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ASSESSMENT OF KNOWLEDGE, ATTITUDE & PRACTICE TOWARDS HIV /AIDS AMONG COMMERCLAL SEX WORKERS OF ALAMATA WOREDA, 2014

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Table of Contents

Contents ***Page No***

List of figure Page

List of tables Page

List of annexes Page

List of acronyms

AIDS…….Acquired immune deficiency disease

BSS……. Behavioral surveillance survey

CDC…….Center for communicable disease control

EDHS…….. Ethiopian demographic and health survey

FSWs……...Female sex workers

HIV…….Human immune deficiency virus

IDU……. Injection drug users

MC…….. Male circumcision

MSM……... Male who have sex with male

STDs……. Sexually transmitted diseases

STIs……. Sexually transmitted infections

SWs…….Sex workers

UNAIDS……..Joint united nations program on HIV and AIDS

Abstract

Background- HIV/AIDS is a major crisis that is increasingly affecting the most productive segments of the population in sub-Saharan African countries

Objective- the main objective of this study is to determine the knowledge, attitude and practice of HIV/AIDS prevention methods among commercial sex workers in Alamata woreda, Tigray, Ethiopia 2013.

Methodology- Community based cross sectional study was conducted in Alamata woreda, Tigray . Those who practice sex work in their home were included in the study using purposive sampling. Data were collected by interviewer administered semi-structured questionnaire and entered using Epi info version 3.4 software and exported to SPSS software version 16 for analyses. Frequencies, percentage, chi-square with p-value were used to describe the study population in relation to relevant variables. The degree of association between independent and dependent variables were assessed using crude odd ratio with 95% confidence interval. Consecutively multiple logistic regression analysis was performed to control the potential confounding variables under the study.

Results- Of those 106 participants 69(65.1%) were from the surrounding rural areas, 49(46.3%) were young aged between 15-25 years old with mean age of 23yrs and 96.2% of them were highly knowledgeable. All of the study participants (commercial sex workers) were most visited (had frequent sexual practice with) farmers. As shown in this study, 24.5% of the commercial sex workers reported as AIDS can be cured. The multivariate logistic regression analysis shows only place of origin was significantly associated with consistent use of condom.

Conclusion - The high level of information and knowledge about AIDS seem to have little impact than the expected. Therefore, level targeted interventions towards sex workers and their clients can reduce HIV risk and vulnerability as well as reduce the number of new HIV infections among sex workers and the general populations.

Recommendation - The ministry of health and other concerned bodies should have effective HIV & STIs programs based on clear understanding of " who the sex workers are, where the sex is practiced, and who their frequent clients are".

1. INTRODUCTION

1.1 Background

HIV/AIDS is a major crisis that is increasingly affecting the most productive segments of the population across development sectors in sub-Saharan African countries including Ethiopia. Globally, 34.0 million people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions (1).

Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa than in Asia, almost 5 million people are living with HIV in South, South-East and East Asia combined. After sub-Saharan Africa, the region‟s most heavily affected are the Caribbean and Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011 (1).

The incidence of HIV/AIDS has been on the rise since the discovery of HIV as the cause of AIDS in 1984 (2). With the explosive rise in HIV incidence in sub-Saharan Africa since this discovery, the countries in this area with growing numbers of HIV positive people have been targeted in the last decade through aggressive HIV/AIDS prevention and education programs. However, there has been a dramatic growth rather than a reduction in HIV incidence, leading to an epidemic in many African countries (1).

1.2 Statement of the Problem

The UNAIDS global report of 2011showed that, 1.7 million people died from AIDS-related causes worldwide. Countries in sub-Saharan Africa accounted for 70% of all deaths from AIDS in 2011 (1).

The number of countries reporting data on epidemiological trends and service coverage pertaining to sex workers significantly increased from 2006 to 2012, reflecting greater official recognition of the HIV-related needs of this population. Among generalized epidemic countries, HIV prevalence is consistently higher among sex workers in the capital city than among the general population with a median of 23%. Median country-reported HIV prevalence among sex workers in the capital cities has remained stable between 2006 and 2011. Similarly, a recent review of available data from 50 countries, which estimated the global HIV prevalence among female sex workers at 12%, found that female sex workers were 13.5 times more likely to be living with HIV than are other women (3).

Female sex work is the most prominent type of sex work in Ethiopia. Female sex workers operate throughout the country and range in age, and socio-economic status. Sex work is fluid dynamic and changing constantly. The HIV risk behaviours of sex workers will remain relatively constant but vulnerabilities will change. Sex work is a mode of HIV/STI transmission between the individual sex worker, other high-risk groups and the general population.

Targeted interventions towards sex workers can reduce their HIV risk and vulnerability as well as reduce the number of new HIV infections among sex workers and the general population. Women living in rural areas are a fast growing HIV/AIDS risk subgroup in developing countries. (5)

As the rate of infection is increasing in women, not only there are physical effects from becoming more susceptible to opportunistic infections, but also psychological and social effects.

These effects can result in discrimination, stigma, cognitive changes, and an imbalance in social roles (5). As a group, women are thought to have higher risk for acquiring and transmitting HIV than men (6).

Poor women in developing countries, have little power to negotiate for their protection in sexual intercourse and are not able to effectively utilize the current strategies for HIV/AIDS prevention that include: decreasing the number of sex partners, using condoms regularly and receiving treatment of sexually transmitted diseases (STD) (7).

Although, assessing the knowledge, attitudes, and behaviours of these populations is vital to design targeted HIV/AIDS interventions; research on this population with regard to these is scarce in Ethiopia.

1.3 Significance of the study

HIV/AIDS prevalence and incidence is high in commercial sex workers. Apart from acquiring the virus, commercial sex workers serve as a bridge for transmission of HIV to the general population. Although, behaviour is one of the determinant factor in the transmission and prevention of HIV/AIDS research related to this is scarce in Ethiopia. Therefore, it is pivotal to assess the knowledge, attitude and practice of sex workers about HIV/AIDS.

Thus, the findings of this research will serve as an input for policy makers, programme planners and educators to formulate appropriate policies, programmes and interventions capable of preventing the transmission of HIV/AIDS.

In addition, the information obtained from this study will serve as base line information for those who want to conduct further study on the same topic.

2. Literature review

2.1 Prevalence of HIV/AIDS

Globally, in 2011, 34.0 million people are living with HIV. Of this figure, adults aged 15-49 years, accounts 0.8%. Additionally, the prevalence of HIV among adults is highest in Sub-Saharan African countries accounting 4.9% of the total world-wide adult prevalence. Similarly, out of the total world HIV prevalence, Sub-Saharan countries accounts the highest figure (23.5 million), followed by south and south East Asia (4.0 million). There were 2.5 million newly infected individuals in 2011 world-wide according to UNAIDS global report on HIV/AIDS. Of this, 1.8 million were from Sub-Saharan African countries (1).

Even though the prevalence rate of HIV infection has shown a decline since 2001 in some regions of the world, it is still spreading at fast rate in Eastern Europe and central Asia which was 970,000 in 2001 increased to 1.4 million in 2011, and in North America from 1.1 million in 2001 to 1.4 million in 2011 (1).

