **Regular Partner** - non - paying spouse or cohabiting (live in) sexual partner.

o) **Teji** - a local beverage prepared from honey, cereals and leaves of a plant called "Gesho (*RHAMNUS prinoides*)" by fermentation process.

p) **Tella** - a local beverage prepared from cereals and leaves of a plant called "Gesho (*RHAMNUS prinoides*)" by fermentation process.

q) **Woyna dega** – a high land climatic zone 1,500-2,200 meter above see level.

4.10. Data Quality Management

To ensure the **external validity (generalizabilty)** of the study, appropriate size and representative type of study units have been selected as described in the appropriate sections above. And to ensure the **internal validity (accuracy and precision**) of the study, maximum effort has been applied to minimize bias and errors using the following strategies:

4.8.1. During data collection process: - in order to enable proper functioning of the questionnaire as per the desired objectives, pre-testing was conducted prior to data collection process. And some of the contents of the questionnaire were also validated by the national

HIV/AIDS BSS of Ethiopia. Then trained data collectors had collected data using the amended questionnaires.

4.8.2. During data entry: - data was double entered using the SPSS soft ware package by the principal investigator and another experienced data clerck. Then the data entered was cross-checked and cleaned for some errors prior to data analysis.

4.8.3. During data analysis and report writing: - SPSS version 12.0 soft ware program was used to analyze the quantitative data with repeated check up deliberation and manual method of analysis after transcribing and summarizing of the FGD outcomes was applied for the qualitative data.

4.11. Analysis Procedure

a. Quantitative part

Based on the study objectives, first independent/explanatory and dependent/response variables were selected for analysis from the already entered variables. Then descriptive (frequency distribution) and analytical (bivariate and multivariate) analyses have been conducted using risk ratio (odds ratio) and multiple logistic regression statistical methods using SPSS version 12.0 computer package. P-values less than or equal to 0.05 are considered as significant.

Bivariate analysis is used to find out the statistical association between commercial sexual engagement and socio-demographic variables namely: age at the time of interview, duration of time in local beverage selling, educational status before local beverage selling, residence before local beverage selling, presence or absence of persons under economic support and presence or absence of additional means of income other than local beverage selling for the females under study.

Multivariate analysis is used to investigate determinant factors of commercial sexual engagement considering the following variables as exposure variables; marriage related factors (death of husband, early marriage, distaste to be a house wife and divorce), history of family related factors (job condition of bread winner of the family, family size, quarrel with parents and death of family) and other socio-economic factors (personal income level, peer pressure, distaste to be house maid, school failure and interest to live in the town).

b. Qualitative part

After the qualitative data was collected using guidelines, the principal investigator analyzed the information obtained manually. This data is used to supplement the results obtained using the quantitative method so that the internal validity of the study is enhanced. Again individual perceptions and opinions of the FGD participants were evaluated that the pre-adjusted questionnaire was unable to obtain. Thus qualitative descriptions and in-depth knowledge and attitudes of the participants about the study matter were obtained that made this research full and qualitatively supported.

4.12. Study variables

1. **Explanatory variables**: -
   - **Socio-demographic variables** (age, educational status, marital history and its conditions, residence and occupation etc…)
   - **Risk factor variables** (marital history, economic background, occupational history, peer pressure, school life, family integrity, future desire, and number of house holds etc…).
   - **Knowledge Attitude and Practice (KAP) on HIV/AIDS and condom use**
2. **Outcome variables**: - Status of commercial sexual practice (CSW or not) and KAP on HIV/AIDS and condom use

4.13. Ethical consideration and dissemination of results

After the proposal has been thoroughly evaluated, it has been approved by the advisor, the DCH and the Research and Duplication Committee of Medical Faculty. The approval of the proposal indicated that this research is scientifically sound and ethically accepted. Right after the approval of the proposal, the DCH itself has funded the research project after which official and informal communications have been conducted with AMA, town administrative and town women affairs offices of the three towns. The supervisor and data collectors have been trained on every ethical issue. Guided by a standard protocol, the data collectors have taken informed verbal consents from each study participant so that all of the participants were convinced and have given the information participated voluntarily. Confidentiality of the information obtained from participants was strictly maintained all throughout and name or any specification of respondent's individual personality was not included in the questionnaire

paper. Primary counseling has been provided to some participants by the Principal Investigator after data has been collected. But no one was referred to health institutions, as there was no need identified.

After the approval of the research paper by the department, it will be disseminated to the DCH of AAUMF, AMA, female affairs, HAPCO, town administration and other offices of each district/woreda and the Amhara Regional Health Bureau.

5. RESULTS

5.1. Quantitative results

i. Socio-demographic characteristics

A total of 354 out of the planned 385 (the non-response rate was 8.9 %) unmarried women at the time of interview, who were leading their lives by selling local beverages (tella, Arakie and teji) in their own houses were interviewed in Debre Markos (140), Dembecha (104) and Finote Selam (110) towns from March 3 – 20, 2007 and the following results have been obtained.

The majority, 106 (29.9 %) of the respondents were 35-44 years old and 103 (29.1 %) of them were 44 and above years old. The rest LBSFs (21.2 %, 15.3 % and 4.5 %) were those 25-34, 15-24 years old and responded that don't know their ages respectively. But none of the interviewed females was less than 15 years old. (Table 1)

Most, 190 (53.7 %) of the respondents have stayed selling local beverages for six and above years and the remaining 18.1 %, 13.8 % and 8.8 % of these females have worked local beverage selling as a mainstay job for 1-3, 4-6 and less than one years respectively while the rest 5.6 % either have no response or do not remember their exact duration of being engaged to this job. (Table 1)

As far as their educational status is concerned, the proportion of illiterates before local beverage selling was 50.6 % and it was 45.6 % at the time of interview. About 12 % of the respondents were included in educational grades 1-4 before engaged in local beverage selling while this figure was raised to 13.3 % at the time of interview. Only 6.2 % of the interviewed females were educated to grades 9-12 before starting local beverage selling while the figure has raised to 12.7 % at the time of interview. (Table 1)

Comparison of educational status was made between the time of starting local beverage selling and the time of interview. Two percent of the females have been found to have started education after already being engaged in local beverage selling. And again changes have been observed at grade ranges 1-4 and 9-12 with 1.2 % and 6.5 % improvements respectively while 3 (0.8 %) of the interviewee were educationally above grade 12 both before starting local beverage selling and at the time of study. (Table 1)

A lion's share of the study participants 163 (46 %) were divorced before starting local beverage selling while the rest 19.8 %, 14.4 %, 14.4 % and 5.4 % were widowed, never been married, married but living separated and married but ran away their husbands with respect of their orders. (Table 1)

Regarding their age at first marriage for ever married local beverage selling females; overwhelmingly, 76 % of them were married before celebrating their 18^{th} birth day (recommended minimum age of marriage), 57.8 % of the females married before 16 years and even more worryingly large proportion (21.5 %) of them while they were kids less than 10 years old. (Table 1)

Again as 72.3 % of the marriages were arranged by sole decision of parents without the knowledge and consent of females to be married, the condition of marriage was claimed to be not appropriate for the studied females. Abduction and marriage without the knowledge and consent of parents were relatively rare cases being 3.3 % and 3.0 % respectively. (Table 1)

Most of the respondents, 156 (44.1 %) were living in the respective town of current residence before starting local beverage selling while the remaining 32.2 % and 22. 9 % came from rural area (peasant associations) and other towns respectively. And about half of them were

housewives and 22.0 % were housemaids before entering to this job while 16.1 %, 6.5 % and 4.0 % were students, unemployed living with their parents and unemployed living with their relatives respectively. (Table 1)

Ninety nine percent of the respondents were Orthodox Christian and 95.5 % of them were Amharas. (Table 1)

More than two-third (64.7 %) of the participants were permanently supporting others economically during the time of interview of which 38.7 % providing support to 1-2 individuals and 19.2 % to 3-4 persons. And 87.5 % of the respondents were supporting their children while the rest to their mothers, fathers and sisters. (Table 1)

Concerning additional jobs other than local beverage selling, 257 (72.6 %) of them have no any additional jobs where as 98 (27.7 %), 9 (2.5 %) and 16 (4.5 %) of them have additional jobs namely: commercial sex, urban agriculture and micro trading respectively. (Table 1)

Table 1. Socio demographic characteristics of local beverage selling females (LBSFs) in towns of Gojjam, March 2007 (n=354)

SN	Variable	Number (percent)
1.	**Age at the time of interview (years),**	
	<15	0 (0)
	15-24	54 (15.3)
	25-34	75 (21.5)
	35-44	106 (29.9)
	>44	103 (29.1)
	Don't know their age	16 (4.5)
2.	**Duration of time in local beverage selling (years)**	
	<1	31 (8.8)
	1-3	64 (18.1)
	4-6	49 (13.8)

	>6	190 (53.7)
	Don't know	11 (3.1)
	No response	9 (2.5)
3.	**Educational status at the time of interview**	
	Illiterate	72 (48.6)
	Read and write	30 (8.5)
	Grade 1-4	47 (13.3)
	Grade 5-8	57 (16.1)
	Grade 9-12	45 (12.7)
	Above grade 12	3 (0.8)
4	**Educational status before local beverage selling**	
	Illiterate	179 (50.6)
	Read and write	30 (8.5)
	Grade 1-4	43 (12.1)
	Grade 5-8	77 (21.8)
	Grade 9-12	22 (6.2)
	Above grade 12	3 (0.8)
5.	**Marital status before local beverage selling**	
	Never married	51(14.4)
	Divorced	163 (46.0)
	Widowed	70 (19.8)
	Married but ran away	19 (5.4)
	Married but separated	51 (14.4)

Table 1. Socio-demographic characteristics… (Continuation)

SN	Variable	Number (percent)
6.	**Age at 1st marriage (for ever married), n=303**	
	<10 years	65 (21.5)
	10-15 years	110 (36.3)
	16-18 years	55 (18.1)
	Above 18 years	33 (10.8)
	Don't know	40 (13.2)
7.	**Condition of first marriage (for ever married), n=303**	

		With full agreement of females themselves	61 (20.1)
		Arranged by family alone with out females' consent	219 (72.3)
		Abduction (telefa)	10 (3.3)
		Female's decision with no family involvement	9 (3.0)
		Don't know	4 (1.3)
8.	**Residence before local beverage selling**		
		Current town	156 (44.1)
		Another town	81 (22.9)
		Rural area	114 (32.2)
		No answer	3(0.8)
9.	**Occupation before local beverage selling**		
		House wife	179 (50.6)
		Housemaid	78 (22.0)
		Student	57 (16.1)
		Unemployed and living with family	23 (6.5)
		Unemployed and living with relative	14 (4.0)
		No answer	3 (0.8)
10.	**Religion**		
		Orthodox Christian	351 (99.2)
		Muslim	3(0.8)
11.	**Ethnicity**		
		Amhara	338 (95.5)
		Agew	8 (2.3)
		Tigrie	3 (0.8)
		Other (Mixed race)	5 (1.4)
12.	**Persons under economic support by LBSFs**		
		No person	125 (35.3)
		1-2 persons	137 (38.7)
		3-4 persons	68 (19.2)
		>4 persons	19 (5.4)
		No answer	5 (1.4)
13	**Relation with economic dependants, n=349**		
		Children	196 (87.5)
		Mother	12 (5.4)
		Father	3 (1.3)
		Sister	13 (7.5)
14.	**Additional means of income (other than selling alcohol)** *		
		No additional means of income	257 (72.6)
		Sex work	98 (27.7)
		Agriculture	9 (2.5)
		Trade	16 (4.5)
		No response	5(1.4)

- ***Multiple responses per respondent were obtained.***

ii. Sexual history and magnitude of commercial sex among LBSFs

Of the total 354 females interviewed, 59 (16.7 %) had claimed to be virgins at the time of interview while 61.2 % of them started sexual intercourse at younger than 18 years and 47.4 % of these females did it before celebrating their 16th birth day. Nine percent of the

respondents have reported that their ages were less than 10 years when they have their first sexual intercourse; however, encouragingly 37 (10.5 %) of the local beverage-selling females interviewed have reported that they have had their first sexual contact at age older than 18 years and the rest 41 (11.6 %) didn't know their ages during their first intercourse at the time of interview. (Table 2)

Comparison was made between the age at first marriage and age at first sexual exposure, which shows that age of first marriage and age of first sexual intercourse were not necessarily of the same timing; for this study participants, females marry earlier than they do first sexual contact. The proportion of LBSFs with age less than 18 years during their first marriage was 76 % while it was 61.2 % for females having first sexual contact before 18 years. Again, 21.5 % of the studied females have married earlier than 10 years of age while 9 % of the same group of females have practiced their first sexual intercourse. (Table 2)

Most, 239 (81 %) of the studied females who have already started sex have started it with their husbands even if 64 (21 %) of the ever married females have reported that they have started sex with somebody other than their husbands (some of them primaritally and some others after their first marriages). The remaining 10.2 % and 8.8 % of the respondents who have started sex have reported that they have started intercourse with their boy friends and with persons whom they don't know, respectively. (Table 2)

The vast majority, 231 (78.3 %) of studied females who have started sexual intercourse had no non-paying regular sexual partners while the remaining 18.6 % and 3.1 % had only one and more than one regular non-paying partners, respectively, during the time of interview. About one-fifth (20.3 %) of the studied females who have started sexual intercourse have reported that they had practiced sex with only one non-paying partner and 7.5 % have done it with two or more of their partners while 69.5 % of them have not practiced sex with non-paying partners with in seven days prior to the day of interview. (Table 2)

Regarding the number of intercourses they had practiced per day with their recent non-paying partners, the percentage of females showed decreasing trend from 34.6 % to 5.8 % as the

number of intercourses per day increasing from 1-2 to more than 6 times per day (i.e. 34.6 % of them practiced sex 1-2 times per day while 5.8 % of them practiced sex more than 6 times per day). (Table 2)

The studied LBSFs were asked if they had ever practiced commercial sex while they were engaged in local beverage selling and it was found that 137 (38.7 %) of them have ever practiced commercial sex once in their lives. However, currently 98 (27.7%) of the interviewed females are practicing sex for money, which indicates 39 (28.5 %) of those who have ever practiced commercial sex have interrupted commercial sex. (Table 2)

Eighty-eight (90 %) of the currently practicing sex workers have reported that they solicit their sex clients within their own home where they sell local beverage and the rest 10 (10 %) of them have reported that they usually search for their client at hotels/bars. (Table 2)

Female Sex Workers (FSWs) of the LBSFs were asked about the job status of their sexual clients and they reported that farmers (91.8 %) were their most frequent clients and merchants (86.7 %), daily laborers (78.6 %), employees (65.3 %) and students (53.1 %) were also their clients in descending order of their frequency. (Table 2)

About 18 % of the studied FSWs have reported that they had commercial sexual exposures with 4-7 persons within a week prior to the day of interview while more than half of the FSWs had practiced it with 1-3 persons with in the same duration. The remaining a third of the FSWs have responded that they had no any sexual contact for money for seven days prior to the date of interview. (Table 2)

Most, 42 (42.9 %) of the FSWs have practiced sex for money with a maximum of two persons/day within 30 days prior to the day of interview while 10.2 %, 27.6 % and 9.2 % of them have practiced commercial sex with a maximum of one, three and more than three persons respectively prior to the day of interview. However, one tenth of the interviewed

FSWs didn't remember the maximum number of clients they had sex with for the last 30 days from the date of interview. (Table 2)

Concerning the number of sexual intercourses per day with the last paying clients to the day of interview, about half of the FSWs have responded that they have practiced intercourse 1-2 times a day with their recent clients while 33.7 % of them had sexual contacts 3-4 times/last day and the rest 7.2 % had contacts more than four times/last day. But 10.2 % of them didn't remember the frequency of sexual contacts with their recent clients. (Table 2)

Table 2. Sexual history and magnitude of commercial sexual practice among LBSFs in towns of Gojjam, March 2007 (n= 354)

SN	Variable	Number (Percent)
1.	**Age at first sexual intercourse (years)**	
	Not started yet	59 (16.7)
	<10	32 (9.0)
	10-15	136 (38.4)
	16-18	49 (13.8)
	>18	37 (10.5)
	Don't know	41 (11.6)
2.	**First sexual intercourse with (for those who started sex), n = 295**	
	Husband	239 (81.0)
	Other regular partner	30 (10.2)
	Unknown person	26 (8.8)
3.	**Current non-paying regular sexual partner (for those who started sex), n = 295**	
	No	231 (78.3)
	One	55 (18.6)
	More than one	9 (3.1)
4.	**Number of non-paying partners in the last 7 days having sex with (for those who started sex), n = 295**	
	No	205 (69.5)
	Only one	60 (20.3)
	2 persons	13 (4.4)
	3-4 persons	9 (3.1)

Don't know	5 (1.7)
No response	3 (1.0)

Table 2. Sexual history and magnitude of commercial sexual practice... (Continuation)

SN	Variable	Number (Percent)
5.	**Number of sexual intercourses/day with recent non-paying partner (for those who started sex), n = 295**	
	1-2 times	102 (34.6)
	3-4 times	65 (22.0)
	5-6 times	39 (13.2)
	> 6 times	17 (5.8)
	Don't know	72 (24.4)
6.	**History of commercial sex work**	
	Not ever practiced	217 (61.3)
	Ever practiced	137 (38.7)
7.	**Current status of commercial sex (practicing commercial sex or not)**	
	Not practicing	256 (72.3)
	Practicing	98 (27.7)
	For currently practicing commercial sex workers only, n = 98	
8.	**Place of soliciting sex with paying clients**	
	Female's own house	88 (89.8)