In Kenya, 1.3 million people between the ages of 15 – 64 are living with HIV, with a national HIV prevalence of 7.1% (8). As the HIV prevalence indicates, Kenya is experiencing a generalized HIV epidemic driven by discordance between sex partners, unprotected sex, multiple and/or concurrent partnerships, low male circumcision (MC) among some cultural groups and low knowledge of HIV status. Although there is a generalized epidemic in the country, different dynamics and drivers exist among certain populations increasing their HIV risk. Populations at higher risk for HIV in Kenya include sex workers (SWs) and their clients, men who have sex with men (MSM), prisoners, and Injecting Drugs Users (IDU). These populations account for one third of new HIV infections in Kenya (9).

Similarly the UNAIDS global report indicates that sexual behaviour among men and women has changed favourably in numerous countries with generalized epidemics. Favourable changes in risky sexual behaviour are evident in many countries, including , Malawi, Mozambique,Namibia,

Nigeria and Zambia. In other countries – such as Côte d'Ivoire, Guyana and Rwanda – increases in sexual risk behaviour are found, highlighting the need to intensify support for behaviour change efforts (1).

According to EDHS 2005, 14% of adults (15-49 years) were reported infected with HIV in 2005 through its prevalence among adult men had been only 0.9%. Further, infection levels are found to be higher in urban areas (5.5% among adults) compared to rural areas (0.7%) (10).

The few available studies on sex workers in Ethiopia suggest that higher rates of HIV infection are associated with increasing age, (probably associated with longer duration in sex work), marital status (high among divorced/widowed), place of work (in those working in bars/hotels), the presence of active syphilis and other STIs, higher numbers of sexual partners, and inconsistent condom use (11).

However reported condom use among sex workers has significantly risen in the past years from only 5.3% in 1989 to 91.6% in 2005, to almost universal condom use during paid sex (99.4%) in 2009 (12).

Studies find that clients of sex workers come from all walks of life, including truckers and intercity bus drivers (22%), merchants and traders (15%), uniformed workers (14%), civil servants, daily laborers and unemployed (12% each). Most clients of sex workers were middle aged, with nearly half between the ages of 30-39 and 14% between 17-24 years. The vast majority (96%) had some education and nearly 70% completed 9th grade (3).

2.2 Knowledge about HIV/AIDS basic facts and source of information

Knowledge and information are the first lines of defense for young people. In Sub- Saharan Africa, only 8% of out of-school youth and slightly more in – school youth have access to prevention education. The equivalent figure for Eastern Europe and Central Asia are 3% of out of school youth and 40% of in-school youth; and for the Caribbean and Latin America, 4% and

38% respectively. One global study showed that 44 out of 107 countries did not include AIDS in their school curricula (13).

According to a study done in South Africa, the major agents of receiving information about HIV/AIDS were in descending order of importance: radio (65.7%), television (50%), poster (42.8%), and health worker (28.6%). More than half of the participants (55.7%) listened to the radio every day and likewise (27.1 %) watched television every day, but (18.6%) said they had not listened to the radio and (30%) said they had not watched television in the last 4 weeks. (26)

As to the study done in Jyotisangh STD clinic 73% of study population(CSWs) do not know about the relationship between HIV & STDs, which shows quite low knowledge level , and majority (86.3%) of CSWs are attending counseling program at Jyotisangh. 97.5% CSWs were aware about condom still 50.5% CSWs were regularly using condom with regular partner while nearly one fourth (26.5%) never used condom (14). Similarly, out of 200 interviewed commercial sex workers only 9%of them knew 3 or more ways of HIV transmission as revealed in the study "strengthening AIDS prevention among commercial sex workers & military forces" in Port Loko, Sierra Leone (15).

As it is revealed in a study done in five districts of Shanghai, the overall correct answer rate of HIV/AIDS-related knowledge was 60.8%, and the knowledge of FSWs from downtown areas was significantly higher than those from suburban areas ($P < 0.05$). The percentage of FSWs who reported having experiences in commercial sexual services without the use of condoms was 33.6%. Condom slippage or breakage was reported as having occurred at least once by 51.2% of the FSWs. FSWs from suburban areas were found to more often engage in high-risk behaviors, including oral and anal sex, than those from downtown areas ($P < 0.001$). Many of the FSWs (65.7%) reported having non-client sexual partners (most were identified as boyfriends or husbands); however, condom usage with these partners were lower (34.3%). More than 50% of the FSWs indicated that they believed HIV-infected individuals should be forcibly isolated (16).

Age-appropriate sexuality education may increase knowledge and contribute to more responsible sexual behavior. However, there are significant gaps in even basic knowledge about HIV and its transmission. In 26 of 31 countries with generalized epidemic in which nationally representative surveys were carried out recently, less than 50% of young women have comprehensive and correct knowledge about HIV. Notably, young women are lacking in knowledge concerning the effectiveness of condoms in preventing HIV transmission. In 21 of 25 countries with nationally representative surveys, young men had less than 50% comprehensive and correct knowledge about HIV (1).

A number of studies on KAP towards HIV/AIDS were done in Ethiopia. According to the behavioural surveillance survey (BSS) in 2002, about 98% of the study population were aware of HIV/AIDS. Almost all groups know at least one prevention method. It is reported that the high levels of knowledge about AIDS had little impact on behavioural change. The study showed that significant proportion of the population were at increased risk of HIV infection despite high level of knowledge (4).

2.3 Practice of prevention methods

Although population-level behavior change has been shown to reduce the prevalence of HIV infection in several countries with generalized epidemics , linking behavior change programming to specific HIV outcomes remains challenging. The consistent association between behavior change and reduced incidence provides plausible support for the impact of behavior change programming in general, but more specific evidence showing which programmatic elements have which effects is urgently needed to help guide wise investment. Disentangling the attribution of effects between specific HIV program elements and more general changes in the enabling environment, such as stigma reduction and universal education, is also difficult (17-18).

According to epidemiological & behavioural surveillance in Baku, 78-86% of interviewed commercial sex workers had never used condom. Among the main reasons they cited for not using a condom was that the client had refused to wear, or they themselves had simply not thought „there is a need" (19).

New evidence in Africa indicates that more women than men are infected with HIV; perhaps 12 or 13 women are infected for every 10 men who are infected (20). Our daily experience and the current epidemiological situation also show the number of deaths due to AIDS is higher for females than males. One possible reason for this difference by gender is that women contract the disease at younger ages and are more likely to become infected during any single exposure. [12]

In Ethiopia, however, reported condom use among sex workers has significantly risen in the past years from only 5.3% in 1989 to 91.6% in 2005, to almost universal condom use during paid sex (99.4%) in 2009 (12).

Condom use with paying clients was almost universal (99.4%) during their most recent client (last seven days) and 86.2% over a 30 days period. However, consistent use of condom with nonpaying partners was only 66%. Compared to the 2005 BSS, there is an increasing trend in condom use with paying partners and a declining trend of consistent condom use with non-paying partners (7).