	Hotel/bar	10 (10.2)
9.	**Job status of paying clients** *	
	Farmers/Peasants	90 (91.80)
	Employees	64 (65.30)
	Merchants	85 (86.70)
	Students	53 (53.10)
	Daily laborers	77 (78.6)
10.	**Maximum number of paying client per day with in the last 1 month (30 days)**	
	1 person	10 (10.2)
	2 persons	42 (42.9)
	3 persons	27 (27.6)
	More than three persons	9 (9.2)
	Don't know	10 (10.2)
11.	**Number of paying clients in the last seven days having sex with**	
	no	30 (30.6)
	1-3 persons	50 (51.0)
	4-7 persons	18 (18.4)
12.	**Number of sexual intercourses/day with recent paying client**	
	1-2 times	48 (49.0)
	3-4 times	33 (33.7)
	5-6 times	3 (3.1)
	> 6 times	4 (4.1)
	Don't know	10 (10.2)

**** Multiple responses per respondent were obtained***

iii. Determinant factors for commercial sex among LBSFs

Different social, cultural and economic factors have been assessed for their associations with commercial sexual practice among the studied 354 local beverage selling females through bivariate and multivariate analyses using risk measurement (odds ratio) and binary multiple logistic regression statistical methods. (Table 3)

Illiteracy among LBSFs studied has been found to be statistically associated with commercial sex with **AOR of 1.1 (95 % CI, 1.01-1.2)**. Again, it is found that as the duration of being engaged in local beverage selling increases from less than or equal to three years to greater than or equal to four years, the tendency to practice commercial sex also increases by 20 % with **AOR of 1.2 (95 % CI, 1.17-1.7)**. This study has also documented that older LBSFs whose ages are greater or equal to 35 years are found to participate in commercial sex in higher proportion than those LBSFs whose ages are less or equal to 34 years old with statistical significance of **AOR, 1.3 (95 % CI, 1.13-2.6)**. LBSFs without additional income meanses tend to practice commercial sex compared to LBSFs who are practicing town agriculture and trade in addition to local beverage selling with AOR of **12.2 (95 % CI of 7.3-15.0)**. However, residence before local beverage selling (rural or town) and supporting others economically or not have no statistically significant association with commercial sexual engagement with 95 % CI AOR of 0.8-1.8 and 0.58-1.20, respectively. (Table 3)

Table 3 – Socio demographic factors affecting LBSFs to practice commercial sex in towns of Gojjam, March 2007 (n=354)

SN	Variable	Status of CSW among LBSFs (n)		COR (95 % CI)	AOR (95 % CI)
		Sex workers	Non-sex workers		
1.	**Educational status before local beverage selling**				
	Illiterates	80	99	**1.37 (1.05-1.8)**	**1.10(1.01-1.20)**
	Literates/at least read and write	57	118	1.00	1.00
2.	**Duration of local beverage selling**				
	≥ four years	89	118	**2.86 (1.80-2.96)**	**1.30(1.20-1.70)**

≤ three years	48	99	1.00	1.00
3. Age at the time of interview				
≥ 35 years	93	119	**1.99 (1.24-3.2)**	**1.30(1.12-2.60)**
≤ 35 years	44	98	1.00	1.00
4. Residence before local beverage selling				
Town	86	154	1.40 (0.9-2.24)	1.12(0.80-1.80)
Rural	51	63	1.00	1.00
5. Persons under economic support by LBSFs				
Yes, present	48	77	1.02 (0.65-1.60)	0.80(0.58-1.20)
No, absent	89	140	1.00	1.00
6. Additional means of income (Agriculture and trade)				
No	64	196	**19.0 (9.67-37.37)**	**12.2 (7.30-15.0)**
Yes	73	12	1.00	1.00

A multivariate analysis of determinant factors for commercial sexual engagement among local beverage selling females was conducted using binary multiple logistic regression taking different family related, marriage related and other socio-economic factors which are assumed to be associated with commercial sexual engagement. (Table 4)

Results from family related factors showed that the job condition of head of the family such as being local beverage seller and daily laborer have statistically significant associations with entering to commercial sex (AOR with 95 % CI of **1.3-12.1** and **1.2–3.6** respectively**).** (Table 4)

Again the study showed that a girl from a commercial sex worker mother has 50 % higher probability to be commercial sex worker compared to a girl from non-commercial sex worker. Other family related factors such as quarrel with family and deaths of either/both parents are also highly associated with commercial sex (AOR with 95 % CI of **8.9-32.2** and **5.3-21.5** respectively). Where as, other family related factors like family size is not found to be associated with commercial sexual engagement. (Table 4)

Marriage related factors like death of husbands, early marriage and distaste to be a housewife have been found to be significantly associated with being commercial sex workers (AOR with 95 % CI of **4.3 - 14.1, 3.5 - 11.5** and **1.53 - 6.10**, respectively). (Table 4)

However, divorce has not exhibited any statistically significant contribution as a determinant factor for commercial sexual engagement. (Table 4)

Other socio-economic factors like personal income level before starting local beverage selling, peer/external pressure, distaste to be a housemaid and self interest to live in towns are also found to contribute their own shares to lead females to commercial sex work with AOR at 95 % CI of **1.4 - 6.9, 11.0 - 80.7, 12.1 - 54.4** and **1.37 - 5.6**, respectively. (Table 4)

Table 4: - Multivariate analysis of socio economic and cultural factors determining status of commercial sex among LBSFs in towns of Gojjam, March 2007 (n=354)

SN	Variable	AOR (95% CI)	P – value
1. Family related factors before starting local beverage selling			
	Job condition of bread winner of the family, local beverage seller	**3.97(1.30-12.1)**	**0.015**
	Job condition of bread winner of the family, commercial sex worker	**1.50(1.20-4.03)**	**0.04**
	Job condition of bread winner of the family, daily laborer	2**.40(1.20-3.60)**	**0.052**
	Family size (above 4)	1.60(0.80-3.10)	0.155
	Quarrel with family	2**3.7(8.9-32.2)**	**0.000**
	Death of either/both parents	**8.70(5.30-21.5)**	**0.000**
2. Marriage related factors before starting local beverage selling			

Death of husband	**7.80(4.30-14.1)**	**0.000**
Early marriage	**6.34(3.50-11.5)**	**0.000**
Distaste to be a housewife	**3.10(1.53-6.10)**	**0.002**
Divorce	1.40(0.80-2.30)	0.254
3. Other socio economic factors before starting local beverage selling		
Personal income level (low and very low)	**3.76(1.40-6.90)**	**0.023**
Peer pressure	**30.0(11.0-80.7)**	**0.000**
Distaste to be housemaid	**25.7(12.1-54.4)**	**0.000**
School failure	1.76(0.86-3.60)	0.120
Interest to live in the town	**2.77(1.37-5.60)**	**0.050**

iv. KAP and risk perception of LBSFs on HIV/AIDS

Almost all (99.2 %) of the study participants have knowledge of HIV/AIDS (100 % of CSWs and 98.6 % on non-CSWs) and the most frequently explained meanses/sources of information explained were radio (90.6 %), TV (80.6 %), health facilities (72.1 %), peer education (70.7 %), NGO programs (57.3 %) and print media (43.3 %) respectively. (Table 5)

Again 72.7 % of the respondents have reported that they know people living with and/or died of HIV/AIDS (27.4 % close relatives, 17.9 % close friends and 27.4 % neither relatives nor friends). (Table 5)

Regarding attitudes of the respondents towards curability of HIV/AIDS, 21.4 % (13.1 % CSWs and 29.7 % non-CSWs, no statistically significant difference) believe that it can be cured by modern medicine (12.8 %), holly water 8.3 % and traditional medicine 0.3 %. Again more than half of the respondents (49.6 % of CSWs and 63.1 % of non-CSWs) believe that all people living with HIV should start ART. (Table 5)

Concerning prevention and self-protection, 12 % of the interviewed females believe that it is non-preventable so that they can't prevent themselves from HIV infection. (Table 5)

Educational status has not exhibited any statistically significant contribution for the knowledge that persistent condom use prevents HIV infection, to know who should start ART and to develop the right attitude on curability of AIDS with 95 % confidence interval COR of 0.4-1.3, 0.4-1.1 and 0.4-1.1 respectively. (Table 5)

Regarding knowledge about HIV prevention, 65 % of the interviewed females have described the three programmatically important prevention methods (abstinence 90.7 %, being faithful 89.4 % and using condoms consistently 81.6 %) properly. And 33.3 % of them (based on the national indicator) have comprehensive knowledge about HIV/AIDS and this figure rises to 37.9 % (according to the UNAIDS indicator). Again it was found that 60.5 % of the respondents have no misconception (no incorrect belief about HIV/AIDS transmission) while the rest 39.6 % have at least one misconception about HIV/AIDS transmission according to the UNAIDS indicator (sharing meal with HIV positive person transmits HIV 7.1 %, eating raw meat prepared by an HIV infected person transmits the virus 20.2 %, eating uncooked egg laid by a chicken that has swallowed used condom can transmit HIV 18.2 %, mosquito bite can transmit the virus 30.8 % and about 12 % of the respondents believe that healthy looking people can't be HIV positive). (Table 5)

As far as the knowledge of respondents on mode of transmission is concerned, 77.8 % of them know that multiple sexual partnership without using condoms can transmit HIV, 86.6 % of them know that sharing sharp tools can transmit the virus, 83.5 % of them know that any blood contact can transmit HIV and 67 % of the respondents also know that HIV can be transmitted from mother to child. (Table 5)

One hundred and one (28.8 %) of the interviewed females have been ever tested for HIV (27 % CSWs and 29.9 % non-CSWs). Of the ever-tested females, 88.1 % have obtained their results while the rest 11.9 % of them didn't obtain it. About 69 % of the ever tested females have been tested with in a year and 28.3 % of them did it with 2-4 years from the day of

interview. Being sex worker or not has not manifested with any significant association with either to be tested or not for HIV/AIDS, with COR of 0.54-1.4 (95 % CI). (Table 5)

For the future, 72.6 % (75.9 % CSWs and 70.9 % non-CSWs) of them have planned to be tested for HIV because of history of unsafe sex (34.1 %), feeling of sickness (25.2 %), sickness or death of partners (24 %), plan to marry (31 %), plan to go to abroad (5.8 %), plan to give birth to baby (16.2 %) and because of pregnancy (4.3 %).(Table 5)

Again females who didn't plan to be tested were asked for their reasons why they didn't plan. The indicated reasons were I don't see the necessity/not applicable to me (67 %), since no cure no need of testing (31.3 %), fear of hearing about positive results (26.6 %) and fear of stigma and discrimination (22.3 %).(Table 5)

Females were asked to rank their chance of being infected with HIV (as no, mild, moderate and high) based on their past sexual and other risk behaviors. One hundred and ninety two (55.8 %) of the respondents perceived that they have no/mild chance of being infected with HIV (37.9 % CSWs and 65.4 % non-CSWs) and 149 (42.4 %) of them perceived that they have moderate/high chance of being positive for the virus (62% CSWs and 29.9% non-CSWs) whilst the rest 1.6 % of the females couldn't grade their chance of being infected with HIV. (Table 5)

Respondents were asked to give reasons for their personal perceived risks of HIV infection. The majority (30.9 %) of LBSFs, who perceived their risk to be nil or mild, said that they have no history of sexual intercourse and 37.6 % have reported that they have limited themselves with single sexual partner. About 10 % of them also said that they persistently use male condoms while the rest 22 % of those who perceived no/mild chance of HIV infection either don't know or have no response for the reasons they said so. (Table 5)

Amongst the LBSFs who perceived their risk of HIV infection as moderate or high, the most common reasons given were sexual exposure with multiple partners with out condoms (83.5 %) and 12.3 % of them have reported also that there was condom breakage during sexual

intercourse while the rest 4.1 % had different reasons like sharing needles and other non-sexual blood contacts. (Table 5)

Table 5. KAP and risk perception on HIV/AIDS and VCT among LBSFs in towns of Gojjam, March 2007 (n=354)

SN	Variable	Status of commercial sex		
		CSW (%)	Non -CSW (%)	Total (%)
1.	**Ever heard of HIV/AIDS**			
	No	0 (0)	3 (1.4)	3 (0.8)
	Yes	137 (100)	214 (98.6)	351 (99.2)
2.	**Means/source of information on HIV/AIDS** *			
	Radio	116 (84.7)	202 (94.4)	318 (90.6)
	TV	103 (75.2)	180 (84.1)	283 (80.6)
	Print media	39 (28.50)	113 (52.80)	152 (43.3)
	Peer discussion	70 (51.5)	178 (83.20)	248 (70.7)
	Health facilities	98 (71.5)	155 (72.4)	253 (72.1)
	NGO programs	75 (54.5)	126 (58.9)	201 (57.3)
3.	**Knowledge of people ill or died of HIV/AIDS**			
	No, don't know any body	29 (21.2)	67 (31.3)	96 (27.4)
	Yes, know and close relative	43 (31.4)	53 (24.8)	96 (27.4)
	Yes, know and close friend	23 (16.8)	40 (18.7)	63 (17.9)
	Yes, know but neither relative nor friend	42 (30.7)	54 (25.2)	96 (27.4)
	No response	1 (0.73)	3 (1.0)	4 (1.0)
4.	**Attitude on curability of HIV/AIDS**			
	Can't be cured	119 (86.8)	157 (73.4)	276 (78.6)
	Yes, by medication	17 (12.4)	28 (13.1)	45 (12.8)
	Yes by holly water	0 (0)	29 (16.6)	29 (8.3)
	Yes, by traditional healers	1 (0.7)	0 (0)	1 (0.3)
	No response	1 (0.7)	3 (1.0)	4 (1.0)
5.	**Attitude on ART (who should take it?)**			
	Any HIV positive person	59 (49.6)	99 (16.6)	29 (8.3)
	When become AIDS cases	50 (42.0)	55 (35.0)	105 (38.0)
	Don't know	10 (8.4)	13 (8.4)	23 (9.0)
6.	**Knowledge on prevention meanness of HIV** *			
	Not preventable	14 (10.6)	27 (12.9)	41 (12.0)
	Abstinence	100 (84.7)	173 (94.5)	273 (90.7)
	Faithful partnership (1 to 1)	92 (78.0)	177 (96.7)	269 (89.4)

	Consistent use of condoms	90 (73.2)	163 (87.2)	253 (81.6)
7.	**Knowledge on mode of transmission of HIV (yes)** *			
	Multiple partner with out condoms	99 (72.3)	174 (81.3)	273 (77.8)
	Multiple partner even with condoms	25 (18.2)	44 (20.6)	69 (19.7)
	Mother to child	113 (82.5)	122 (57.0)	235 (67.0)
	Blood contact	114 (83.2)	179 (83.6)	293 (83.5)
	Sharing sharp tools	120 (87.6)	184 (86.0)	304 (86.6)
	Sharing meal together	13 (9.5)	12 (5.6)	25 (7.1)
	Kissing	24 (17.5)	12 95.6)	36 (10.3)
	Breathing	8 (5.3)	32 (15.0)	40 (11.4)
	Mosquito bite	47 (39.3)	61 (28.5)	108 (30.8)
	Via eggs of hen	35 (25.5)	29 (13.6)	64 (18.2)
	Via meat handled by HIV positives	40 (29.2)	31 (14.4)	71 (20.2)
	Shaking of hands	15 (10.9)	22 (5.6)	27 (7.7)

* ***Multiple responses per respondent were obtained***

Table 5. KAP and risk perception on HIV/AIDS and VCT... (Continuation)

SN	Variable	Status of commercial sex		
		CSW (%)	Non -CSW (%)	Total (%)
8.	**Can healthy looking people be HIV positive?**			
	No	19 (13.9)	24 (11.2)	43 (12.3)
	Yes	105 (76.4)	171 (79.9)	276 (78.6)
	Don't know	12 (9.0)	23 (1.0)	35 (9.0)
9.	**Trust of LBSFs for confidentiality of HIV testing for positives in their community**			
	Yes, trusted	95 (69.3)	156 (72.9)	251 (71.5)
	No, don't trusted	32 (23.4)	42 (19.6)	74 (21.1)
	Don't know	9 (7.0)	20 (9.0)	29 (8.0)
10.	**Ever tested for HIV (yes)**	37 (27.0)	64 (29.9)	101 (28.8)
11.	**For ever tested, status of obtaining their results, n = 101**			
	No, not obtained	5 (13.5)	7 (10.9)	12 (11.9)
	Yes, obtained	32 (86.5)	57 (89.1)	89 (88.1)
12.	**For ever tested, duration of tasting, n = 101**			
	With in the past year	29 (82.9)	39 (60.2)	68 (68.7)
	Between one 1-2 years ago	3 (8.6)	3 (4.7)	6 (6.1)