Another study on sex workers in five big cities of the country showed that 76% maintained only commercial/non-regular sexual partners, while one-quarter had regular cohabitating or non-cohabitating partners. Respondents had an average of 4.2 paying clients in the past week, with those working in red light districts having considerably more partners (a mean of 5.8) compared to those working in hotels or bars (a mean of 2.9 partners). Condom use was very high, with 99% reporting condom use during last sex, and 98% reporting consistent condom use with their five most recent non-regular partners. Consistent condom use was lower with regular partners (61%). At the same time, 9% of respondents reported a suspected or confirmed sexually transmitted infection in the previous 12 months (19).

As to a study done in India, Andhra Pradesh, the logistic regression analysis showed that marital status, migration, typology (brothel or street based sex work), age or educational status had no influence on consistent condom use (CCU). Condom use in last sex was 91 percent and 84.7

percent with occasional and regular clients, respectively, as against only 8.9 percent with nonpaying regular partners. Consistent condom use (CCU) was slightly lesser with regular clients compared to occasional clients and nearly a quarter (28.7%) of the FSWs could not use condom though they desired. A high proportion of FSWs (89%) reported that they had at least one of the three STI symptoms (vaginal discharge, lower abdominal pain or ulcer) at least once during the last year. More than 95 per cent (3061) of the FSWs heard of HIV, but about 99 per cent believed that HIV/AIDS cannot be prevented; 77 percent of the FSWs reported having ever undergone a HIV test among the different districts covered. More than 35 percent felt that they were „at-risk" for HIV infection. (25)

2.4 Commercial sex workers

Sex work is broadly defined as the exchange of money for sexual services. Persons who engage in sex work exchange sex acts for something of value including cash, material items, etc that would otherwise not be extended to them by their sex partners. Sex partners that exchange something of value for sex are referred to as clients of sex workers. Female sex workers are women who exchange anal, vaginal and/or oral sex for money or other items of value primarily with men (21).

In some cities, such as Lagos, Rio de Janeiro and Bombay, the HIV prevalence of female sex workers was found to be more than 20 times higher than among pregnant women (1).
Surveys conducted in various big cities of Ethiopia over the past few years have documented high rates of HIV infection among commercial sex workers. For example, in Nazreth and Bahar Dar HIV infection levels above 65-70% among commercial sex workers were reported. In some other towns such as Mettu, the prevalence rates of HIV infection among commercial sex workers have either doubled or tripled within two or three years (10).
A recent analysis of data from mobile counseling and testing clinics in 40 towns located on the major transportation corridors that link Addis Ababa to Ethiopia"s borders found that 25.3% of the sex workers who received the service were HIV positive. The study also documented that despite high levels of risk perception, high levels of trust on condoms and preference to use

condoms, sex workers sometimes fail to negotiate safer sex. The reported reasons for the lack of consistent condom use among sex workers were violence, financial incentives and preference for unprotected sex with trusted partners (12).

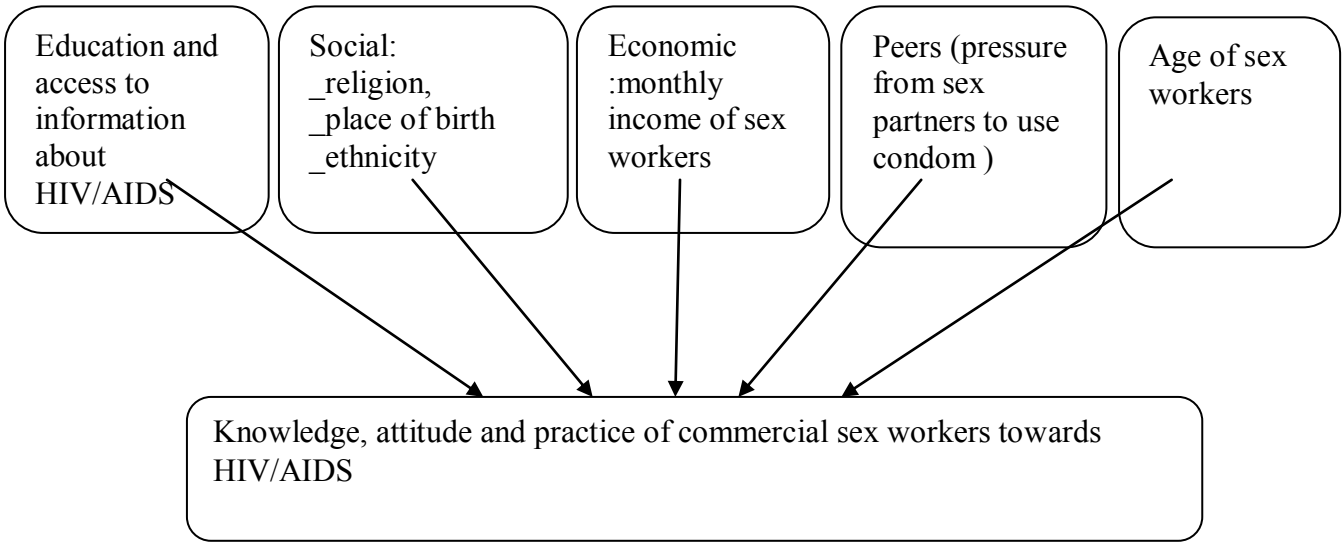
Furthermore, recent behavioral study focusing on venue based sex workers conducted in ten small and major towns of the country documented that sex workers are young, with a mean age of 22 years a range of 14-54 years with a third of them under the age of 20 years. This mean age and percentage of sex workers under the age of 20 have remained relatively constant since 2002. However, the mean age is much lower than that recorded (31.5 years) in Addis Ababa ten years ago. There are concerns that younger women engaging in sex work may be less likely to negotiate safer sex such as condom use with their partner (22).
The same study demonstrated a significant increase in sex workers" mean number of clients per week from three in 2000 to five in 2005. This trend suggests an increased demand for paid sex and may also mean an increase in the number of unprotected sexual acts if condom use is assumed to be equal or decreases. About 88% of sex workers reported having sex with at least one paying partner in the seven days preceding the study. The study also showed that about one-third of sex workers reported having one or more non-paying partners in the 30 days preceding the study, with a mean of 2.5 non-paying partners in a month. When paying and non-paying partners are combined, sex workers have a mean of 20-23 sexual partners per month (22).

In Ethiopia, poor economic conditions and a lack of well-paid jobs or alternative employment opportunities is undermining the local traditional values and family relations. Desperate conditions have forced an increasing number of people to seek any source of income, including commercial sex work. As there is no policy regarding sex work in Ethiopia, surveying the actual number of CSWs is very difficult and any estimate tends to be inaccurate. (13)

Generally, effective HIV/STI programs for sex workers have to be programmed based on a clear understanding of who the sex workers are, where, when and how they do their work, who their clients are, and the factors that affect their use of HIV/STI and other services.

Therefore, the purpose of this study is to identify the level of knowledge, attitude and practice of commercial sex workers so as to make intervention plan appropriate to their levels.

3. Conceptual frame work



This conceptual frame work is adopted from previously done research in Kenya.