	Between one 3-4 years ago	3 (8.6)	19 (29.7)	22 (22.2)
	More than 4 years ago	0 (0)	3 (4.7)	3 (3.0)
	Don't know (forgotten)	2 (5.0)	0 (0)	2 (2.0)
13.	**Plan to be tested for HIV (self)?**			
	No, I don't plan	33 (24.1)	63 (29.4)	96 (27.4)
	Yes, I planned	104 (75.9)	151 (70.9)	255 (72.6)
14.	**Reason for planning (for those who planned to be tested)** *			
	History of unsafe sex	58 (55.8)	30 (19.3)	88 (34.1)
	Sickness feeling	30 (28.8)	35 (27.7)	65 (25.2)
	Sickness or death of partner	20 (28.8)	32 (20.8)	62 (24.0)
	Plan to marriage	16 (15.4)	64 (41.6)	80 (31.0)
	Plan to go abroad	5 (4.8)	10 (6.5)	15 (5.8)
	Plan to have baby	11 (10.5)	31 (20.1)	42 (16.2)
	Pregnancy	0 (0)	11 (7.1)	11 (4.3)
15.	**Reason for not planning (for those who don't plan to be tested)** *			
	Not necessary	17 (50)	46 (76.7)	63 (67.0)
	Fear of stigma and discrimination	8 (23.5)	13 (21.7)	21 (22.3)
	Fear of being positive	22 (64.7)	3 (5.0)	25 (26.6)
	Assume no change because no cure	22 (62.9)	8 (13.1)	30 (31.3)
16.	**Self risk perception**			
	No/nil	27 (19.7)	116 (54.2)	143 (41.8)
	Mild	25 (18.2)	24 (11.2)	49 (14.0)
	Moderate	44 (32.2)	46 (21.5)	90 (25.6)
	High	41 (29.9)	18 (8.4)	59 (16.8)
17.	**Reason for assuming no and mild self risk of HIV infection (for those who have no and mild risk perception), n = 157**			
	No sexual history	0 (0)	43 (36.0)	43 (27.0)
	Limited with one partner	0 (0)	62 (53.0)	62 (39.0)
	Persistent condom use	20 (52.0)	5 (4.0)	25 (15.0)
	Don't know the reason	18(48.0)	9 (9.0)	27 (17.0)
18.	**Reason for assuming moderate and high self risk of HIV infection (for those who have moderate and high risk perception), n = 150**			
	Sex with out condom	50 (58.8)	43 (66.2)	93 (62.0)
	Multiple partner	19 (22.4)	11 (16.9)	30 (20.0)
	Condom broken	16 (18.8)	4 (6.2)	20 (13.3)
	Don't know the reason	0 (0)	7 (10.8)	7 (4.7)

* ***Multiple responses per respondent were obtained***

v. KAP of LBSFs on Condom use with non-paying sexual partners

A great majority, 312 (88.1 %), of the respondents (100 % FSWs and 80.6 % non-FSWs) have heard of male condoms. However, when we look to the use status of the interviewed females, only 35.9 % of them have reported that they have ever used male condoms throughout their lives (65.7 % FSWs and 12.6 % non-FSWs). The ever-using females were also asked if they used male condoms during their recent sexual exposure with their non-paying partners to the day of interview and 62.5 % of them have reported that they have used it (65.6 % FSWs and 50 % non-FSWS). They have reported again that joint decision (both by males and females) to use condoms is the predominant one (70 %) while the rest 30 % said that it is females themselves who initiated condom use during the recent sex with their non-paying partners. (Table 6)

Those who didn't use condoms during their last sex to the day of interview have reported that self rejection (30.3 %), in accessibility of condoms (20.7 %), using other contraceptives (13 %) partner rejection (7.7 %), forgetting to use condoms (2.2 %), expensiveness of condoms (1.4 %) and alcohol intoxication (0.5 %) were the reasons raised by some females for not using male condoms that day. (Table 6)

Regarding frequency of condom use (among ever used) with non-paying partners with in the past six months from the day of interview, about 40 % (42.2 % FSWs and 27.8 % non-FSWs) of them have reported that they used condoms every time when they have sex with their non-paying sexual partners while the remaining 18.5 %, 34.3 % and 6.4 % have reported that they used almost every time, they used some times and they never used condoms respectively. (Table 6)

The studied females were also asked if they refuse sex without condoms with their non-paying partners and 68.6 % said that they refuse it while the rest 12.9 % and 13.2 % have reported that they didn't refuse it whatever the condition was and they accepted having sex without condoms depending on the type of partners respectively. The selection criteria for

partners to have unprotected sex were being fat (43.0 %), being old and respected (36.0 %) and being married and living with his wife (21.0 %) in respect of their orders. (Table 6)

Table 6. KAP of LBSFs on male condoms with non-paying sexual partners in towns of Gojjam, March 2007 (n=354)

SN	Variable	Status of commercial sex		
		CSW (%)	Non -CSW (%)	Total (%)
1.	**Knowledge about condoms**			
	Never heard of it	0 (0)	42 (19.4)	42 (11.9)
	Heard of it	137 (100)	175 (80.6)	312 (88.1)
2.	**Use status of condoms among those who have knowledge of it (ever used)**			
	No	47 (34.2)	153 (87.4)	200 (64.1)
	Yes	90 (65.7)	22 (12.6)	112 (35.9)
3.	**Use of condoms with non-paying partner during the recent sex (among the ever used)**			
	No	31 (34.4)	11 (50.0)	42 (37.5)
	Yes	59 (65.6)	11 (50.0)	70 (62.5)
4.	**Initiator of condom use during the recent sex with non-paying partner (for those who used condoms during recent sex)**			
	Female	13 (22.0)	8 (72.7)	21 (30.0)
	Male partner	0 (0)	0 (0)	0 (0)
	Together	46 (78.0)	3 (27.3)	49 (70.0)
5.	**Reason for not using condoms during the last sex with non-paying partner (for those who did not use condoms during recent sex)** *			
	Far or not available	15 (70.7)	28 (20.7)	43 (20.7)
	Too expensive	3 (4.1)	0 (0)	3 (1.4)
	Partner rejected	11 (15.1)	5 (3.7)	16 (7.7)
	I rejected	26 (35.6)	37 (27.4)	63 (30.3)
	Drunken/intoxicated	1 (1.4)	0 (0)	1 (0.5)
	Forgot it	0 (0)	6 (4.4)	6 (2.2)
	Other contraceptives used	8 (11.0)	19 (14.1)	27 (13.0)

6.	**Frequency of condom use with non-paying partner in the last 6 months (among the ever used)**			
	Every time	38 (42.2)	5 (27.8)	43 (39.8)
	Almost every time	12 (13.3)	8 (44.4)	20 (18.5)
	Some times	34 (37.8)	3 (16.7)	37 (34.3)
	Never use	3 (3.3)	22 (11.1)	5 (4.6)
7.	**Refuse sex with out condoms with non-paying partners**			
	No	22 (17.3)	15 (10.0)	37 (13.0)
	Yes	88 (65.4)	114 (78.0)	197 (72.0)
	Depends on type of partner	22 (17.3)	16 (11.0)	38 (13.0)
8.	**Selection criteria for partners in order not to use condoms (for those who don't refuse sex with out condoms)**			
	Fatness	13 (40.0)	6 (50.0)	19 (43.0)
	Healthy looking	0 (0)	0 (0)	0 (0)
	Partner has wife	6 (20.0)	3 (25.0)	(20.0)
	Partner is wealthy	0 (0)	0 (0)	0 (0)
	Partner is old and respected	13 (40.0)	3 (25.0)	16 (36.0)

vi. KAP of LBSFs practicing commercial sex towards condom use with paying clients

Even if all of the FSWs interviewed have knowledge of condoms, 53 (44.2 %) of them didn't use condoms during their recent commercial sex to the day of interview. Commonly pointed reasons for not using condoms that day were females themselves didn't want to use condoms (48.8 %), other contraceptives were used (23.3 %), male clients have rejected (16.3 %) and condoms were expensive (11.6 %) respectively. And again, 48.2 % of the FSWs who have reported that they have no/low risk perception towards HIV infection didn't use condoms during their last commercial sexual exposure to the day of interview. (Table 7)

As far as initiators of condom use during the recent commercial sex is concerned, half of those who used male condoms have reported that joint decision was made to use condoms both by females and their clients while 41.9 % of them said that it was initiated by females alone and the rest 8.1 % disclosed that the initiation was made by males only. (Table 7)

FSWs were asked about the socio-economic category of their clients who usually reject to use male condoms. In this case, peasants/farmers stood first (38 %) to reject condom use and the rest 26.4 %, 26.4 %, 7.4 % and 1.7 % of the FSWs have reported that daily laborers, students, employees and merchants usually reject to use condoms respectively. (Table 7)

About half (50.8 %) of the FSWs have reported that they used male condoms during all commercial sexual exposures consistently during the last 30 days prior to the day of interview. However, 18.2 % of them did never use condoms for any commercial sex they practiced during the last 30 days prior to the day of interview and the remaining 5.8 % and 25.6 % FSWs interviewed have used male condoms almost every time and sometimes, respectively, during their business sexes of the last 30 days prior to the day of interview. (Table 7)

FSWs were also asked about places from where they obtain male condoms when they need and shops, pharmacies, clinics, family planning centers, hospitals, community based health workers (CBHWs), bars/hotels and open markets were the reported places where they obtain condoms in respect of their orders. (Table 7)

Table 7. KAP of LBSFs practicing commercial sex towards condom use with paying clients in towns of Gojjam, March 2007 (n=137)

SN	Variable	Number (percent)
1.	**Condom use during the last sex with paying client**	
	No	53 (44.2)
	Yes	67 (55.8)
2.	**Initiator of condom use during the last sex with paying client (for those who used condoms)**	
	Female	26 (41.9)
	Male partner	5 (8.1)
	Together	31 (50.0)
3.	**Category of clients usually rejecting to use condoms** *	
	Farmers	46 (38.0)
	Daily laborers	32 (26.4)

		Merchants	2 (1.7)
		Students	32 (26.4)
		Employees	9 (7.4)
4.	**Reason for not using condoms during the last sex with paying client (for those who do not use condoms)**		
		Far or not available	0 (0)
		Too expensive	5 (11.6)
		Partner rejected	7 (16.3)
		I rejected	21 (48.8)
		Drunken/intoxicated	0 (0)
		Forgot it	0 (0)
		Other contraceptives used	10 (23.3)
		Don't know the reason	0 (0)
5.	**Frequency of condom use with paying client in the last 1 month**		
		Every time	61 (50.8)
		Almost every time	7 (5.8)
		Some times	31 (25.6)
		Never use	22 (18.2)
6.	**Refuse sex with out condoms with non-paying partners**		
		No	26 (22.0)
		Yes	86 (72.9)
		Depends on type of client	6 (5.1)
7.	**Selection criteria for clients in order not to use condoms (for those who don't refuse sex with out condoms), n = 6**		
		Fatness	6 (100)
		Healthy looking	0 (0)
		Partner has wife	0 (0)
		Partner pays better amount of money	0 (0)
		Partner is old and respected	0 (0)
8.	**Knowledge of places to obtain condoms ***		
		Shop	82 (74.5)
		Pharmacy	55 (50.0)
		Market	14 (12.7)
		Clinic	52 (47.5)
		Hospital	43 (39.1)
		Family planning center	47 (42.7)
		Bar/hotel	29 (29.0)
		Peer educator	32 (32.0)
		Friend	37 (38.1)

****Multiple responses per respondent were obtained***

5.2. Qualitative results (Focus Group Discussion)

Six participatory FGDs (10 females in each group) were conducted with a total of 60 LBSFs (30 practicing CSW and 30 not practicing CSW) in the three towns and the results are described as follows:

I. Risk factors and challenges leading LBSFs to commercial sexual engagement

Both groups (sex workers and non sex worker local beverage selling females) in the three towns have discussed on this thematic issue. The focus group discussant females have pointed that economic, social and cultural problems were the main factors that drive them to practice local beverage selling and as a consequence to commercial sex work.

Regarding the socio-economic factors, most of the females reported that they were economically dependant to their parents, relatives, and husbands or to those to whom they were housemaids before they started to practice local beverage selling.

Most of them were coming from the rural community or from other smaller towns in response to early marriage followed by poverty, parental poverty and interest to live in the town among many other socio-economic and cultural reasons. As reported by the discussants, these females would have started their lives in the towns being housemaids, kitchen workers to hotels and bars and assistant Tella and Arakie sellers.

For these females working in areas where most of the users are farmers is easier than working in big hotels as most of them are non-educated and less adapted to working in big hotels. And they finally become LBSFs by renting their own houses alone or being assistant to others.

As reported by the focus group discussants, after starting to lead their private lives by selling local beverages they used to encounter with a lot of socio-economic challenges which really enforced some of them to practice CSW side by side with local beverage selling.

Some of the socioeconomic factors of local beverage sellers leading them to commercial sex work expressed by the FGD participants are:

- Needing some more money in addition to the money earned from local beverage selling as it was not enough to pay for house rents, living costs, supporting others other expenses.
- Some of them also claimed that almost all of their beverage customers are males and they usually are urged either physically or psychologically to have sex with the most frequent customers or with those who are late drinkers during late evenings or nights.
- Some others also have reported that they themselves used to drink alcohol being hosted by their customers that lead them to practice sexual intercourse with them due

to either the alcohol intoxication itself or in order to pay for the alcohol invitation to the hospitable males and to get some extra money from sex.

One of the 34 years old FGD participant FSWs during the time of interview said:

"I remember when I was around 16 years old, I was a mother of a baby around 8 months old and I was living with my mother; divorced and living with 2 of her sons, during which I was hopeless to live in my village; Enerata (a rural village some 20 kms away from Debre Markos), with my mother and my two brothers any more. This was because my mother was very poor and no body wanted to marry me again because of my kid. So, I came to Debre Markos leaving my kid with my mother searching for job to improve my life and to assist my family at Enerata. Housemaid was the first job I found at Debre Markos and some six months later I escaped out of that house and started selling Tella with a friend of me renting a small house together. First it was apparently good as I got money and decided by my own for the first time in my life. But later, I quarreled with a female with whom I was living and I started the job alone. This time I should pay for the house rent alone and there were also a lot of other expenses. Added to it, as I was alone some of my peers and Tella customers were challenging me to have sex with them so that they will give me additional Birr. No choice, I started it with a farmer as a 'kimit' and later I became "kimit" to some more males and then I started selling my own body for money using condoms even for any body whom I don't know before."

During the FGD, there were also some discussant females who have grown in their existing town and are practicing commercial sex. These females have reported that they started to practice commercial sex because their mothers were local beverage sellers and they have been grown up assisting their mothers of selling local beverages early from their childhood. Later they have replaced their mothers when their mothers get old and they have also started commercial sex as an additional means of income.

One of these females said:

"***I have grown up here in Dembecha. My father; the sole bread winner of the family, was a traditional carpenter in the town and my mother was a house wife. I am the 4th child to my parents and I had two brothers and four sisters adding totally to nine members of the family***

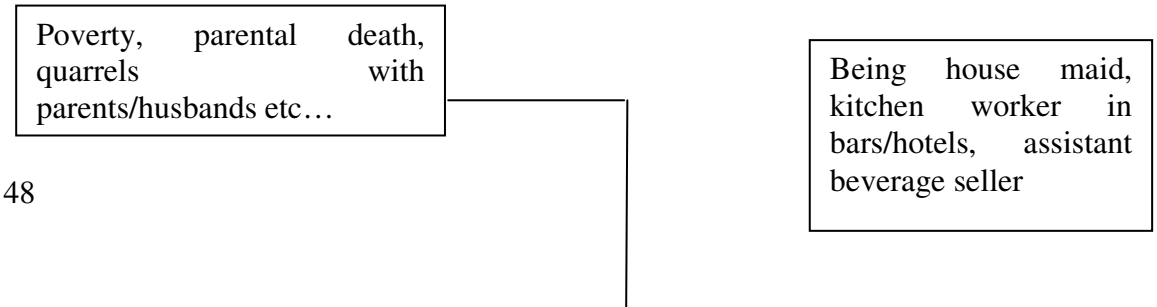
(including mom and dad). As the number of the family members increase in our home, life became miserable. On top of this, father's income was on and off and even very small compared to the family size. Again he used to drink alcohol and waste some money from the already poor income. Thus, mom started to sell Arakie and Tella (local alcohols) in our home and I and two of my sisters started to help her. Later, my father died and my family's income entirely depended on local alcohol selling. Some years later, mom has also died and some of my sisters and brothers started marring and being engaged in some other labor works. Thus, I replaced my mother for local beverage selling. Recently, I have started commercial sex as I found difficult to lead my life with the income I obtain from local beverage selling".

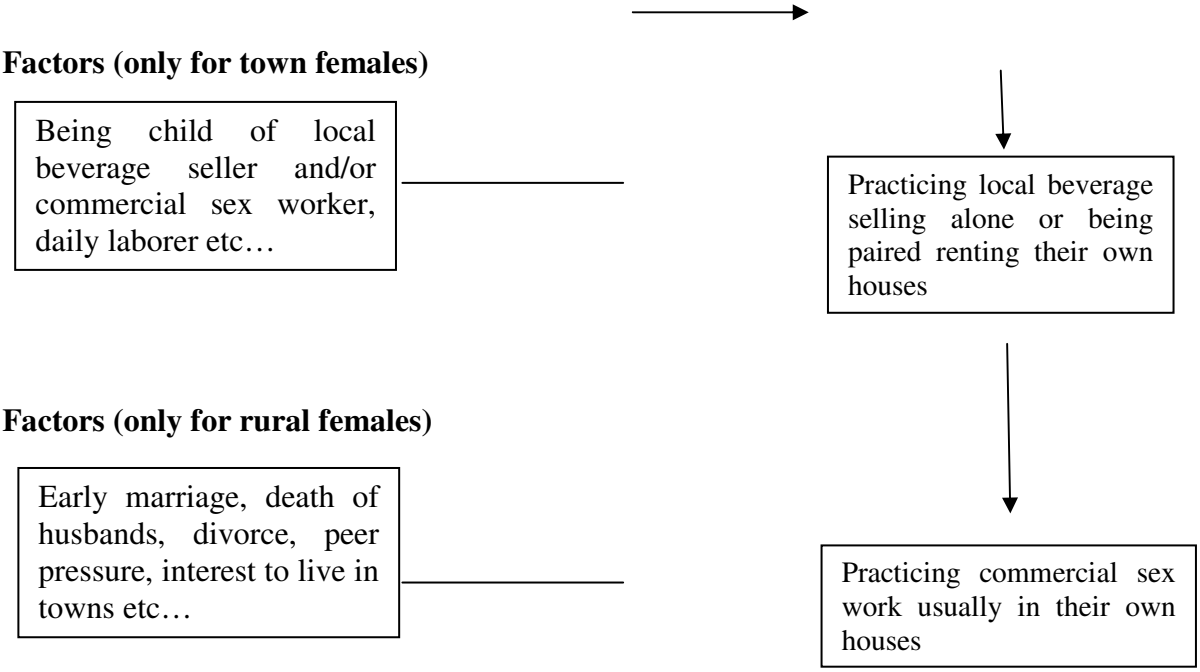
Some others again reported that they have entered to this life because of school failure, disinterest to be housemaids, quarrel with parents/guardians, distaste to be housewives and quarreling and running away from their husbands.

Generally, factors that have already lead the FSWs to commercial sex and factors that are still challenging those LBSFs who don't practice CSW yet to lead them to commercial sex are similar following common frameworks.

Fig 2: Frame work of factors of LBSFs leading to commercial sex work

Factors (common both for rural and town females)





There were some local beverage selling females who didn't start commercial sex that supported the idea of those females who have already started commercial sex. These females said that they know that commercial sex is not a good job in many aspects including predisposing to HIV infection; however, they added that their lives are deteriorating from time to time as there is price inflation in all aspects of life so that they may start practicing it soon unless either government or some other organizations assist them economically and technically to start other income generating activities like micro trades and urban agricultures.

But there are also local beverage selling females who don't practice commercial sex and don't want to practice it as they have out weighed their lives than money. Some of these females prefer even begging to commercial sex provided that they can't survive with the money they are earning from local beverage selling. These females believe that they should do other additional income generating activities like Injera (Ethiopian local flat bread) and bread selling, labor works and any other activities with out undermining any work. Again still there were some discussants who have reported that they have interrupted CSW due to capacity building and financial assistance by NGOs like AMA and local government bodies.

II. Awareness level opinion and practice on HIV/AIDS and condom use

All of the FGD participants know about the existence of HIV/AIDS even if some of them have misconceptions about the mode of transmission and means of preventions.

The most commonly explained misconception about mode of transmission (wrongly believed by the discussants, especially by non-sex worker discussants) are malaria mosquito, kissing, feeding on eggs that has swallowed used condoms and meat handled by PLWHA can transmit the AIDS virus. But still there were very few participants (both sex workers and non-sex workers) who wrongly believe that feeding together can transmit the virus, PLWHA should be quarantined and healthy looking people can't be HIV positive.

Almost all sex workers have properly explained the three programmatically important meanses of prevention (ABC methods) and the three most common modes of transmission (unprotected sex, mother to child and any form of blood contact) even if still there were some, especially elderly and non-sex workers who have negative attitude towards condom use and still there were some of them who were unaware of mother to child transmission of HIV.

As explained by the discussion participants, radio and peer education initiated by NGOs like AMA and government institutions like HAPCO are the most common sources of information concerning HIV/AIDS and condom use. But still TV, print media and health facilities are important sources of information to some females who are economically well and educated in relative terms.

Most of the FGD participants, especially sex workers believe that HIV/AIDS is non-curable except two sex worker discussion participants from Dembecha town that had strongly argued that it is curable by holly water if there is strong personal religious belief and they raised "Entoto Mariam" as example.

ART was another discussion issue raised during FGDs and everybody of the participants had knowledge of the existence of ART. But there was a remarkable misconception concerning the time to start the drugs (there were females who believe that all HIV positives should start the drugs).

Regarding VCT, participants raised that they have heard of the existence of HIV testing facilities in all target towns (Debre Markos, Dembecha and Finote Selam) but still there is little knowledge among themselves about the pre-test and pos-ttest counseling services. Some

of the discussion participants were not comfortable to discuss about VCT related issues as there were some fear that the discussion facilitators will ask them to be tested or tell the results if tested. In order to make the discussion as passionate as before, the facilitators (we) had made it clear that no body tested is obliged even allowed telling the result and it is also the right of individuals to be tested. Thus, all of them who reported that they have been tested said that they have taken the results. But there was sense of fear to be tested and, expected positive results and stigma and discrimination were some of the most commonly raised reasons leading them not to plan to be tested. Some participants have raised examples about local beverage sellers who were perceived by the community as AIDS patients. These females were stigmatized and marginalized socially (from idirs and mahibers), economically (no one was going to buy and drink alcohol sitting in their houses) and culturally also. The participants strongly argued that still there is stigma and discrimination among the community not alone when results are disclosed but also when sex workers get sick and reduce body size which hinders them from being tested for their sero status.

Concerning male condoms, almost all discussion participants know about its existence and even there were participants who request for broad supply of female condoms. When we come to consumption, the participants and, especially, the sex workers have reported that they are using male condoms. But still there were discussants, especially, elderly ones who said that they never used condoms throughout their lives (both with paying clients and non paying partners). These females justified the reason why they never used it by stating that it may minimize their sexual satisfaction and they added also that it is God who knows who will die of what reason/disease. On the contrary, there were females (both sex workers and non-sex workers) who have given their personal testimonies that condom has nothing to do with reduction of sexual satisfaction and they said also as far as they are not married, condom is their only choice to prevent them from unwanted pregnancy, STIs and basically HIV infection.

As appreciated from the discussion, there was some degree of shyness about buying condoms from shops and pharmacies and even there were females who didn't use condoms even if they want to use it due to fear to buy condoms from people whom they know as the towns are very small. Another barrier raised was that there were females who want to use it but didn't dare to

tell their partners/clients to use it. Still there were females (both sex workers and non-sex workers) who blamed their clients and partners, especially, non-educated ones of not being cooperative to use condoms for their bilateral advantages.

The supply was another raised problem by some users. These females blamed, especially, the town government institutions like health facilities and HIV/AIDS prevention and control offices that sometimes condoms are not available there. They have also doubt on the quality of condoms in shops as they are put together with some other sharp objects and as the merchants do not take care of them. Even some of the females said that there are some greedy merchants who are selling expired condoms in their shops.

III. Possible measures recommended by LBSFs to reduce commercial sexual engagement among themselves

1) Females especially those who are primary bread winner of their family like LBSFs should be empowered economically, technically and educationally by joint efforts of the government, the community and civil society organizations so that we will not be engaged in risky sexual practices like commercial sex.
2) Especial emphasis should be given to high risk females like us to drive us out of commercial sex through alternative income generating activities
3) Credit and saving facilities should be available to us with sustainable business advices.
4) Early marriage should be eliminated through joint efforts of the government, the community and other civil society organizations.
5) The right of females should not be violated at all levels (at household level, during marriage and divorce and at work).
6) Awareness raising and behavioral changing education should be given on HIV/AIDS and condom use to females under risk of HIV infection sustainably.
7) Condoms (both male and female) should be supplied free of charge to females like us in adequate quantity and quality through easily accessibly meanses.

6. DISCUSSION

Results are discussed in relation to other literatures and qualitative results are also used to strengthen and substantiate quantitative findings.

Fifty nine percent of the respondents in this study were older than 35 years and all of them were above 15 years old which doesn't agree with results of similar studies conducted by Dorman LE et al in India indicating the average age of FSWs was 26 years [7] and again by Atalay A. et al in 2006, showing the great majority (91 %) of the studied FSWs were less than 30 years old [10]. It also doesn't agree with the national HIV/AIDS Behavioral surveillance Survey (BSS) round II result which shows the average age of FSWs was 25.1 years [2].

This disparity can be explained by the fact that study targets for the national HIV/AIDS BSS and other studies referred above are FSWs of all types (bar/hotel, street and home based). However, targets for this study are those females who sell different types of local beverages independently in their own houses (may or may not be sex workers). And again they usually start local beverage selling during late in their lives after being engaged with other life experiences like being housemaids, housewives, or even either street or bar/hotel based sex workers as obtained from the qualitative and quantitative results of this study.

Just like the 2006 national HIV/AIDS BSS [2] and other similar study conducted in Addis Ababa by Mengistu M. et al in 1990 [11] , there was a very high (45.6 %) illiteracy rate observed among the studied females.

About 86 % of the study targets were found to be ever married and this finding doesn't match with the results of the 2006 HIV/AIDS BSS which shows that only about 37 % of the studied FSWs were ever married [2]. The reason may be attributed to the fact that the 2006 HIV/AIDS BSS includes all types (bar/hotel, street and home based) of FSWs most of which are younger and never married while this study includes LBSFs most of whom are relatively older and married once in their past time. The above result also doesn't agree with findings from a study conducted by Atalay A. et al in 2006 on FSWs all over Ethiopia [10] and by Mengistu M. et al in 1990 on FSWs of Addis Ababa [11] and it can be justified by the same reason above.

In the referred studies above including this study, divorce followed by widowness have been observed to be the most frequent end results of most marriages of the ever married females studied.

As observed from the result part, early marriage is the predominant problem among females in Gojjam (21.5 % married before 10 years old, 57.8 % before 16 and 76 % before 18). And most females (72.3 %) had no knowledge and consent to marry during their first marriages while abduction is rare in the study area. These findings appeared to agree with results obtained from the study conducted by Dawit B. in 2002 in West Gojjam [(16)].

Unlike females included in the 2006 HIV/AIDS BSS [(2)], most of the females included in this study were in the towns where they were living before starting local beverage selling and it is followed by those who came from rural areas and from other towns respectively. This can be explained by the fact that there are non commercial sex worker respondents in this study (only 27.7 % are commercial sex workers at the time of interview) while those in the BSS are all FSWs and most of them don't want to practice commercial sex in their birth places.

Even if a little bit latter than their age at first marriage, most of the studied females have started sex at their earlier ages (47.4 % of them started it before 16 years, 9 % before 10 years old and 61.2 % before 18 years old) and the result agrees with that of the 2006 national HIV/AIDS BSS results which shows 46.2 % of the respondents started sex before 16 years old and 89 % of them before 19 years old, respectively [(2)]. As most of the respondents were ever married, most of them have started sexual experience with their former husbands.

About 22 % of the respondents have reported that they had non-paying regular sexual partners during the time of interview which is a little bit lesser than the results obtained from the second round HIV/AIDS BSS which was 35 % [(2)]. And the frequency of sexual exposure with non-paying partners was less which shows that about 73 % of the respondents who have non-paying regular sexual partners had no sexual exposure with in a week prior to the day of interview.

The study has found out that 38.7 % of the interviewed LBSFs have ever experienced CSW in their lives and 27.7 % of the respondents are still practicing it (28.5 % of the ever FSWs have interrupted it). As obtained from the focus group discussions, sex worker focused interventions implemented by NGOs like AMA and the local government efforts in these specific towns have liberated them out of commercial sex (for those who have interrupted

commercial sex) through awareness raising and behavioral changing activities and alternative income generating schemes. And most (90 %) of them are home based female sex workers.

Both the qualitative and quantitative results showed that most of the paying sexual clients of the studied sex workers are farmers as it is cheaper to them to drink local alcohol and to have sex with home based sex workers who are also local alcohol sellers compared to visiting sex workers at high level bars and hotels which is more costly.

Eighty two percent of the FSWs have practiced commercial sex with less than or equal to three paying sexual clients with in a week prior to the day of interview whereas the result of a study conducted by Mengistu M et al in 1990 on FSWs is 85.3 % [(11)]. And it is also observed from the study that about one-third of the FSWs participated in this study have not practiced any commercial sex during that week which may be due to lack of visiting paying sexual client and the Ethiopian famous long fasting season (Abiy tsom) may contribute to lesser sexual acts during that time as almost all of their clients are Orthodox Christians.

Again from the study it is observed that practicing commercial sex with more than one person per day with in 30 days was a common phenomenon (79.9%) which increases the risk to contract HIV infection. And the frequency of sexual contact per day with a single client was again reasonably high (40.8 % of them have practiced it for greater than or equal to 3 times with a client) which is another risk factor that increases the chance of contracting the virus.

From the analytical quantitative result, the risk measurement (AOR) results show that illiteracy (**AOR, 95 % CI of 1.01-1.2**), duration of local beverage selling **(AOR, 95 % CI of 1.3-1.7)**, age at the time of interview **(AOR, 95 % CI of 1.12-2.6)** and absence of additional meanses of income other than local beverage selling **(AOR, 95 % CI of 7.3-15.0)** have been observed significantly and positively associated with commercial sexual engagement among LBSFs studied. These positive statistical associations among exposure socio-demographic variables and commercial sexual engagement can be explained by the fact that illiterate LBSFs have less income generative alternatives and low awareness level towards HIV/AIDS than literates, as the duration of local beverage selling increases, their exposure to challenges

also increases and aged females have low level of awareness towards HIV/AIDS compared to their younger counterparts, respectively.

However, residence before local beverage selling (town or rural) (AOR, 95 % CI of 0.8-1.8) and supporting others economically (AOR, 95 % CI of 0.58-1.2) have no significant association with commercial sexual engagement.

The multivariate analysis using binary multiple logistic regression indicated that family related factors before starting local beverage selling like job conditions of head of the family (local beverage selling **(AOR, 95 % CI of 1.3-12.1),** being daily laborer **(AOR, 95 % CI of 1.2-3.6)** and being commercial sex worker **(AOR, 95 % CI of 1.2 – 4.03)**), death of either or both of the parents/guardians **(AOR, 95 % CI of 5.3 – 21.5)** and quarrel with family **(AOR, 95 % CI of 8.9 – 32.2)** are statistically significant factors for the LBSFs to be engaged in to commercial sex work. The reason may be attributed to the facts that poor socio-economic conditions and unpleasant relations with parents can lead their female children to commercial sexual engagement.

Marriage related factors before starting local beverage selling like death of husbands **(AOR, 95 % CI of 4.3-14.1),** early marriage **(AOR, 95 % CI of 3.5-11.5)** and distaste to be housewives **(AOR, 95 % CI of 1.53-6.1)** are also observed to be statistically significant factors for LBSFs to be deployed to commercial sex work. The reason may be explained by the fact that death of husbands, early marriage and absence of love between husbands and wives can result in commercial sexual engagements of females.

Again other socio-economic factors like personal income level **(AOR, 95 % CI of 1.4 – 6.9)**, peer pressure **(AOR, 95 % CI of 11.0-80.7),** distaste to be housemaids **(AOR, 95 % CI of 12.1-54.4)** and interest to live in towns **(AOR, 95 % CI of 1.37-5.6)** are statistically significant factors for commercial sexual engagement. All of the above factors are supported by the FGD (qualitative) results except for school failure for which the FGD pointed out as one of the factors for LBSFs to engage in to commercial sex work but not supported by the quantitative result as not statistically significant.

The result of the multivariate analysis is supported by the 2006 Ethiopian national HIV/AIDS BSS which states that the main reasons explained by FSWs to start commercial sex are financial problems, death of parents, disagreement with family and desire to be female sex worker [2].

Almost all (99.2 %) of the study participants and, especially, all of those participants who practice commercial sex have heard of HIV/AIDS even if the degree of their knowledge varies and this result is not as such far from other results like the 2006 national HIV/AIDS BSS (94 %) [2] and a study conducted by Atalay A et al in 2006 in south-west of Ethiopia (97.2 %) [10].

The most common sources of information about HIV/AIDS were radio, TV, health facilities, community peer educators, NGO programs and print media with respective of their frequency which also is supported by results of the 2006 national HIV/AIDS BSS [2].

Again a great majority of the respondents (72.7 %) know people living with or died of HIV/AIDS most of whom are either close relatives or close friends which is a little bit lesser than the result obtained from the second HIV/AIDS BSS (80.8 %) [2] and a study conducted by EPHA in 2002 [9].

The knowledge of the local beverage selling females regarding HIV/AIDS prevention methods was also assessed and unexpectedly and worryingly there were respondents (12 %) who still believe that HIV/AIDS is non-preventable regardless of any intervention. This belief may arise because of confusing the fact that AIDS is non-curable with non-preventable due to less comprehensive knowledge. But on the other side 65 % of the respondents have described all the three basic programmatically important prevention methods which is again lesser than the second round national HIV/AIDS BSS (75.9 %) [2].