4. Objectives

4.1 General objectives

To assess the knowledge, attitude and practice of HIV/AIDS among commercial sex workers in Alamata Woreda, Tigray, Ethiopia 2014.

4.2 Specific objectives

- To assess the knowledge of commercial sex workers about HIV/AIDS transmission and possible risk factors
- To identify their source of information about HIV/AIDS
- To determine the attitude of commercial sex workers towards HIV prevention methods
- To describe HIV prevention practice of commercial sex workers.

5. Methodology

5.1 Study area

The study area is Raya Alamata District which is found 600km away from Addis Ababa and 185km south of Mekelle, the Capital City of the Tigray Region. The District has four urban kebeles and 15 rural tabias. Its population is estimated to be 141,695 based on census 2007 and the rural accounts 70% of the population. It has one district hospital, six health centers and 13 health posts. The data was collected from March, 30 – April, 30/2013/2014 GC.

5.2 Study design

A community based cross-sectional study design was employed to assess the knowledge, attitude and practice towards HIV/AIDS prevention methods among commercial sex workers.

5.3 Source population

The source population was all female commercial sex workers in Alamata Woreda.

5.4 Study population

The study population was all female commercial sex workers who practice sex work in their home. This is because, from my personal experience about the study area, home based commercial sex work is most commonly practiced in the Woreda.

5.5 Inclusion criteria

All female commercial sex workers who practice sex in their home were included in the study.

5.6 Exclusion criteria

Street sex workers and sex workers who work in bars, hotels, restaurants, and motels were excluded.

5.7 Sample size and Sampling technique

Purposive sampling technique was used because there were no any recorded data regarding the number of sex workers and the types of commercial sex practices**.** However, from my personal experience, home based commercial sex work is commonly practiced in Alamata town in kebeles 03 and 04. The sample size was 106 commercial sex workers who practice sex in their home and were available in their home during the data collection period, in the two kebeles of Alamata town.

5.8 Variables

5.8.1 Dependent variable

- ✓ Knowledge of sex workers about possible risk factors and transmission methods of HIV/AIDS
- ✓ Attitude of sex workers towards prevention methods of HIV/AIDS
- ✓ practice of prevention methods of HIV/AIDS by sex workers

5.8.2 Independent variable

The independent variables are age, educational status, place of birth, religion, income level, marital status, and ethnicity.

5.9 Operational definitions

Knowledge; in this context the range of information obtained about HIV/AIDS, risk factors, its mode of transmission and prevention. Their knowledge score was graded as follows;

>85 = very good 70-84= good

60-69= satisfactory <59= poor

Attitude; the way of thinking, feeling or behaving related to HIV/AIDS.

Practice; the consistency of condom use with regard to the prevention of HIV/AIDS. Their level of practice was graded as follows;

Always=excellent Sometimes= very good

Occasionally=good/satisfactory Never=poor

5.9 Data collection Tools and Procedures

Interviewer based structured questionnaire was used to collect the data. The questionnaire has four parts, and is designed to assess the socio-demographic characteristics, knowledge, attitude and practice levels of the study participants. The English version of the questionnaire was adopted from previous researches done on this topic. The English version of the questionnaire was translated in to Amharic language for better understanding by the data collectors and respondents. Consistency was checked by translating the Amharic version back to English by another individual fluent in both languages. Data were collected using face to face interview after receiving verbal consent from the respondents. The time needed to complete the interview was from 25-30 minutes.

5.10 Data collectors

Data collectors were eight diploma nurses who work in Alamata woreda health center and two BSc Nurses who work in Alamata woreda general hospital for supervision activities. Training was given for data collectors and supervisor for about two days on method of extracting the needed information through interviewing the commercial sex workers, how to fill the information on a structured questionnaire and the ethical aspect in approaching the commercial sex workers which was in a polite and respectful manner. The interviewers collected the information based on the given guide line using a structured questionnaire. The supervisors had monitored the data collection process of the interviewers and tried to solve problems by themselves and by informing the principal investigator.

5.11 Data quality control

To ensure the quality of data, only trained diploma nurses were involved. Since the questionnaire was adopted from previous research, it was not necessary to do a pre-test. On the days of data collection, the principal investigator and supervisors have monitored the data collection process by checking completeness of the data. For those problems which had occurred corrections were taken on the data collection site. Data was checked again for its completeness before data entry and the cleaning process was done by running simple frequency after data entry for its consistency. Data which were not consistent was checked referring the hard copy questionnaire. Finally data analysis was started after completion of these activities.

5.12 Data processing and analysis

After data collection, each questionnaire was checked visually for completeness and coding was given at the right margin of the questionnaire followed by almost all variables in the questionnaire. The template scheme for data entry was developed and pre-tested for ranges, skipping patterns and allowed legal values by entering about 15 questionnaires. After this validation the principal investigator sorted the data using EPI INFO version 3.4 and then the data was exported to SPSS version 16.0 statistical software packages for data cleaning and analysis.

Frequencies, percentage, chi -square with p-value were used to describe the study population in relation to relevant variables. The degree of association between independent and dependent variables was assessed using crude odds ratio with 95% confidence interval or with respective to p-value. Consecutively multiple logistic regression analysis was performed to control the potential confounding variables under the study to identify the independent determinant factors.

The knowledge level of the respondents was graded according to the number of correct answers they score from the questions about knowledge related to transmission ways and possible risk factors of HIV/AIDS. The grading was as follows;

>85 = very good	70-84= good
60-69= satisfactory	<59= poor

And their attitude towards the risk factors and prevention methods of HIV/AIDS was classified as agree, disagree and no idea according to their response to attitude questions. However, the practice level of the respondents was only determined by their habit of using condom during sexual intercourse. And the scoring was as follows;

Always = excellent Sometimes= very good

Rarely/occasionally=good/satisfactory Never=poor

5.13 Ethical considerations

Ethical approval was obtained from the department of Nursing and Midwifery, Addis Ababa University. A formal letter was written to Alamata Woreda health department for permission and support. The woreda health department had also written a letter to all concerned bodies. The purpose of the study was clearly explained to concerned bodies. Similarly, all the study participants were informed about the purpose of the study. Their right to refuse and informed verbal consent was obtained prior to the interview. The participants were also told that the information obtained from them will be treated with complete confidentiality and will not cause any harm to them.

5.14 Dissemination of result

The primary objective of this thesis was for partial fulfillment in the requirements to degree of master in adult health nursing; it will be submitted to the Department of Nursing and Midwifery, Addis Ababa University. It will also be submitted to Alamata Woreda health department. Presentations at professional, local, national and international meetings and publication in peer reviewed national or international journals will be attempted.