When we see the status of comprehensive knowledge of the interviewed females, 33 % according to the national indicator and about 38 % based on the UNAIDS indicator have comprehensive knowledge about HIV/AIDS. Again it is also found that 60.5 % of them had no misconception (incorrect belief) about HIV/AIDS transmission even if the rest 39.5 % had at least one misconception based on the UNAIDS indicator which disagrees with the 2006

national HIV/AIDS BSS result (89.7 %) [2]. The most frequently observed misconceptions were that mosquito bite can transmit HIV (30.8 %), eating raw meat handled by HIV infected people can transmit the virus (20.2 %) and eating eggs laid by a chicken that has swallowed used condom can transmit the virus (18.2 %) and the rest of misconceptions explained about HIV/AIDS transmission by some study participants were breathing, kissing, hand shaking and sharing meal together with HIV positive people can transmit the virus respectively.

Other knowledge and attitude indicators of HIV/AIDS assessed during the study were attitude towards curability of HIV/AIDS and their opinion about ART. In this regard, significant proportion (21.4 %) of the LBSFs wrongly believed that it is curable which was emphasized by two female sex worker participants from Dembecha town. And the most commonly described means of cure were modern medicine (12.8 %), holly water (8.3 %) and traditional medicine (0.3 %). Regarding ART, again it is worrying that more than half of the respondents don't know who should start the drugs as they responded that all HIV positive individuals should start ART.

It is known from the study that level of knowledge has no statistically significant contribution among the studied LBSFs to know persistent condom use can prevent from HIV infection, to know who should start ART and to know that HIV/AIDS is non curable.

Even if there were lots of knowledge gaps and misconceptions about mode of transmission, means of prevention and curability of HIV/AIDS and ART as explained above, it is known from the study that more than two-third of the respondents know that multiple sexual partnership without using condoms can result in HIV infection, about 84 % of them know that any blood contact with HIV infected people can end with infection with the virus and 67 % of them also know that HIV can be transmitted from infected mother to her child.

About 29 % of the participants have been ever tested for HIV of which 88 % have obtained the results which agrees with the second round national HIV/AIDS BSS indicating that 28 % of the studied FSWs have ever been tested for the virus [2]. There was no statistically significant difference seen between FSWs and non-FSWs regarding using the VCT services. Again more interestingly, about two-third of the study participants have planned to be tested

for HIV for the future mainly because of; as they reported, past history of unprotected sex, feeling of sickness, partner's death/sickness and plan to marry.

Those who didn't plan to be tested were also asked about the reasons why they didn't plan to do so and the raised reasons based on their frequency were thinking that it is not necessary/not applicable to them to be tested, believing that testing has no value as there is no cure, fearing of hearing positive results and fearing of stigma and discrimination.

Compared to the second round national HIV/AIDS BSS results, risk perception towards HIV infection for these study participants is observed to be high, 42.4 % of the study participants have either high or moderate risk perception (22.5 % for the 2006 national BSS). And 55.8 % of the respondents had either no or low risk perception towards contracting the virus and other risk behaviors (it was 48.5 % for the 2006 national BSS). Another change observed from this study compared to the above mentioned BSS study is that only 1.6 % of respondents for this study were unable to grade their chance of HIV infection as no, low, moderate and high. These comparatively improved risk perception findings compared to the 2006 national HIV/AIDS BSS results (even if not the same group of participants) may be because of the effectiveness of anti HIV/AIDS programs from year to year and it may also be explained by the fact that an NGO called AMA is running sex worker focused anti HIV/AIDS programs in different towns of Gojjam including towns where this study focuses.

Multiple sexual partnerships with out using condoms and breakage of condoms during past sexual contacts were the main reasons described by LBSFs for their moderate/high risk perception of contracting HIV.
And those respondents who perceived their risk to be as no or low have described their reasons as no history of sexual intercourse (30 %), have limited themselves with one sexual partner (37.6 %) and are using condoms persistently (10 %).

Eighty eight percent of the LBSFs (100 % for FSWs) included in this study have knowledge of male condoms which is lesser than results obtained from a study conducted by EPHA in 2002 at North-West of Ethiopia showing that 96.2 % of the studied FSWs know the presence of male condoms [(9)] and the 2006 national HIV/AIDS BSS indicating all of the participating

FSWs know it [2]. The reason for lesser result may be explained by the fact that most of the participants in this study are non-sex workers who are not usually worried about condoms as there is adaptation for new technology and are also older compared to the study participants of the referred two studies.

About sixty three percent of the studied LBSFs have reported that they have ever used male condoms which is a bit better than that of the result indicated in the study conducted by EPHA in 2006 in North-West of Ethiopia (32.5 %) [9]. But this result is still lower than the result obtained from a study conducted in Panama City in 2001 (99 %) [6] and the 2006 national HIV/AIDS BSS (99.2 %) which may be explained by the same reason above. And again about half (48.2 %) of the FSWs who have reported that they have no/low risk perception towards HIV infection did never use condoms during their last commercial sexual exposure to the day of interview.

Out of the FSWs who have ever used condoms, about 65.6 % of them have reported that they have used male condoms during their recent sexual contact to the day of interview with regular non-paying partners (25 % for a study in Panama City in 2001 [6]) and 65.8 % of them also have reported that they have used it during resent sexual exposure with their paying clients indicating that the FSWs studied have almost equal risk perception of HIV contracting chance both from paying and non-paying partners and the vise versa.

As reported by the interviewed FSWs, joint decision to use condoms (both by males and females) was the most frequent type of decision followed by decisions made by females alone (both with paying and non-paying partners).

The most common reason of LBSFs for not using condoms during the last sexual contact at the time of interview with their non-paying partners were self rejection by females (30.3 %), inaccessibility of condoms (20.7%), using other contraceptives (13 %) and rejection by partners (7.7 %) among other minor reasons like forgetting to use condoms, expensiveness of condoms and alcohol intoxication.

And the frequently raised reasons for not using condoms with their paying clients were females themselves didn't want to use condoms (48.8 %), instead other contraceptives were used (23.3 %), male clients have rejected (16.3 %) and condoms were expensive (11.6 %).

In both cases above (sex with non paying partners and paying clients), the most common cause for not using condoms is rejection by females themselves (different from the traditionally said reasons, male rejection) which needs further efforts on LBSFs about behavioral changes towards condom use.

The studied commercial sexual practicing LBSFs were asked that which social group of their clients usually reject to use condoms during their recent sexual contact and farmers (38 %); who are also their most frequent clients, were first in rejection of condom use whose reason may be attributed to the fact that their educational status and awareness level towards HIV/AIDS and condom use are low as compared to other social classes; this finding is supported by result of a study conducted by EPHA in 2002 at North-West of Ethiopia [(9)]. Daily laborers (26.4 %) and students (26.4 %) were also blamed by a majority of studied FSWs of rejecting condom use next to farmers while merchants and employees were explained as relatively careful and voluntary to practice protected sex.

For sexual contacts that LBSFs who practice commercial sex have practiced with their non-paying partners during the last six months prior to the day of interview, 42.2 % of them were using condoms persistently (12.8 % for a study conducted by EPHA in 2002 at North-West of Ethiopia [(9)], 13.3 % of them almost every time, 37.8 % of them some times and the rest 3.3 % of them did never use condoms completely. And for sexual contacts that the above mentioned females have practiced with their paying clients during the last 30 days prior to the day of interview, about half of them were using condoms persistently, 5.8 % of them almost every time, 25.6 % of them sometimes and the rest 18.2 % didn't use condoms completely.

For LBSFs who have ever used condoms; shops, pharmacies, family planning centers, clinics and hospitals are the most common places where they used to obtain condoms and some of them also obtain condoms from bars/hotels, peer educators, friends and even from open markets.

7. STREANGTH AND LIMITATIONS

Limitations

1. As there is little done on this specific title, especially, in Ethiopia or any other country socio-economically related to Ethiopia, there is limitation of access to articles and other literatures directly related to this research. As a result, most of the literatures included in this document are proxy literatures to this work.
2. The sensitive nature of most of the questions may have affected the level of validity of the research as some respondents may have given reserved/conserved answers to sensitive questions regardless of the effort applied to minimize such bias.
3. The timing of the survey has coincided with the fasting season of Orthodox Christians. This may affect the momentum of commercial sexual transaction in the study area as almost all of the FSWs and their clients are Orthodox Christians in the study area.
4. As the study design is cross-sectional survey, the information obtained may not be as strong as comparative designs like follow up studies to detially investigate the trend, determinant factors, its role in the dissemination of HIV/AIDS to the rural area and solutions of commercial sexual engagement among local beverage sellers.

Strength

1. Both quantitative and qualitative methods were applied so that the information less investigated by one method was investigated well by another method and that comparison of results by the two methods was possible.
2. All of the exposure or determinant variables to commercial sexual engagement were events that happened before starting local beverage selling so that there is no problem of temporal relationship and possibility of inverse causation between exposure and outcome variables unlike other cross-sectional studies.
3. Both the Principal Investigator and the data collection supervisors are program workers of Anti Malaria Association and have implemented a capacity building project to the studied females. Thus, the Principal Investigator knew the problem well and the research question arises from observed facts which again made the whole work easy as the respondents and the Principal Investigator knew each other.

8. CONCLUSION

Most of the study participants were relatively older and there was also a very high illiteracy rate. Both early marriage and sexual exposure at early ages were very high and most marriages were arranged with sole decision of parents with out consents of girls to be married.

The magnitude of commercial sexual practice among LBSFs was 27.7 % during the time of interview (38.7 % have ever practiced commercial sex of which 28.5 % have interrupted the practice).

Farmers are the commonest clients of FSWs of the LBSFs and they are also first in rejecting condom use during commercial sexual acts. Thus, the wide range of commercial unprotected sexual transaction between farmers and LBSFs is expected to result in the rapid dissemination of HIV/AIDS to the rural area.

More than two-third of the FSWs of the LBSFs have practiced commercial sex with at least one client with in a week and 79.6 % of them have practiced it with two or more clients per day with in 30 days prior to the day of interview. The frequency of sexual intercourses with the recent paying client was also high.

All of the above commercial sexual indicators increase the chance of transmission of HIV/AIDS between FSWs and their clients specifically and at large among the community.

Illiteracy, long duration of engagement in LBS, increasing in ages and lack of additional meanses of income have been observed statistically associated with being engaged in commercial sex among LBSFs.

Again most previous family related factors of the current FSWs like job condition of the head of the family, death of both/either parents/guardians and quarrel with parents, previous marriage related factors and other previous socio-economic factors are statistically significant factors for commercial sexual engagement.

There was very high level of awareness for HIV/AIDS (99.2 %) being radio, TV and community based education the main sources of information. The comprehensive knowledge about HIV/AIDS was observed to be 33 % (according to the national indicators) and 38 %

(based on the UNAIDS indicators). Whereas about 40 % of them had at least one misconception (wrong belief) about HIV/AIDS transmission while the majority (60 %) had no misconception at all. Again misconceptions about curability of AIDS and who should start ART have been observed.

Twelve percent of the interviewed females still believe that HIV infection is non-preventable regardless of any effort. But 65 % of the respondents have described the ABC methods.

Regarding VCT service, about 29 % of the studied females have been ever tested for HIV (88 % have obtained their results) and two-third of them have planned to be tested for the future.

About 43 % of the studied females have perceived their chance of being infected with HIV to be high/moderate and 55.8 % of the respondents had no/low self risk perception towards HIV infection based on their past risk behaviors.

Eighty-eight percent of the interviewed females have knowledge of male condoms and 63 % of them have ever used it of which 65.8 % of the FSWs used during the sexual practice with their recent paying clients. This indicates that FSWs under this study have equal risk perception of HIV infection both from paying clients and non-paying partners. The most common type of decision regarding condom use was joint decision (by both males and females) and decision by females alone is the second type of decision.

Unlike the traditionally complained reason for rejection of condom use (male rejection); rejection by females themselves, use of other contraceptives and inaccessibility of condoms were the main reasons for not using condoms.

During sexual exposures with their paying clients with in 30 days prior to the day of interview, 50 % of FSWs have used condoms persistently, 5.8 % almost always, 37.8 % some times and 18.2 % never used at all.

Shops, pharmacies, clinics and hospitals were the most frequent sources of condoms as reported by the ever condom used local beverage sellers studied.

9. RECOMMENDATION

9.1. Short term recommendations

- Action oriented programs and demonstrations should be implemented to the LBSFs who practice commercial sex and multi-sexual partnership to use condoms persistently and correctly.
- Free and sustainable condom supply should be insured to local beverage selling females.
- Conversation sessions and associations should be established to LBSFs so that they can share their experiences and intervention programs can easily address their problems.
- Further efforts should be applied to increase the comprehensive knowledge of LBSFs towards HIV/AIDS and to minimize misconceptions on mode of transmission and means of prevention of HIV/AIDS.
- Access to friendly counseling, testing and support system should be available to local beverage sellers so that they will know their HIV status and plan for their future.
- Massive community mobilization and participatory interventions should be realized to raise the awareness level and to bring about behavioral changes among farmers and the rural community as a whole to minimize the rapid dissemination of HIV infection to the rural community through farmers of low educational and awareness level that practice commercial sex with local alcohol sellers.
- Further expanded multi-disciplinary study is needed to detially investigate the trend, determinant factors, its role in the dissemination of HIV/AIDS to the rural area and solutions of commercial sexual engagement among local beverage sellers.

9.2. Long term recommendations

- Violence against women like domestic violence by husbands and parents/guardians and work place violence should be abolished so that females will not be forced to engage in commercial sex work as their last job alternative.

- Early and non-mutually consented marriages should be eliminated through joint efforts of the government and other stakeholders including the community itself so that rural-urban migration of young females will be minimized whose consequence will be minimized magnitude of commercial sexual engagement in small towns.
- LBSFs should be empowered technically and economically to start alternative income generating schemes like small scale trades, labor works and urban agriculture so that they will not choose commercial sex work as their last choice of means of survival.
- Credit and saving facilities should be available to LBSFs as a whole and especially to FSWs with sustainable business advice and mentoring follow-ups so that number of female sex workers will be minimized.

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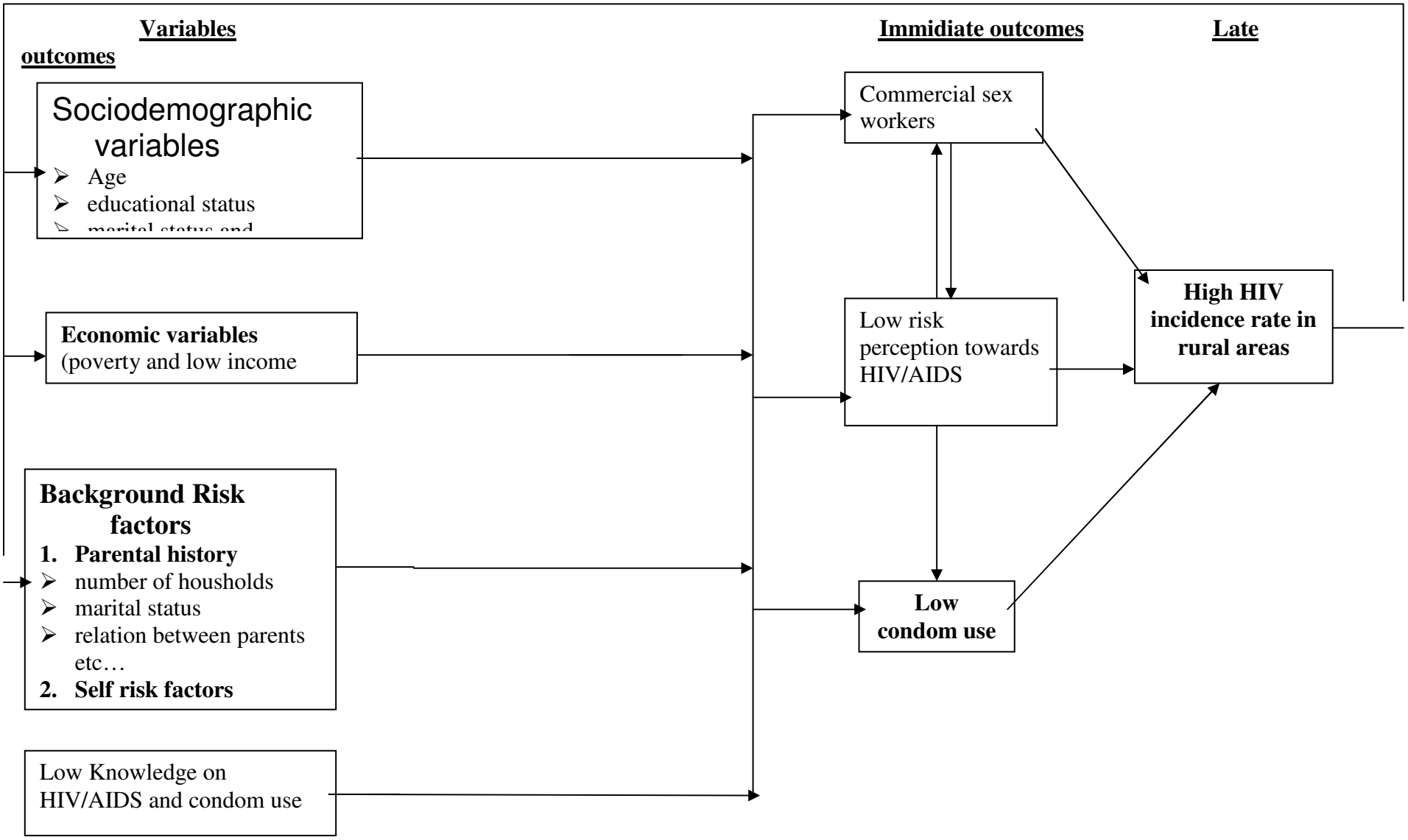
Annex 1 : Conceptual frame on commercial sex work among local beverage sellers and increasing incidence rate of HIV infection in rural Ethiopia



Annex 2: Informed consent form (to be taken by data collectors)

Hello, my name is ---------- and I am working with Ato Tenaw Bawoke from Community Health Department of Addis Ababa University Medical Faculty. I am here to enroll and take interview from eligible study participants like you and fill in the questionnaire forms prepared by Ato Tenaw. I am glad to inform you that you are one of the chosen study participants to participate in this study the purpose of which is to assess different health related factors associated with local beverage selling in the 3 towns (Finote selam, Dembecha and Debre markos). The study results will be used to address issues related to local beverage selling in rural towns of Ethiopia.