5: RESULTS

5.1.Socio demographic characteristics of commercial sex workers

A total of 106 female commercial sex workers participated in the study. Of these 69(65.1%) were from the surrounding rural areas. Overall, 49(46.3%) were between 15-24 years old with mean age of 23yrs, 64(60.4%) were between grade 1-8th, 24(22.6%) able to read and and 12(11.3%) illiterate. According to their monthly income 11(10.4%) of them have <150.00 birr, 25(23.6%) between 150-300 birr, and most of them 44(41.5%) have monthly income between 300-700 birr. Additionally 43(40.6%) of them were divorced where as 37(34.9%) and 26(24.5%) of them were single(never married) and widowed respectively. (Table 1)

Table 1: Socio demographic characteristics of commercial sex workers in Alamata wareda, June, 2014 G.C

Variables	Characteristics	Frequency	Percent
Age	15-24	49	46.3
	25-34	34	32
	35-44(+)	23	21.7
	TOTAL	106	100
Educational status	Illiterate	12	11.3
	Read and write	24	22.6
	Grade 1-8th	64	60.4
	Grade 9th -12th	4	3.8
	>12+	2	1.9
	Total	106	100
Ethnicity	Tigre	38	35.8
	Amhara	22	20.8
	Afar	9	8.5
	Agew	37	34.9
	Others	-	-
	Total	106	100
Religion	Orthodox	84	79.3
	Muslim	19	17.9
	Protestant	3	2.8
	Total	106	100
Income level monthly income	<150 Birr	11	10.4
	150-300 Birr	25	23.6
	300-700 Birr	44	41.5
	700-1000 Birr	17	16
	>1000 Birr	9	8.5
Place of origin	Rural	69	65.1
	Urban	37	34.9
	Total	106	100
Previous marital status	Single	37	34.9
	Divorced	43	40.6
	Widowed	26	24.5
	Total	106	100

5.2. Knowledge about HIV/AIDS transmission

According to the findings of this study, all respondents (100%) know that HIV/AIDS can be transmitted by unprotected sex, transfusion of infected blood and blood products, and from mother to fetus. But 12.3% and 2.8% of them respectively believed as HIV/AIDS can be transmitted by kissing, and coughing, sneezing or breathing the same air with persons having the virus. Similarly all of the study participants responded as abortion, other STDs, frequent sex, alcohol/drug abuse, prostitution and sex with sex workers, and having multiple sexual partners are risk factors of HIV/AIDS. However, 5.7% and 13.2% of them respectively said that early sexual activity and anal & oral sex are not risk factors. (Table 2)

Knowledge of the participants about possible risk factors and transmission ways of HIV/AIDS was scored out of 100% based on the number of correct responses to knowledge questions. Of all the participants, 96.2% scored greater than 85%, 1.9% scored between 70-84%, and 1.9% scored less than 69%. (Table 2)

Table 2: Knowledge about HIV/AIDS transmission among commercial sex workers. June, 2014 GC.

Transmission methods and possible risk factors	**No**	**%**
Unprotected sex	106	100
Transfusion of infected blood and blood products	106	100
Mother to fetus	106	100
Kissing	13	12.3
Breathing the same air with persons having AIDS	3	2.8
Insect bits	-	-
Sharing utensils	-	-
Prostitution and sex with sex workers	106	100
Anal and oral sex	92	86.8
Having multiple sex partners	106	100
Alcohol and/or drug abuse	106	100
Early sexual activity	100	94.3
Frequent sex	106	100
Abortion	106	100
Other STDs	106	100
Knowledge score		
Very good	102	96.2
Good	2	1.9
Satisfactory	2	1.9
Poor	-	-
Total	106	100

5.3. Sources of information about HIV/AIDS

As it is shown in table 3, 100% of the study participants got information about HIV/AIDS from television, and health personnel, 90.6% of them reported from radio, 75.5% of them from family and friends, and 80.2% and 88.7% of them from news papers and notice.

Table 3: Sources of information about HIV/AIDS. JUNE, 2014 GC.

Source of information	**Frequency**	**%**
Radio	96	90.6
Family/friends	80	75.5
Television	106	100
Health personnel	106	100
News papers	85	80.2
Notice	94	88.7

5.4. Attitude towards HIV /AIDS

As it is revealed in this study, all of the study respondents believed in the existence of AIDS, AIDS is preventable, AIDS is most serious problem, education is important to prevent AIDS, condom can protect from HIV/AIDS and are afraid of getting AIDS. Furthermore, 64.2% of them agreed to avoid multiple sexual partners.

On the other hand 35.8% of them disagreed to avoid multiple sexual partners since their income depends on their number of sexual partners. In addition, 36.8% of the participants disagreed to discuss HIV/AIDS related issues with their partners. Furthermore, 9.4% of them agreed to have sex without condom if a man offers them a lot of money where as 14.2% of them did not know what to decide / had no idea.

With regard to cure of HIV/AIDS 24.5% of the study participants agreed that HIV/AIDS can be cured and 12.3% of them responded that they had no idea. Of all who believed that HIV/ AIDS can be cured 100% believed that it can be cured by using holy water, and 57.7% said by fasting and praying, and 38.5% believed it can be cured by traditional healers. (table 4)

Table 4: Attitude towards HIV /AIDS among commercial sex workers. June, 2014 GC.

S.N	Attitude Questions	Attitude			
		Agree No(%)	Disagree No(%)	No idea No(%)	Total No(%)
1	Do you believe in the existence of AIDS	106(100)	-	-	106(100)
2	Are afraid of getting AIDS?	106(100)	-	-	106(100)
3	AIDS is preventable?	106(100)	-	-	106(100)
4	Do you think HIV/AIDS is the most serious problem	106(100)	-	-	106(100)
5	Condom can protect from HIV/AIDS	106(100)	-	-	106(100)
6	Do you agree to a void multiple sexual partners?	68(64.2)	38(35.8)	-	106(100)
7	Do you agree to discuss with your sexual partner & friends on issues related to HIV/AIDS	48(45.3)	39(36.8)	19(17.9)	106(100)
8	Are you volunteer to have sex without condom if a man offers you a lot of money	10(9.4)	81(76.4)	15(14.2)	106(100)
9	Patients with HIV AIDS be isolated	2(1.9)	104(98.1)	-	106(100)
10	AIDS can be cured	26(24.5)	67(63.2%)	13(12.3)	106(100)
	HIV can be cured by:				**No%**
	By traditional medicine (healers)				10(38.5)
	Holy water				26(100)
	Fasting & praying				15(57.7)

5.5. Sexual practice

As it is revealed in this study, of all the study participants 45.3% had less than 3 sex clients per week, where as 28.3% and 26.4% had 4-6 and >7 clients per week respectively.

Similarly, all the study participants (100%) had sex most frequently with farmers, 55.7% with drivers, 42.5% with students, and 28.3% of them had with different government employees. Regarding to the purpose of condom use, all of the respondents know its purpose for STD & HIV protection, however, pressure from sex partner to use condom is minimal accounting 55.7%.

Majority of them also know the purpose of condom use for protection against pregnancy, 96.2%. And 80.2% of the participants have been using condom consistently during their sexual practices, where as 17% and 2.8% have been using sometimes and very occasionally respectively.