The information in this questionnaire will be kept strictly confidential, will not be divulged to any one and only the research group will have access to the information you gave but your name and address will not be recorded or identified even by the research team.

However, it is your right to terminate your participation at any time (from the very beginning or you can answer some questions you like to do so). I will appreciate and respect what so ever your decision will be.

Thus, this questionnaire will be filled only if you agree to take part in the study and I sincerely ask you to give your genuine and true responses to the questions provided you would agree to participate in the study.

So, would you like to participate in the study?

Yes/agree ----------
No/disagree ----------

Thank you!

Date - ----------

(----------)
Signature of the interviewer/data collector to certify the informed consent verbally

Annex 3: Ÿum S[Í Ò` ¾Ø“ƒ }dƒö T[ÒÑÝ pÎ (uÇ□ cwdu=¬/ª ¾T>VL)

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Annex 4: Questionnaire for local beverage (Araki and Tella) selling females in D/Markos, Dembecha and Finote Selam Town

Date of interview ---------
Respondent identification number---------
Interviewer Code No --------
Time of start of interview--------
Time of end of interview---------

1. *Socio demographic Characteristics*

SN	Questions	Coding categories	Skip to
101	What age are you now (age in complete years)? **(Choose the appropriate one)**	• Less than 15 years 0 • 15 - 24 years 1 • 25 - 34 years 2 • 35 - 44 years 3 • Above 44 years 4 • Don't know 88 • No response 99	
102	For how long did you practice local beverage selling? **(Choose the appropriate one)**	• <1 year 0 • 1-3 years 1 • 4-6 years 2 • > 6 years 3 • Don't know 88 • No response 99	
103	What is your educational status by now? **(Choose the appropriate one)**	• Illiterate 0 • Read and write 1 • Grade 1-4	

SN	Questions	Coding categories	Skip to
		2 • Grade 5-8 3 • Grade 10-12 4 • Above grade 12 5	
104	What was your educational status when you had first started beverage selling? **(Choose the appropriate one)**	• Illiterate 0 • Read and write 1 • Grade 1-4 2 • Grade 5-8 3 • Grade 9-12 4 • Above grade 12 5	
105	What was your marital status when you started local beverage selling? **(Choose the appropriate one)**	• Never married 0 • Divorced 1 • Widowed 2 • Married but run away 3 • Married but separated 4 • No response 99	→108
106	How old were you during your first marriage? **(Choose the appropriate one)**	• Less than 10 years 0 • 10 - 15 years 1 • 16 – 18 years 2 • Above 18 years 4 • Don't know 88 • No response 99	

SN	Questions	Coding categories	Skip to
107	What was the condition of your first marriage? **(Choose the appropriate one)**	• With your agrement 1 • Arranged by family 2 • Telefa/abduction 3 • Ran away to him 4 • Others specify----------? • Don't know 88 • No response 99	
108	Where did you live before you sart beverage selling? **(Choose the appropriate one)**	• This town 1 • An other town 2 • Rural area 3 • Don't know 88 • No response 99	
109	What was your occupation before you start selling beverage? **(Choose the appropriate one)**	• House wife 1 • House maid 2 • Student 3 • Unemployed with family- 4 • Unemployed with relative 5 • Others, specify ------? • No response 99	
110	What religion do you follow? **(Choose the appropriate one)**	• Orthodox Christian 1 • Muslim 2 • Protestant christian 3 • Others, specify --------	

SN	Questions	Coding categories	Skip to
		? • No response 99	
111	What is your ethnicity? **(Choose the appropriate one)**	• Amhara 1 • Agew 2 • Tigrie 3 • Others, specify -------- ? • No response 99	
112	Do you support others economically by now? **(Choose the appropriate one)**	• No 0 • Yes 1 • no response 99	→ 11
113	How money persons do you support? **(Choose the appropriate one)**	• 1-2 0 • 3-4 1 • > 4 3 • no response 99	
114	What is the relation of your dependants with you? **(Choose the appropriate one)**	• Children 1 • Mother 2 • Father 3 • Brother 4 • Sister 5 • Grand parents 6 • Others, specify ?	
115	Do you have other means of income (other than beverage selling)? **(Choose the appropriate one)**	• No 0 • Yes 1	→ 20

SN	Questions	Coding categories	Skip to
		• No response 99	
116	Describe the type of work that you earn additional income **(more than one response is possible)**	**No** **Yes** • Sex work 0 1 • Agriculture 0 1 • Trading 0 1 • Other, specify 0 1 • No response 99	

2. *Sexual history and status of commercial sexual practice*

SN	Questions	Coding categories	Skip to
201	Have you ever practiced sex? **(circle one)**	• No 0 • Yes 1 • No response 99	→ 301
202	How old were you when you had started sex first (in complete years)? **(Choose the appropriate one)**	• Less than 10 years 0 • 10 - 15 years 1 • 16 – 18 years 2 • Above 18 years 4 • Don't know 88 • No response 99	
203	With whom did you practice sex at first time? **(Choose the appropriate one)**	• Husband 1 • Regular partner 2 • Unknown person 3 • Don't know 88	

SN	Questions	Coding categories	Skip to
		• No response 99	
204	Now, do you have a non-paying sexual partner? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	→ 206
205	Please tell me the current number of your non-paying sexual partners **(Choose the appropriate one)**	• Only one 1 • More than one 2 • No response 99	
206	With how many non-paying partners do you practice sex in the last seven days? **(Choose the appropriate one)**	• I never made sex 0 • With 1 person 1 • With 2 persons 2 • With 3-4 persons 3 • With > 4 persons 4 • Don't know 88 • No response 99	
207	How many times did you practice sex with your non-paying partner duiring your recent exposure to him? **(Choose the appropriate one)**	• 1-2 times 0 • 3-4 times 1 • 5-6 times 2 • More than 6 times 3 • Don't know 88 • No response 99	
208	Have you ever received money for sex or have you ever-practiced commercial sex? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response	→ 301

SN	Questions	Coding categories	Skip to
		99	
209	Are you receiving money for sex by now (do you practice commercial sex by now)? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	→ 301
210	Where do you negotiate with your paying clients? **(Choose the appropriate one)**	• My own home 1 • Hotel/bar 2 • Street 3 • No response 99	
211	Type of paying clients duiring the last 2 weeks **(more than one response is possible)**	No Yes • Farmers 0 1 • Employees 0 1 • Merchants 0 1 • Students 0 1 • Soliders 0 1 • Daily laboror 0 1 • Others, specify 0 1 • Don't know 88 • No response 99	
212	With how many paying clients do you practice sex with in the last seven days? **(Choose the appropriate one)**	• I never made sex 0 • With 1-3 person 1 • With 4-7 persons 2 • With 8-10 persons 3 • With > 10 persons 4	

SN	Questions	Coding categories	Skip to
		• Don't know 88 • No response 99	
213	On busy day you remember in the last month, how many clients did you have per day? **(Choose the appropriate one)**	• With 1 person 0 • With 2 persons 1 • With 3 persons 2 • With > 3 persons 4 • Don't know 88 • No response 99	
214	How many times did you practice sex with your paying client duiring your recent exposure to him? **(Choose the appropriate one)**	• 1-2 times 0 • 3-4 times 1 • 5-6 times 2 • More than 6 times 3 • Don't know 88 • No response 99	

3. *Risk background (before starting selling local beverage)*

SN	Questions	Coding categories	Skip to
301	Parental marital status (mother and father) **(Choose the appropriate one)**	• In union 1 • Divorced 2 • Separated 3 • One died 4 • Both died 5 • Non married 6 • No response 99	

SN	Questions	Coding categories	Skip to
302	**Occupation of the bread winner (parent)** **(more than one response is possible)**	No 0 Yes 1 • Beverage seller 0 1 • Sex worker 0 1 • Farmer 0 1 • Merchant 0 1 • Daily laboror 0 1 • Employee 0 1 • Other, specify 0 1 • Don't know 88 No response 99	
303	Number of household members **(Choose the appropriate one)**	• 2 - 3 0 • 4 - 5 1 • Above 4 2 • Don't know 88 • No response 99	
304	Based on your estimation, how was your income per day (before resorting to beverage selling)? **(Choose the appropriate one)**	• Very low 1 • Low 2 • Fair 3 • Good 4 • Very good 5 • Don't know 88 • No response 99	

SN	Questions	Coding categories	Skip to
305	Please answer yes or no for the following possible reasons of resorting to commercial sex practice **(more than one response is possible)**	History No Yes DN NR • Husband died 0 1 88 99 • Divorce history 0 1 88 99 • Peer preasure 0 1 88 99 • Ran away from Hausband 0 1 88 99 • Family quarrel 0 1 88 99 • Hate to be maid 0 1 88 99 • Hate to be wife 0 1 88 99 • Parental loss 0 1 88 99 • Early marriage 0 1 88 99 • School failure 0 1 88 99 • Like to live urban 0 1 88 99 • Others, specify 0 1 88 99	

4. *Selected Knowledge, opinion, Attitude and practice towards HIV/AIDS*

SN	Questions	Coding categories	Skip to
401	Have you ever heard of HIV/AIDS? **(Choose the appropriate one)**	• No 0 → • Yes 1 • No response 99	end
402	How did you hear about HIV/AIDS? **(more than one response is possible)**	**Means no yes** • Radio 0 1 • Television 0 1 • Print materials 0	

SN	Questions	Coding categories	Skip to
		1 • Peer discussion 0 1 • Health facility 0 1 • NGO program 0 1 • Other, specify 0 1	
403	Do you know any one who is infected with HIV or died of AIDS? **(Choose the appropriate one)**	• No 0 • Yes, close relative 1 • Yes, close friend 2 • Yes, but niether relative nor friend 3 • No response 99	
404	Can it be possible to cure after being infected with HIV? **(Choose the appropriate one)**	• No 0 → 406 • Yes, by medication → 406 1 406 • Yes, by holly water 2 • Yes, by traditional healer 3 • No response 99	
405	Who should take these drugs? **(Choose the appropriate one)**	• Any HIV positive person 1 • When become AIDS cases 2 • Don't know 88 • No response 99	
406	Do you think that it is possible to protect oneself from HIV infection?	• No → 408 0 • Yes 1 • No response 99	
407	What methods of prevention do you know?	**Method no**	

SN	Questions	Coding categories	Skip to
	(more than one response is possible)	**yes** • Abstenence 0 1 • Faithfulness 0 1 • Consistent use condom use 0 1 • Others, list 0 1	
408	Do you think that any of the following could transmit HIV? **(more than one response is possible)** **Read the responses to the respondent**	no yes DN NR • One to one sex (even faithfully) 0 1 88 99 • Sex with multiple partners with out condom 0 1 88 99 • Sex with multiple partners with condom 0 1 88 99 • Mother to child 0 1 88 99 • Blood contact 0 1 88 99 • Sharing sharp tools 0 1 88 99 • Meal sharing 0 1 88 99 • Kissing 0 1 88 99 • Breathing 0 1 88 99 • Mosquito bite 0 1 88 99 • Via eggs of hen that swallowed used condoms 0 1 88 99 • Via raw meat handled by HIV positives 0 1 88 99 • Shaking of hands	

SN	Questions	Coding categories	Skip to
		0 1 88 99	
409	Do you think that healthy looking people could have HIV in their blood? **(Choose the appropriate one)**	• No 0 • Yes 1 • Don't know 88 • No response 99	
410	I don't want you tell me the result but have you ever been tested for HIV? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	→ 413
411	Still don't tell me the result, but did you obtain the result for the test? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	
412	When did you have your most recent test? **(Choose the appropriate one)**	• With in the past year 1 • B/n 1-2 years ago 2 • B/n 3-4 years ago 3 • More than 4 years ago 4 • Don't know 88 • No response 99	
413	Do you have a plan to be tested for HIV in the future? **(Choose the appropriate one)**	• No 0 • Yes 1 • Don't know 88 • No response 99	→ 415
414	If yes to question number 413, what is the reason for deciding to be tested? **(more than one response is possible)**	no yes • I had history of unsafe sex 0 1 • I feel sick 0 1 • My partner is died or sick 0 1 • I planned to leave this job 0 1 • I am going to marry 0 1 • I planned to go abroad 0 1 • I planned to have baby 0 1 • I am pregnant 0 1	
415	Why don't you plan to be tested for HIV? **(more than one response is possible)**	no yes • I don't see the necessity 0 1 • I fear the stigm and discrimination 0 1 • I afraid if I become positive 0 1 • no change because no cure 0 1 • others, specify 0 1 • No response 99	
416	Do you think that you are at risk of contracting HIV? **(Choose the appropriate one)**	• No 0 • Low 1 • Moderate 2 → 422 • High 3 → 422 • Don't know 88 → 501 • No response 99 → 501	
417	Why is it no/low? **(Choose the appropriate one)**	• No sexual history 1 • Limited with one partner 2 • Consistent condom use 3 • Don't know 88	

SN	Questions	Coding categories	Skip to
		• No response 99	
418	Why is it moderate/high? **(Choose the appropriate one)**	• Sex with out condom 1 • Multiple partner 2 • Condom broken 3 • Don't know 88 • No response 99	

5. *Knowledge and attitude towards condom use*

SN	Questions	Coding categories	Skip t
501	Have you ever heard of a male condom? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	→ end
502	Have you ever used condoms? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	→ 505
503	With your non-paying partner, did you use condoms during your last sex? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	→ 505
504	Who suggested condom use that time with your non-paying partner? **(Choose the appropriate one)**	• Myself 1 • My partner 2 • Together 3 • Don't know 4 • No response 5	→ 506
505	Why not use condoms that time with your non-	• Not available or far	

SN	Questions	Coding categories	Skip t
	paying partner? **(Choose the appropriate one)**	1 • Too expensive 2 • Partner rejected 3 • I rejected 4 • I was drunken 5 • Forgot it 6 • Used other contraceptives 7 • Don't know 88 • No response 99	
506	With what frequency did you and your partner (non-paying) use condoms over the last 6 months? **Choose the appropriate one)**	• Every time 1 • Almost every time 2 • Some times 3 • Never use 4 • Don't know 88 • No response 99	
507	Do you refuse sex with out condom with any one of your non-paying partner? **Choose the appropriate one)**	• No 0 • Yes 1 Depends on type of partner 2 • No response 99	→50
508	Your selection criteria of partners for not using condom? **Choose the appropriate one)**	• Fat 1 • Healthy looking 2 • Married and in union 3 • Wealthy 4 • Old and respected 5 • Others, specify ……. ? • No response 99	

Only for female sex workers			
509	With your paying client, did you use condoms during your last sex? **(Choose the appropriate one)**	• No 0 • Yes 1 • No response 99	511 →
510	Who suggested condom use that time with your paying client? **Choose the appropriate one)**	• Myself 1 • My client 2 • Together 3 • Don't know 88 • No response 99	
511	Which category of clients usualy reject to use condoms?	• Farmers 1 • Daily laborer 2 • Merchants 3 • Students 4 • Employees 5	
512	Why not you use condoms that time with your paying client? **Choose the appropriate one)**	• Not available or far 1 • Too expensive 2 • Partner objected 3 • Me objected 4 • I was drunken 5 • Forgot it 6 • Used other contraceptives 7 • Don't know 88 • No response 99	
513	If any before, with what frequency did you and your paying clients use condoms over the last 30 days? **Choose the appropriate one)**	• Every time 1 • Almost every time 2 • Some times 3 • Never use 4 • Don't know 88 • No response 99	
514	Do you refuse sex with out condom with your clients what ever amount of money they pay you? **Choose the appropriate one)**	• No 0 • Yes 1 • It depends 2 • No response 99	
515	Your selection criteria for not using condom with clients? **Choose the appropriate one)**	• Fat 1 • Healthy looking 2 • Married and in union 3 • Amount of money 4 • Old and respected 5 • Others, specify ……. ? • No response 99	
516	Which place do you know where you can obtain condoms? **(more than one response is possible)**	no yes • Shop 0 1 • Pharmacymarket 0 1 • Clinic 0 1 • Hospital 0 1 • Family planning center 0 1 • Bar/hotel 0 1 • Peer educator 0 1 • Friend 0 1 • Other, specify…… 0 1 • Don't know 88 • No response 99	

Annex 5 - በደብረ ማርቆስ፣ በደምበጫ እና በፍኖተ ሰላም ከተማ ውስጥ ለሚኖሩ እና ባሕላዊ መጠጦችን /አረቄ እና ጠላ/ በመሸጥ ለሚተዳደሩ ሴቶች የተዘጋጀ የቃለ-መጠይቅ ፎርም

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SÖÃl ¾}Ö"kkuƒ cነƒ ---------

1. **<u>ማሕበራዊ እና ስነ-ሕዝባዊ ሁኔታዎች</u>**

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
101	**በአሁኑ ወቅት እድሜዎት ስንት ነው?**	Ÿ 15 ነSƒ u□ሪ	0	
		Ÿ 15 - 24 ነSƒ	1	
		Ÿ 25 - 34 ነSƒ	2	
	/ነÓvw ÁK¬ ነ"É SMe w‰/	Ÿ 35 - 44 ነSƒ	3	
		Ÿ 44 ነSƒ uLÃ	4	
		አላውቅም	88	
		መልስ የለም	99	
102	**ባሕላዊ መጠጥ በመሸጥ ስንት ዓመት ሆነዎት?**	Ÿ 1 ነSƒ u□ሪ	0	
		Ÿ 1-3 ነSƒ	1	
	/ነÓvw ÁK¬ ነ"É SMe w‰/	Ÿ 4-6 ነSƒ	2	
		Ÿ 6 ነSƒ uLÃ	3	
		አላውቅም	88	
		መልስ የለም	99	
103	**በአሁኑ ጊዜ የትምህርት ደረጃዎት ምን ይመስላል?**	**ማንበብ መጻፍ አልችልም**	0	
		ማንበብ መጻፍ እችላለሁ	1	
	/ነÓvw ÁK¬ ነ"É SMe w‰/	**ከ1-4ኛ ክፍል**	2	
		ከ5-8ኛ ክፍል	3	
		ከ9-12ኛ ክፍል	4	
		ከ12ኛ ክፍል በላይ	5	
104	**ባሕላዊ መጠጥ መሸጥ ሲጀምሩ የትምህርት ደረጃዎት እንዴት ነበር?**	**ማንበብ መጻፍ አልችልም**	0	
		ማንበብ መጻፍ እችላለሁ	1	
		ከ1-4ኛ ክፍል	2	
	/ነÓvw ÁK¬ ነ"É SMe w‰/	**ከ5-8ኛ ክፍል**	3	
		ከ9-12ኛ ክፍል	4	
		ከ12ኛ ክፍል በላይ	5	
		ምንም አላገባሁም ነበር	0 →	108
105	**ባሕላዊ መጠጥ መሸጥ ከመጀመርዎት በፊት የጋብቻ ሁኔታዎት ምን ይመስል ነበር?**	**አግብቼ ፈትቼ ነበር**	1	
		ባሌ ሞቶብኝ ነበር	2	
	/ነÓvw ÁK¬ ነ"É SMe w‰/	**አግብቼ ጠፍቼ መጣሁ**	3	
		አግብቼ ተለያይተን እንኖር ነበር	4	
		መልስ የለም	99	
106	**የመጀመሪያ ባልዎትን ሲያገቡ እድሜዎት ስንት ነበር?**	Ÿ 10 ነSƒ u□ሪ	0	
		Ÿ 10 - 15 ነSƒ	1	
		Ÿ 16 - 18 ነSƒ	2	

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
	/›ÓvwÁK¬›"É SMe w‰/	Ÿ 18 ›Sƒ uLÃ	4	
		አላውቅም	88	
		መልስ የለም	99	
		ተስማምቼ ነው	1	
	የመጀመሪያ ጋብቻዎት ›ðéçU G<'@□	በቤተሰብ ፈቃድ ብቻ ነው	2	
		በጠለፋ ነው	3	
107	□"Èƒ }Ÿ‟'' **?**	ከቤተሰብ ፈቃድ ውጪ ጠፍቼ ነው	4	
		አላውቅም	88	
	/›ÓvwÁK¬›"É SMe w‰/	መልስ የለም	99	
108	**ባሕላዊ መጠጥ መሸጥ ከመጀመርዎት በፊት ይኖሩ የነበረው የት ነው?**	እዚህ ከተማ	1	
		ሌላ ከተማ	2	
	/›ÓvwÁK¬›"É SMe w‰/	ገጠር	3	
		አላውቅም	88	
		መልስ የለም	99	
	ባሕላዊ መጠጥ መሸጥ ከመጀመርዎት በፊት ምን ይሠሩ ነበር?	የቤት እመቤት	1	
		የቤት ሠራተኛ	2	
		ተማሪ	3	
109	/›ÓvwÁK¬›"É SMe w‰/	ያለስራ ከቤተሰብ ጋር	4	
		ያለስራ ከዘመድ ጋር	5	
		መልስ የለም	99	
	የየƒ•ው ኃይማኖት }Ÿ□ይ 'ዎት?	ኦርቶዶክስ ክርስቲያን	1	
		ሙስሊም	2	
110		ፕሮቴስታንት	3	
	/›ÓvwÁK¬›"É SMe w‰/	መልስ የለም	99	
	የየትኛው ብሔር ተወላጅ ነዎት?	አማራ	1	
		አገው	2	
111	/›ÓvwÁK¬›"É SMe w‰/	ትግሬ	3	
		መልስ የለም	99	
112	**በአሁኑ ወቅት** u□`e- usT>'ƒ ÉÒð ¾T>ÁÑ–<		የK<ም →	115
	c-‹ ›K<?		0	
			አK<	
	/›ÓvwÁK¬›"É SMe w‰/		1	
		መልስ የለም	99	
		ክ 1-2	0	
113	□`e- usT>'ƒ **የሚረዱአቸው ሰዎች ቁጥር ስንት**	ክ 3-4	1	
	ነው? /›ÓvwÁK¬›"É SMe w‰/	ክ 4 በላይ	2	
		መልስ የለም	99	
	ከሚረዷቸው ሰዎች ጋር ያለው የስጋ ዝምድና	ልጅ ነው/ናት	1	
	ምንድን ነው?	እናቴ ናት	2	
		አባቴ ነው	3	
114		ወንድሜ ነው	4	
	/›ÓvwÁK¬›"É SMe w‰/	እህቴ ናት	5	
		አያቴ ነው/ናት	6	
115	**ከመጠጥ ሽያጭ ውጪ ሌላ የገቢ ምንጭ**	የለኝም	0 →	201
	አለዎት? /›ÓvwÁK¬›"É SMe w‰/	አለኝ	1	
		መልስ የለም	99	

			አይደለም	ነው
	የስራውን ዓይነት ቢገልጹልኝ?	ሴተኛ አዳሪነት	0	1
		እርሻ	0	1
116		ንግድ	0	1
	ከአንድ በላይ መልስ መስጠት ይቻላል ::	መልስ የለም		99

2. <u>የግብረ ሥጋ ግንኙነት እና ሴተኛ አዳሪነትን በተመለከተ</u>

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
201	የግብረ ሥጋ ግንኙነት አድርገው ያውቃሉ? /›Óvw ÁK¬ ›''É SMe w‰/	የለም	0	301
		አዎ	1	
		መልስ የለም	99	
202	በስንት ዓመትዎት ነው የመጀመሪያውን የግብረ ሥጋ ግንኙነት ያደረጉት? /›Óvw ÁK¬ ›''É SMe w‰/	Ÿ 10 ›Sƒ u□‹	0	
		Ÿ 10 - 15 ›Sƒ	1	
		Ÿ 16 - 18 ›Sƒ	2	
		Ÿ 18 ›Sƒ uLÃ	3	
		አላውቅም	88	
		መልስ የለም	99	
203	ከማን ጋር '¬ የመጀመሪያ የግብረ ሥጋ ግንኙነት ያደረጉት? /›Óvw ÁK¬ ›''É SMe w‰/	ከባለቤቴ	1	
		ከወንድ ጓደኛዬ	2	
		ከማላውቀው ሰው ጋር	3	
		አላውቀም	88	
		መልስ የለም	99	
204	በአሁኑ ወቅት የጾታ ጓደኛ /ወንድ/ አለዎት? /›Óvw ÁK¬ ›''É SMe w‰/	የለኝም	0	206
		አለኝ	1	
		መልስ የለም	99	
205	በአሁኑ ወቅት ያለዎትን ወንድ የጾታ ጓደኛዎት ብዛት ቢነግሩኝ? /›Óvw ÁK¬ ›''É SMe w‰/	አንድ	1	
		ከአንድ በላይ	2	
		መልስ የለም	99	
206	ባለፉት 7 ቀናት ውስጥ ከስንት የማይከፍሉ የወንድ ጓደኛዎት ጋር የግብረ ሥጋ ግንኙነት ፈጽመዋል? /›Óvw ÁK¬ ›''É SMe w‰/	›MðÖUŸ<U	0	
		Ÿ 1 c¬ Ò`	1	
		Ÿ 2 c¬ Ò`	2	
		Ÿ 3 - 4 c¬ Ò`	3	
		Ÿ 4 c¬ uLÃ	4	
		አላውቅም	88	
		መልስ የለም	99	
207	በቅርብ ጊዜ የግብረ ሥጋ ግንኙነት ካደረጉት የጾታ ጓደኛዎት ጋር በቀን ስንት ጊዜ የግብረ ሥጋ ግንኙነት አደረጉ? /›Óvw ÁK¬ ›''É SMe w‰/	Ÿ 1 - 2 Ñ>²?	0	
		Ÿ 3 - 4 Ñ>²?	1	
		Ÿ 5 - 6 Ñ>´	2	
		Ÿ 6 Ñ>²? uLÃ	3	
		አላውቅም	88	
		መልስ የለም	99	

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
208	ገንዘብ በማስከፈል (ሀሴተኛ አዳሪነት) የግብረ ሥጋ ግንኙነት ፈጽመው ያውቃሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አላውቅም አውቃለሁ መልስ የለም	0 1 99	→ 301
209	በአሁኑ ጊዜ የሴተኛ አዳሪነት ሥራ ይሠራሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አልሰራም እሠራለሁ መልስ የለም	0 1 99	→ 301
210	የግብረ ሥጋ ግንኙነት ደምበኞችዎን የሚያገኙአቸው የት ነው? /ከአንድ በላይ ማክበብ ይቻላል/	እራሴ ቤት ሆቴል/ሀ<'' ሀ?ƒ መንገድ ላይ SMe ¾KU	1 2 3 99	
211	የግብረ ሥጋ ግንኙነት ደምበኞችዎ የሥራ ሁኔታ ምን ይመስላል? ከአንድ በላይ መልስ መስጠት ይቻላል :: ምርጫዎቹ ይነበቡ		አይደለም ነው ገበሬ 0 1 ቅጥር 0 1 ነጋዴ 0 1 ተማሪ 0 1 የቀን ሠራተኛ 0 1 ሌላ 0 1 አላውቅም 88 መልስ የለም 99	
212	ባለፉት 7 ቀናት ውስጥ ከስንት የሚከፍሉ የግብረ ሥጋ ግንኙነት ደምበኛዎት ጋር ወሲባዊ ግንኙነት ፈጽመዋል? /›Óvw ÁK¬ ›''É SMe w‰/	›MðÖUŸ<U Ÿ 1 - 3 c¬ Ò` Ÿ 4 - 7 c¬ Ò` Ÿ 8 - 10 c¬ Ò` Ÿ 10 c¬ ULÃ አላውቅም መልስ የለም	0 1 2 3 4 88 99	
213	ባለፈው አንድ ወር ውስጥ በዛ ሲባል በቀን ስንት የወሲብ ደምበኛዎት ጋር ወሲብ ፈጽመዋል? /›Óvw ÁK¬ ›''É SMe w‰/	Ÿ 1 c¬ Ò` Ÿ 2 c¬ Ò` Ÿ 3 c¬ Ò` Ÿ 3 ULÃ አላውቅም መልስ የለም	0 1 2 3 88 99	
214	በቅርብ ጉዜ ካጋጠመዎት የወሲብ ደምበኛዎት ጋር በቀን ስንት ጊዜ ወሲብ ፈጽመዋል? /›Óvw ÁK¬ ›''É SMe w‰/	Ÿ 1 - 2 Ñ>²? Ÿ 3 - 4 Ñ>²? Ÿ 5 - 6 Ñ>´ Ÿ 6 Ñ>²? ULÃ አላውቅም መልስ የለም	0 1 2 3 88 99	

3. <u>ለሴተኛ አዳሪነት እና ለኤች አይ ቪ/ኤድስ ተጋላጭነት ሁኔታ</u> (መጠጥ መሸጥ ከመጀመርዎት በፊት)

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
301	የወላÐ‹- (እናት እና አባት-ƒ) የጋብቻ ሁኔታ ምን ይመስላል? /›Óvw ÁK¬ ›''É SMe w‰/	አብረው ይኖሩ ነበር ተፋተው ነበር ሳይፋቱ ተለያይተው ይኖሩ ነበር ከሁለት አንዳቸው ሞተው ነበር ሁለቱም ሞተው ነበር ሳይጋቡ ነው የወለዱኝ መልስ የለም	1 2 3 4 5 6 99	
			<u>አይደለም</u> <u>ነው</u>	
302	የቤተሰቡ ኃላፊ የሥራ ሁኔታ ምን ይመስል	መጠጥ መሸጥ ሴተኛ አዳሪ ገበሬ	0 1 0 1 0 1	

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
	ነበር? ከአንድ በላይ መልስ መስጠት ይቻላል ::	ነጋዴ የቀን ሠራተኛ የመንግስት ሠራተኛ ሌሎች አላውቅም መልስ የለም	0 0 0 0	1 1 1 1 88 99
303	የቤተሰብ አባላት ብዛት ስንት ነበር? /›Óvw ÁK¬ ›''É SMe w‰/	Ÿ 2 - 3 Ÿ 4 - 5 Ÿ 4 ULÃ አላውቅም መልስ የለም		0 1 2 88 99
304	በርስዎ አስተሳሰብ፣ የርስዎ የገቢ ሁኔታ ምን ይመስል ነበር? /›Óvw ÁK¬ ›''É SMe w‰/	በጣም ዝቅተኛ ዝቅተኛ መጠነኛ በቂ/ጥሩ በጣም ጥሩ አላውቅም መልስ የለም		1 2 3 4 5 88 99
305	እባክዎት የሚከተሉትን ለሴተኛ አዳሪነት የሚያጋልÖ< ሁኔታዎችን በርስዎ ላይ ተከስተው ከሆነ «ነው» ካልሆነ ደግሞ «አይደለም» በማለት መልስ ይስጡ:: ከአንድ በላይ መልስ መስጠት ይቻላል ::		አይደለም	ነው አላ. መ.የለ
		ባሌ ሞቶብኝ ነበር	0	1 88 99
		ከባሌ ተፋትቼ ነበር	0	1 88 99
		የጓደኛ ጫና ነበር	0	1 88 99
		ከቤተሰቦቼ ተጣልቼ ነበር	0	1 88 99
		የቤት ሠራተኛ መሆን አስጠልቶኝ ነበር	0	1 88 99
		የቤት እመቤት መሆን አስጠልቶኝ ነበር	0	1 88 99
		ቤተሰብ ሞተውብኝ ነበር	0	1 88 99
		ያለዕድሜዬ ተድሬ ነበር	0	1 88 99
		ከት/ቤት ወድቄ ነበር	0	1 88 99
		ከተማ መኖር ፈልጌ ነው	0	1 88 99
		ሌሎች	0	1 88 99

4. ለኤች አይ ቪ/ኤድስ ያለ እውቀት፣ አመለካከት እና ባሕርይ

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
401	ኤች አይ ቪ/ኤድስ ስለሚባለዉ በሽታ ሰምተው ያውቃሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አላውቅም አውቃለሁ መልስ የለም		0 → መጨረሻ 1 99
402	ስለ ኤች አይ ቪ/ኤድስ ከየት ሰሙ? ከአንድ በላይ መልስ መስጠት ይቻላል ::		አይደለም	ነው
		ራዲዮ	0	1
		ቴሌቭዥን	0	1
		በሕትመት ውጤቶች	0	1
		በጓደኛ አማካይነት	0	1
		ከጤና ተቋማት	0	1
		መንግሥታዊ ካልሆኑ ድርጅቶች	0	1
		ሌሎች	0	1
		የለም		0
403	በበሽታው የሞተ ወይም የታመመ ሰው ያውቃሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አዎ፣ ቅርብ ዘመዴ አዎ፣ ቅርብ ጓደኛዬ አዎ Ó'' ዘመዴU ÕÅ—U አይደለ SMe ¾KU		1 2 3 99
404	የኤድስ በሽታ Ãድናል ብለው ያምናሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አይድንም በዘመናዊ መድኃኒት ይድናል		0 1 → 406

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር	ወደ ተ.ቁ.
		በፀበል ይድናል	2 → 406
		በባሕላዊ ህክምና ይድናል	3 → 406
		መልስ የለም	99
405	የእድሜ ማራዘሚያ መድኃኒቱን መውሰድ ያለበት ማነው? /)Óvw ÁK¬)"É SMe w‰/	ማንኛውም ከቫይረሱ ጋር የሚኖር ሰው	1
		ወደ ኤድስ ደረጃ ሊሸጋገር	2
		አላውቅም	88
		መልስ የለም	99
406	እራe-ƒ" ከቫይረሱ መጠበቅ እ‹LKG< ብለው ያምናሉ? /)Óvw ÁK¬)"É SMe w‰/	አንችልም	0 → 408
		እንችላለን	1
		መልስ የለም	99

	አይደለም	ነው
መታቀብ	0	1
1 ለ1 መወሰን	0	1
ኮንዶም መጠቀም	0	1
ሌሎች ይዘርዘሩ	0	1

407 እርስዎ ምን ምን የመከላከያ መንገዶችን ያውቃሉ?