As to history of STDs, 23.6% of all the respondents had STD over the last one year. Of which vaginal ulcer accounts 16.1%, swelling over the groin accounts 4.7%, and urethral discharge 2.8%. Majority of the respondents, 85.9%, had been tested for HIV even though they were not volunteer to tell their status because of fear of confidentiality break. The study results showed 37.7% of all the participants had history of illicit abortion, however, majority of them, 62.3%, had no history of abortion. (Table 5)

Table 5: Sexual practice of commercial sex workers in Alamata wareda, June, 2014 G.C

Variables	Characteristics	Frequency	Percent
No of clients per week	<3	48	45.3
	4-6	30	28.3
	>7	28	26.4
	Total	106	100
With whom do you frequently practice sex	Drivers	59	55.7
	Gov't employees	30	28.3
	Merchants	29	27.4
	Students	45	42.5
	Soldiers	11	10.4
	Farmers	106	100
Purpose of condom use	For STDs & HIV protection	106	100
	To avoid pregnancy	102	96.2
	Peer pressure	59	55.7
Consistency of condom use	Always	85	80.2
	Sometimes	18	17
	Very occasionally	3	2.8
	Not at all	-	-
	Total	106	100
STDs over the last one year	Urethral discharge	3	2.8
	Swelling over the groin	5	4.7
	Vaginal ulcer	17	16.1
	Total	25	23.6
HIV tested	Yes	91	85.9
	No	15	14.1
	Total	106	100
History of unsafe abortion	Yes	40	37.7
	No	66	62.3
	Total	106	100

5.6. Determinants of condom use

The degree of association between consistent condom use and independent variables was described using bi-variate and multivariate logistic regressions with 95 % confidence interval. On the binary logistic regression analysis; educational status and monthly income level were significantly associated with consistent use of condom. The multivariate logistic regression analysis shown only place of origin was significantly associated with consistent use of condom. In this study, however, age, religion, previous marital status, and ethnicity were not associated with consistent use of condom when the confounding factors controlled. On the other hand, the multivariate logistic regression analysis revealed that the habit (performance) of using condom consistently during sexual intercourses was significantly higher among FSWs who come from the rural areas than those who come from urban areas (Reference Category, RC) [AOR = 2.41, 95% CI: 1.01, 5.80].

Table 6: Association of Socio-Demographic Characteristics of commercial sex workers with their consistency of condom use, in Alamata woreda, June, 2014 GC.

Variables	consistently use condom		COR (95% CI)	AOR(95%CI)
	Yes Freq. (%)	No Freq. (%)		
Education				
None	8(7.5)	4(3.8)	1	
Read & write	22(20.7)	2(1.9)	0.70(0.36, 1.36)	0.98(0.33,2.69)
Primary (1-8)	50(47.2)	14(13.2)	0.36(0.14, 0.91)*	0.66(0.17,2.61)
Secondary(9-12)	4(3.8)	0(0)	0.45(0.32, --)	0.99(0.42, --)
Higher (>=12)	2(1.9)	0(0)	0.52(0.43, --)	0.77(0.92,--)
Age				
15-24	40(37.7%)	9(8.5)	5.95(0.00,--)	2.5(0.00,--)
25-34	28(26.4)	6(5.6)	4.11(0.00, --)	7.32(0.00, --)
35-44(+)	17(16)	6(5.7)	1	
Place of origin				
Rural	54(50.9)	15(14.2)	1.30(0.74, 2.33)	2.41(1.01,5.80)**
Urban	31(29.2)	6(5.7)	1	
Religion				
Orthodox	74(69.9)	10(9.4)	1	
Muslim	10(9.4)	9(8.5)	1.12(0.65, 2.15)	0.55(0.28,1.09)
Protestant	2(1.9)	1(0.9)	2.28(0.91, 5.67)	0.57(0.20,1.59)
Ethnicity				
Tigre	29(27.3)	9(8.5)	1	
Amara	17(16)	5(4.7)	0.64(0.33, 1.24)	0.60(0.25,1.44)
Afar	6(5.7)	2(1.9)	0.42(0.13, 1.39)	0.40(0.10,1.64)
Agew	32(30.2)	5(4.7)	0.62(0.32, 1.22)	0.85(0.34,2.14)
Previous marital status				
Widowed	21(19.8)	5(4.7)	1	
Single	27(25.5)	10(9.4)	0.08(0.03, 0.22)	9.28(0.00, --)
Divorced	37(34.9)	6(5.7)	5.3(0.00, --)	1.45(0.00, --)

Income				
<150	4(3.9)	8(7.6)	1.86(1.11, 3.1)	1.89(0.97,3.68)
151-300	15(14.2)	10(9.4)	0.35(0.15, 0.91)*	0.65(0.18,2.5)
301-700	42(39.6)	2(1.9)	0.48(0.42, --)	0.87(0.33,--)
701-1000	16(15.1)	1(0.9)	0.37(0.17, 0.47)	0.68(0.19,2.63)
>1000	8(7.6)	1(0.9)	1	

Note:

* Statistically significant on bi-variant logistic regression analysis

** Statistically significant on multi-variant logistic regression analysis

6: DISCUSSION

This study aimed to explore the knowledge, attitude and practice of commercial sex workers towards HIV/AIDS among commercial sex workers in Alamata woreda.

Nearly half of female commercial sex workers participated in this study are between the age 15-24 with the mean age of 24. This result is comparable with a behavioral study focusing on venue based sex workers conducted in ten small towns of Ethiopia where the mean age were 22years.(7)

Of all the commercial sex workers, 96.2% of them had knowledge about HIV/AIDS. This finding is comparable with the behavioral surveillance survey where 98% of them were knowledgeable. However, this result is higher than the research done in Jyotisangh STD clinic where only 73% of the study population knows about the relationship between HIV and STD. Similarly it is in contrast with a study done in five districts of Shanghai where the overall correct answer rate of HIV related questions was 60.8%. This difference may be due to the sample size variation and difference in socio-demographic characteristics of study populations. (14)

All (100%), of the study participants in this study get information about HIV/AIDS from television, and health personnel, 90.6% of them reported from radio, 75.5% of them from family and friends, and 80.2% and 88.7% of them from news papers and notice. However, according to a study done in sub-urban areas of South Africa, the major agents of receiving information about HIV/AIDS were in descending order of importance: radio (65.7%), television (50%), poster (42.8%), and health worker (28.6%). The difference may be because the later study is done in sub-urban areas of South Africa where possibly the access for the sources of information may be rare. (26)

As shown in this study, 24.5% of the commercial sex workers reported as AIDS can be cured and 12.3% of them had reported as they had no idea. This shows the attitude of the commercial sex workers towards the traditional ways of curing from HIV/AIDS is positive with 24.5% of them believing by holy water, fasting and praying. Additionally only 1.9% of the FSWs indicated that they believed HIV-infected individuals should be forcibly isolated. However, this finding is in contrast to a study done in China where more than 50% of FSWs agreed on isolation of HIV-infected individuals. This difference may occurred because of variation in societal structures of both study areas in addition to sample size difference.(16)

Almost all of the study participants know all the risk factors for HIV/AIDS. However, 35.5% of them disagreed to avoid multiple sexual partners. Their reason was because their income depends on their number of sexual partners. The more the number of sexual partners the more their income. Similarly, 9.4% of them agreed to have sex without condom if a man offer them a lot of money where as 14.2% of them did not know what to decide (had no idea). The reason for lack of consistent condom use and not avoiding multiple sexual partner are in line with a study done in mobile counseling and testing clinics in 40 towns located on the major transportation corridors that link Addis Ababa to Ethiopia‟s borders.(12)

Furthermore, 23.6% of the study population reported suspected or confirmed sexually transmitted infections in the last one year. This figure is high in contrast to a study done in five big cities of Ethiopia where history of sexually transmitted infections in one year were only 9%. This may be because of difference in sample size and in use of condom and other HIV & STIs prevention methods consistently. (19)

However, this figure is low relative to a study done in India where a high proportion of FSWs (89%) reported that they had at least one of the three STI symptoms (vaginal discharge, lower

abdominal pain or ulcer) at least once during the last year. This variation may occurred because the habit of condom use among the commercial sex workers in the later study is low. (25)

All of the study participants were most visited (had frequent sexual practice with) farmers, 100%, followed by drivers and students, 55.7% and 42.5% respectively. However, this finding is in contrast with the study done on "analysis of the health sector aid architecture in April 2009",where the high risk groups are long truck drivers, uniformed workers and civil servants.
This may be because all the participants of this study (commercial sex workers) sell local drinks such as "tela" and "teji" on market days in addition to sex. And the favorite places of entertainment for the farmers and students on market days are those places.(3)

Relative to a study done in Jyotisangh STD clinic, where the consistent or regular use of condom was 50.5%, the percentage of consistent condom use in this study is high, accounting 80.2%. However, this result is low relative to a study done in five big cities of Ethiopia where consistent use of condom were 99%. This difference may be due to sampling technique and sample size variation.(19)
According to this study, 17% and 2.8% of the participants only used condom sometimes and very occasionally respectively. Among the main reasons they cited were that the clients refused to wear, having sex with condom with regular and non-paying partners doesn't feel comfortable, and they themselves had simply not thought "there is a need".
But this result is not comparable with a study done in five big cities of Ethiopia where consistent condom use was 61% with regular partners. The difference may be because this study is done among those sex workers who practiced sex work in their home while the later one is among

those who practiced sex work in bars, hotels and red light districts. It may also be due to sample size variations (19).

Majority of the respondents in this study, 85.9%, had been tested for HIV which is higher than a study done in India where 77 % of the FSWs reported having ever undergone HIV test among the different districts covered. On the binary logistic regression analysis of this study; educational status and monthly income level were significantly associated with consistent use of condom. But this is not in line to a similar study done in India, Andhra Pradesh, where the logistic regression analysis showed that educational status were not associated with consistent condom use (CCU). This difference may be occurred due to the sample size variation. (25)

7: CONCLUSION

The overall correct answer rate of HIV/AIDS-related knowledge was 96.2%. However, high levels of knowledge seem to have a little impact on use of condom since nearly 20% of the sex workers lack consistent use of condom. Additionally 9.4% reported/ agreed to have sex without condom if a person offer them a lot of money where as 14.2% didn"t know what to decide.

Even though all the sex workers believe as AIDS is preventable and most serious problem, 24.5% of them believe as AIDS can be cured by using holy water, fasting and praying. This shows the attitude of the sex workers towards the traditional beliefs is strong which possibly enhance the negligence in using condom.

The most frequent visitors of sex workers as revealed in this study are farmers, drivers and students which in turn make susceptibility of house wives high. Furthermore, FSWs who come from the rural areas were found to more consistently use condom (2.4x) than those who come from the urban areas; as revealed by multi-variant logistic regression analysis.

Generally the high level of information and knowledge about AIDS seem to have little impact than the expected. Therefore, targeted interventions towards sex workers and their clients can reduce HIV risk and vulnerability as well as reduce the number of new HIV infections among sex workers and the general population.

8 :STRENGTH AND LIMITATIONS OF THE STUDY

Strength;

There was 100% response rate. The data collectors were professional nurses and standardized data collection tools were used for data collection.

Limitations;

Domestic literatures on the study topic were not adequately available. Findings of this study would not be representative of the source population, since the study did not include those commercial sex workers who were working in the streets, hotels and bars. Qualitative study was not incorporated.

9: RECOMMENDATIONS

Based on the study findings from this study, the following recommendations are drawn;

- Health extension workers of the district should incorporate HIV & STIs prevention methods in their teaching package during their home to home visit.
- Health professionals who are in charge in VCT department (in hospitals and health centers of the district) should assess the knowledge, attitude and practice levels of clients about HIV/AIDS during counseling and testing.
- Health center directors should integrate HIV & STIs prevention methods in their health education program
- The woredaʻs health bureau should give special attention to farmers, students, drivers and sex workers related to HIV & STIs to increase the HIV/STIs prevention practices.
- The ministry of health and other concerned bodies should have effective HIV & STIs programs based on clear understanding of "who the sex workers are, where the sex is practiced, and who their frequent clients are".

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Annex I: Information sheet for participants

Currently I, the undersigned at Addis Ababa University College of Health Sciences Department of Nursing Graduate studies Program, am undertaking research on a topic entitled assessment of knowledge, attitude and practice towards HIV/AIDS among commercial sex workers at Alamata, south Tigray, Ethiopia. For this study, you will be selected as a participant and before getting your consent or permission of your participation, you need to know all necessary information related to the study. Thus, this information will be detailed as;

 Objective: To determine the knowledge, attitude and practice level of commercial sex workers towards HIV/AIDS Alamata, south Tigray, Ethiopia.

 Significance of the study: This study will help policy makers in formulating policy to stop the rapid spread of HIV/AIDS. Additionally it can also serve as a base line data for further studies to be done on same topic.

Participants to be included: All commercial sex workers who practice sex in their home are the participants of this study.

 Confidentiality: All information you give will be kept confidential and will not be accessible to any third party. Your name will not be registered on the question sheet so that you will not be identified.

 Risks and Benefits of the study

Risks: The study will be carried out simply by interviewing you, with the already prepared and structured questions. The procedure doesn't bear any physical or psychological trauma. Furthermore, you will not be forced to respond to the information you do not know.

 Benefits: For your participation in the study no payment will be granted or has no any special privilege to you. But, participating in the study and giving your information to questions asked will have great input in efforts to improve utilization of institutional delivery.

 Consent: Your participation in the study will be totally based on your willingness. You have the right not to participate from the beginning, or stop any time after starting participation. You will not be forced to respond to the information you do not know.

 Time: the time to complete this interview may take from 25-30 minutes.

 Name of principal investigator: Abebe Amare

Date: _____ Signature_____

 Address of PI: Mobile: +251932151030 Email:abebeamare2013@gmail.com

Annex-II

Consent Form

Dear my participants

To formulate appropriate health policies and strategies related to HIV/AIDS prevention, the understanding of the major health problems of this group of population is important. Additionally this study is proposed to assess the knowledge, attitude of HIV /AIDS and related issue among commercial sex workers of Alamata woreda. You are chosen to participate in this study using purposive sampling method.

In order to effectively attain the objectives of this study, we are kindly asking you for your generous response to the questions. There is no need to put your name on the questionnaires .No individual response will be reported. It is your full right to participate or refuse in the study. But your honest participation will have a great contribution. So please take a few minute to answer the questions. If there is anything that requires clarification please don‟t hesitate to ask the facilitator for clarification.