ከአንድ በላይ መልስ መስጠት ይቻላል ::

	አያስ	ያስ.	አላው	መ/የ
አንድ ለአንድ መወሰን	0	1	88	99
	ከብዙ ወንዶች ጋር ያለ			
ኮንዶም ግንኙነት መፈፀም	0	1	88	99
	ከብዙ ወንዶች ጋር			
በኮንዶም ግንኙነት በመፈፀም	0	1	88	99
ከእናት ወደ ልጅ	0	1	88	99
በደም ንክኪ	0	1	88	99
ስል ነገሮችን በጋራ በመጠቀም	0	1	88	99
አብሮ መመገብ	0	1	88	99
በመሳሳም	0	1	88	99
በትንፋሽ	0	1	88	99
በወባ ትንኝ አማካኝነት	0	1	88	99
ጥቅም ላይ የዋለ ኮንዶም በዋጠች ዶሮ እንቁላል አማካኝነት	0	1	88	99
ከቫይረሱ ጋር የሚኖር ሰው ባዘጋጀው ጥሬ ስጋ አማካኝነት	0	1	88	99
በመጨባበጥ	0	1	88	99

408 ከሚከተሉት መንገዶች ውስጥ የትኛው ኤች አይ ቪ ያስተላልፋል ብለው ያስባሉ?

ከአንድ በላይ መልስ መስጠት ይቻላል ::

መልሶቹ ይነበቡ

409	ሲታዩ ጤናማ የሚመስሉ ሰዎች ቫይረሱ በደማቸው ውስጥ ሊኖር ይችላል ብለው ያስባሉ? /)Óvw ÁK¬)"É SMe w‰/	አይኖርባቸውም 0 ሊኖርባቸው ይችላል 1 አላውቅም 88 መልስ የለም 99
410	ውጤቱን እንዲነግሩኝ አልፈልግም፣ እርስዎ የኤች አይ ቪ የደም ምርመራ አድርገው ያውቃሉ? /)Óvw ÁK¬)"É SMe w‰/	አላውቅም 0 → 413 አውቃለሁ 1 መልስ የለም 99
411	ውጤቱንስ ሔደው ሰምተዋል/ተቀብለዋል? /ውጤቱን አይንገሩኝ) /)Óvw ÁK¬)"É SMe w‰)	አልተቀበልኩም 0 ተቀብያለሁ 1 መልስ የለም 99
412	በቅርብ ጊዜ ያደረጉት ምርመራ መቼ ነበር? /)Óvw ÁK¬)"É SMe w‰/	በአንድ ዓመት ውስጥ 1 ከ1-2 ዓመት በፊት 2 ከ3-4 ዓመት በፊት 3 ከ4 ዓመት በፊት 4 አላውቅም 88 መልስ የለም 99
413	ወደፊትስ ለመመርመር አቅደዋል? /)Óvw ÁK¬)"É SMe w‰/	አላቀድኩም 0 → 415 አቅጃለሁ 1 አላውቅም 88 መልስ የለም 99

ለጥያቄ ቁጥር 413 መልስዎ አዎ ከሆነ ለመመርመር እንዲያቅዱ ያሳሰቡዎት

	አይደለም	ነው
ጥንቃቄ የጐለው		
ወሲብ ስለፈፀምኩ	0	1
የሕመም ስሜት ስለተሰማኝ	0	1
የጸታ ጓደኛዬ		

414 ምክንያት ምንድን ነዉ?

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
	ከአንድ በላይ መልስ መስጠት ይቻላል ።	ስለታመመ/ስለሞተ	0	1
		ላገባ ስለፈለኩ	0	1
		ውጪ መሔድ ስለፈለኩ	0	1
		መውለድ ስለፈለኩ	0	1
		ነፍሰ ጡር ስለሆንኩ	0	1
			አይደለም	ነው
		አስፈላጊነቱ አልታኝም	0	1
		ማግለል እና መድሎውን ስለምፈራ	0	1
		ቫይረሱ አለብሽ		
		እንዳልባል ስለፈራሁ	0	1
		መድኃኒት ስለሌለው		
		ምን ያደርግልኛል	0	1
		ሌላ ካለ ይዘርዝር		
415	ለጥያቄ ቁጥር 413 መልስዎ አላቀድኩም ከሆነ ለምንድን ነው መመርመር የማይፈልጉት? ከአንድ በላይ መልስ መስጠት ይቻላል ።	መልስ የለም		99
416	ቫይረሱ በደሜ ውስጥ አለ ብለው ያስባሉ? ወይም ለቫይረሱ ተጋልጫለሁ ብለው ያስባሉ? /›Óvw ÁK¬ ›''É SMe w‰/	ምንም		0
		ዝቅተኛ		1
		መጠነኛ		2 → 422
		ከፍተኛ		3 → 422
		አላውቅም		88 → 501
		መልስ የለም		99 → 501
417	ለምንድን ነው በቫይረሱ የመያዝ እድሌ ምንም ወይም ዝቅተኛ ነው ሊK< የቻሉት? /›Óvw ÁK¬ ›''É SMe w‰/	¾Ów[eÒ Ó''–<'ƒ ›É`Ó ›L¬pU		1
		›''É w‰ ÕÅ— '¬ ÁK˜		2
		G<K?U ¢''ÊU □ÖkTKG<		3
		አላውቅም		88
		መልስ የለም		99
418	ለምንድን ነው በቫይረሱ የመያዝ እድሌ መጠነኛ ወይም ከፍተኛ ሊሉ የቻሉት? /›Óvw ÁK¬ ›''É SMe w‰/	ያለ ኮንዶም ወሲብ ስለፈፀምኩ		1
		ብዙ የጾታ ጓደኞች ስላሉኝ		2
		ኮንዶም ስለፈነዳብኝ		3
		አላውቅም		88
		መልስ የለም		99

5. ስለ ኮንዶም ያለ እውቀት፣ አመለካከት እና ግንዛቤ እንዲሁም አጠቃቀም

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር		ወደ ተ.ቁ.
501	ስለ ¨''É ኮንዶም ሰምተው ያውቃሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አላውቅም	0	→ መጨረሻ
		አውቃለሁ	1	
		መልስ የለም	99	
502	ከዚህ በፊት በማንኛውም ወቅት ኮንዶም ተጠቅመው ያውቃሉ? /›Óvw ÁK¬ ›''É SMe w‰/	አላውቅም	0	→ 505
		አውቃለሁ	1	
		መልስ የለም	99	
503	ገንዘብ ከማይከፍሉዎት የጾታ ጓደኛዎት ጋር በመጨረሻ ጊዜ የግብረ ስጋ ግንኙነት ሲፈጽሙ ኮንዶም ተጠpመው ነበርን? /›Óvw ÁK¬ ›''É SMe w‰/	አልተጠቀምኩም	0	→ 505
		ተጠቅሜአለሁ	1	
		መልስ የለም	99	

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር	ወደ ተ.ቁ.
504	በዘያን ወቅት ኮንዶም የመጠቀም ሃሣብን ያመነጨው ማን ነው /›ÓvwÁK¬›''É SMe w‰/	እኔ 1 የወሲብ ጉዳኛዬ 2 ሁለታችንም 3 አላውቅም 88 መልስ የለም 99	506
505	ገንዘብ ከማይከፍል የጾታ ጓደኛዎት ጋር በመጨረሻ ጊዜ የግብረ ስጋ ግንኙነት ወቅት በምን ምክንያት ነበር ኮንዶም ያልተጠቀሙት? /›ÓvwÁK¬›''É SMe w‰/	ኮንዶም በቅርብ ስላልነበረ 1 ኮንዶም ዋጋው ስለተወደደ 2 እርሱ እምቢ ስላለ 3 እኔ ስላልፈለክ 4 ሰክሬ ነበር 5 እረሳሁት 6 ሌላ የወሊድ መከላከያ ተጠቅሜአለሀ 7 አላውቅም 88 መልስ የለም 99	
506	ባለፉት 6 ወራት ውስጥ ገንዘብ ከማይከፍሉ የጾታ ጓደ™ዎት ጋር ኮንዶም አጠቃቀማች ሁ እንዴት ነበር? /›ÓvwÁK¬›''É SMe w‰/	ሁልጊዜ 1 በብዛት 2 አልፎ አልፎ 3 ምንም አልተጠቀምኩም 4 አላውቅም 88 መልስ የለም 99	
507	የጾታ ጓደኛዎት ያለ ኮንዶም መጠቀም ቢፈልጉ እርስዎ እምቢ ይላሉ? /›ÓvwÁK¬›''É SMe w‰/	እምቢ አልልም 0 እምቢ እላለሁ 1 እንደሰውየው ሁኔታ ይወሰናል 2 መልስ የለም 99	509
508	ያለ ኮንዶም ወሲብ ለመፈፀም ሰዎችን የሚመርÖ<ሀት መስፈርት ምንድን ነው? /›ÓvwÁK¬›''É SMe w‰/	ወፍራም መሆን አለበት 0 ሲያዩት ጤነኛ መሆን አለበት 1 ባለትዳር መሆን አለበት 2 ባለትዳር መሆን አለበት 3 ሀብታም መሆን አለበት 4 ትልቅ እና የተከበረ ሰው መሆን አለበት 5 ሌሎች ይዘርዝሩ---------- መልስ የለም 99	

ለሴተኛ አዳሪዎች ብቻ

509	በቅርቡ ገንዘብ ከከፈለዎት የወሲብ ደምበኛዎት ጋር የግብረ ሥጋ ግንኙነት ሲፈጽሙ ኮንዶም ተጠቅመው ነበር? /›ÓvwÁK¬›''É SMe w‰/	አልተጠቀምኩም 0 ተጠቅሜአለሁ 1 መልስ የለም 99	ወደ. 511
510	ከተጠቀሙ፣ የመጠቀም ሃሣቡን ያመነጨው ማን ነው? /›ÓvwÁK¬›''É SMe w‰/	እኔ ራሴ 1 እርሱ ነው 2 ሁለታችንም 3 አላውቅም 88 መልስ የለም 99	
511	በአብዛኛው ኮንዶም አንጠቀምም የሚሉዎት ምን አይነት ደምበኞችዎ ናቸው? /›ÓvwÁK¬›''É SMe w‰/	አርሶ አደሮች 1 የቀን ሠራተኞች 2 ነጋዴዎች 3 ተማሪዎች 4 ተቀጣሪ ሠራተኞች 5	
512	በቅርብ ጊዜ ካጋጠመዎት ደምበኛዎት ጋር ኮንዶም ካልተጠቀሙ፣ ለምንድን ነው ያልተጠቀሙት? /›ÓvwÁK¬›''É SMe w‰/	ኮንዶም ስላላገኘሁ ወየም ስለራቀኝ 1 ኮንዶም በጣም ስለተወደደብኝ 2 እርሱ አልፈልግም ስላለኝ 3 እኔ ስላልፈለኩኝ 4 ሰክሬ ነበር 5 እረሳሁት 6 ሌላ የወሊድ መከላከያ ተጠቅሜያለሀ 7 አላውቅም 88 መልስ የለም 99	
513	ኮንዶም ተቀጥመው የሚያውቁ ከሆነ ገንዘብ	ሁልጊዜ 1	

ተ.ቁ.	ጥያቄ	የኮድ ቁጥር	ወደ ተ.ቁ.
	ከሚከፍሉ ደምበኞችዎት ጋር ባለፉት 30 ቀናት /1 ወር/ ውስጥ እንዴት ነው የተጠ ቀሙት?	በአብዛኛው 2 አለፎ አልፎ 3 አልተጠቀምኩም 4 አላውቅም 88 መልስ የለም 99	
	/›Óvw ÁK¬ ›''É SMe w‰/		
514	የፈለጉትን ያህል ገንዘብ ቢከፍሉዎት ያለኮንዶም ወሲብ ቢጠየቁ እምቢ ይላሉ?	እምቢ አልልም 0 → 516 እምቢ እላለሁ 1 → 516 እንደ ሁኔታው 2 → 516 መልስ የለም 99 → 516	
	/›Óvw ÁK¬ ›''É SMe w‰/		
	ያለ ኮንዶም ወሲብ ለመፈፀም ሰዎችን እንዴት ይመርጣሉ?	ወፍራም ሲሆኑ 1 ጤናማ ቁመና ሲኖራቸው 2 ባለትዳር ከሆኑ 3 በርከት ያለ ገንዘብ ከከፈሉኝ 4 የተከበሩ እና ትልቅ ሰው ከሆኑ 5 ሌላ ካለ ይጠቀስ----------	
515			
	/›Óvw ÁK¬ ›''É SMe w‰/		
		መልስ የለም 99	
		አይደለም ነው	
		ሱቅ 0 1	
		ፋርማሲ 0 1	
		ገበያ 0 1	
		ክሊኒክ 0 1	
		ሆስፒታል 0 1	
		ቤተሰብ መምሪያ 0 1	
		ሆቴል 0 1	
		አቻ ለአቻ አስተማሪ 0 1	
		ጓደኛ 0 1	
		አላውቅም 88	
		መልስ የለም 99	
516	ኮንዶም ሲፈልጉ ከየት ያገኛሉ?		
	ከአንድ በላይ መልስ መስጠት ይቻላል ::		

uÉÒT> አመሰግናለሁ !

Annex 6 - Focus Group Discussion Guide line

Participants – 10 local beverage selling females who practice commercial sex and 10 similar groups who don't practice commercial sex work from 3 towns (totally 60 participants)
Study site – Debre Markos, Dembecha and Finote Selam towns

1. **To local beverage seller females who practice commercial sex work**

    i. What are the social, economical, cultural and other precipitating factors that lead females to practice local beverage selling and in turn to practice commercial sex work?
    ii. Knowledge Attitude and Practice of Female Sex Workers on HIV infection and condom use?
    iii. Possible alternatives to drive them out of commercial sex work?

2. **To local beverage seller females who do not practice commercial sex**

    i. What challenging factors are there that may lead local beverage selling females like you to practice commercial sex work?
    ii. Knowledge Attitude and Practice of local beverage selling females who do not practice commercial sex on HIV infection and condom use?
    iii. Possible prevention actions to be taken in order you not to enter to commercial sex practice?

Annex 7 - የትኩረት ቡድን ውይይት መመሪያ

<u>ተሳታፊዎች</u>:- 10 ባሕላዊ መጠጥ በቤታቸው እየሸጡ የሴተኛ አዳሪነት ሥራም የሚሠሩ ሴቶች እና 10 የባሕላዊ መጠጥ በቤታቸው የሚሸጡ ነገር ግን ¾ር?}— አዳሪነት ሥራ የማይሰሩ ሴቶች ከሦስቱም ከተሞች /በድምሩ 60 ተሳታፊዎች/

<u>የጥናት ቦታ</u>:- ደብረ ማርቆስ፣ ደምበጫ እና ፍኖተ ሰላም

1. **<u>ባሕላዊ መጠጥ በቤታቸው እየሸጡ የሴተኛ አዳሪነት ሥራም ለሚሰሩ ሴቶች</u>**

    * ሴቶችን ለባሕላዊ መጠጥ ሻጭነት ብሎም ለሴተኛ አዳሪነት የሚያጋልጡ ማኅበራዊ፣ ኢኮኖሚያዊ፣ ባሕላዊ እና ሌሎችም መንስኤዎች ምን ምን ናቸው ብለው ያምናሉ?
    * ስለ ኤች አይ ቪ እና ኮንዶም አጠቃቀም ያለዎትን እውቀት፣ አመለካከት እና ልምድ ቢያካፍሉን?
    * አሁን ካሉበት የ?ተኛ አዳሪነት ሥራ ለመውጣት ምን ምን አማራጮች አሉ ብለው ያምናሉ?

2. **<u>ባሕላዊ መጠጥ በቤታቸው ለሚሸጡ ነገር ግን የሴተኛ አዳሪነት ሥራ ለማይሰሩ ሴቶች</u>**

    * ልክ እንደእርስዎ ባሕላዊ መጠጥ በቤታቸው የሚሸጡ ሴቶችን ወደ ሴተኛ አዳሪነት ሥራ የሚገፋፉ ጫናዎችን ያብራሩ?
    * ስለ ኤች አይ ቪ እና ኮንዶም አጠቃቀም ያለዎትን እውቀት፣ አመለከካከት እና ልምድ ቢያካፍሉን?

ባሕላዊ መጠጥ በመሸጥ የሚተዳደሩ ሴቶች ወደ ሴተኛ አዳሪነት ሕይወት እንዳይገቡ ምን ምን የመከላከያ እርምጃዎች