So, do you want to participate in the study?

Yes, I want to participate in the study (please go to the next page)

No, I don‟t want to participate. (Stop)

THANK YOU VERY MUCH!!

Annex-III

QUESTIONNAIRE

ADDIS ABABA UNIVERSITY

COLLEGE OF MEDICAL AND HEALTH SCIENCES

DEPARTMENT OF NURSING AND MIDWIFERY

Questionnaire prepared for assessing knowledge attitude and practice towards HIV/AIDS prevention among sex workers in Alamata Woreda.

Part I: socio demographic characteristics

1. Age -------
2. Place of birth A/ Rural------ B/ Urban------
3. Educational level
    A. Illiterate
    B. Read and write
    C. Grade 1-6th
    D. Grade 7-12th
    E. Above 12th
4. Monthly income
    A. <150 birr
    B. 150-300birr
    C. 301-700birr
    D. 701-1000birr
    E. >1000birr
5. Previous marital status
    A. Single
    B. Divorced
    C. Widowed
    D. Other

6. Ethnicity
    A. Tigrae
    B. Amhara
    C. Agew
    D. Afar
    E. Others

7. Religion
    A. Orthodox
    B. Muslim
    C. Protestant
    D. Catholic

Part II: KNOWLEDGE QUESTIONS

1. Do you know about HIV/AIDS?

    A. Yes B. No

2. If yes, from where do you get information about HIV/AIDS?
    A. Radio
    B. Family/friends
    C. Television
    D. Health personnel
    E. Newspapers/book
    F. Notice
    G. others

3. What is/are the mode/s of transmission?

    A. Unprotected sex with anybody
    B. Transfusion of infected blood and blood products
    C. Mother to fetus/child
    D. Kissing
    E. Sharing of utensils
    F. Coughing, sneezing or breathing the same air with person having AIDS
    G. Insect bits
    H. Using toilets in common

4. Which of the risk factors do you know for acquiring HIV?
    A. Unprotected sex with anybody
    B. Prostitution and sex with sex workers
    C. Anal and oral sex
    D. Having multiple sex partners
    E. Alcohol drinking and/or any drug abuse
    F. Early sexual activity
    G. Frequent sex
    H. Abortion
    I. Other STDs
    J. Others
5. Can a person infected with HIV be asymptomatic for many years? A/ Yes B/ No
6. Can people with HIV develop AIDS and die of it? A/ Yes B/ No

7. Can AIDS be cured if diagnosed early? A/ Yes B/ No
8. Is there any vaccine discovered which can prevent people from getting HIV

   A. Yes B. No

9. Can a person infected with HIV transmit the virus to others throughout his/her life

   A. Yes B. No

10. Can you tell a person that he/she has HIV/AIDS only by his/her look?

    A. Yes B. No

11. What prevention methods of HIV/AIDS do you know?
    A. Abstinence
    B. Faithful
    C. Using condom
    D. Complete and careful sterilization of materials contaminated with blood and other body fluids
    E. Others

PART THREE: ATTTUDE QUESTIONS

1. Do you believe in the existence of AIDS? A/Agree B. Disagree C. No idea
2. Are you afraid of getting AIDS? A/ Agree B. Disagree C. No idea
3. Is HIV/AIDS preventable? A. Agree B. Disagree C. No idea
4. Do you believe that HIV/AIDS is the most serious problem?

   A. Agree B. Disagree C. No idea

5. Do you believe that condom can protect from HIV/AIDS?

   A. Agree B. Disagree C. No idea

6. Do you agree to avoid multiple sexual partners?

   A/ Agree B. Disagree C. No idea

7. Do you agree to discuss the issue of HIV/AIDS with your partner and friends?

   A. Agree B. Disagree C. No idea

8. Are you volunteer to have sex without condom if a man offers a lot of money?

A. Agree B. Disagree C. No idea

9. Do you believe that HIV/AIDS patients be isolated?

A. Agree B. Disagree C. No idea

10. Do you believe that AIDS is curable? A. Agree B. Disagree C. No idea
11. If agree, how?

A. Using herbs B. Using holy water

C. By fasting and praying D. Others

PART FOUR: PRACTICE QUESTIONS

1. How many sexual partners do you have per a week? (in number……)
2. With whom do you usually practice sex?
   A. Drivers
   B. Government employees
   C. Merchants
   D. Students
   E. Soldiers
   F. Farmers
   G. Others
3. For what purpose do you use condom?
   A. To prevent STD and HIV/AIDS
   B. To avoid pregnancy
   C. Peer pressure
   D. Others(specify)
4. How consistent do you use condom?

   A. Always B. Sometimes

   C. Very occasionally D. Not at all

5. Have you ever had STD over the past one year? A. Yes B. No
6. If yes, what was the sign of the illness?
   A. Urethral discharge
   B. Urethral ulcer
   C. Swelling on the groin
   D. others
7. Have you ever been tested for HIV? A. Yes B. No
8. Do you have a history of illicit abortion/curettage? A/Yes B. No

Annex-IV

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አዲስ አበባ ዩኒቨርሲቲ
ነርሲንግ ትምህርት ክፍል

ስለ ኤድስ በሽታ እውቀትን አመለካከትን ተግባርን ለመገምገም የተዘጋጀ ጥያቄ

ይህ መጠይቅ የተዘጋጀው በአላማጣ ከተማ,,,,,, ስለ ኤድስ በሽታ ያላቸውን አጠቃላይ እውቀት አመለካከት ልምድና ጥንቃቄ ነመገምገም ነው.በመሆኑም እርስዎ የሚሰጡት ምላሽ በሚስጥር እንደሚያዝ አውቀው ትክክለኛ መረጃ እነዲሰጡን በትህትና እንጠይቃለን፡፡

ክፍል አንድ: አጠቃላ መረጃ/ከቁጥር አንድ በስተቀር ሌሎችን ጥያቄዎች የተሰጡተን አማራጮች ይምረጡልን

1. እድሜ .....
2. የትውልድ ቦታ ሀ/ ገጠር ለ/ ከተማ
3. የትምህርት ደረጃ
   ሀ/ ማንበብና መጻፍ የማይችል ለ/ ማንበብና መጻፍ የሚችል
   ሐ/ ከ 1-8 መ/ ከ 9-12 ሠ/ ከ12ኛ በላይ
4. የጋብቻ ሁኔታ ሀ/ ያላገባች ለ/ የተፋታች ሐ/ የትዳር ጓደኛ የሞተባት
5. ሐይማኖት ሀ/ኦርቶዶክስ ለ/ ሙስሊም ሐ/ፕሮቴስታንት መ/ካቶሊክ ሠ/ሌሎች
6. ብሄረሰብ ሀ/ ትግሬ ለ/ አማራ ሐ/ አፋር መ/ አፋር ሠ/ ሌሎችም
7. የወር ገቢ መጠን/በብር/ ሀ/ ከ150ብር ያነሰ ለ/ ከ150-300 ሐ/ ከ301-700 መ/ ከ701-1000 ሠ/ ከ1000በላይ

ክፍል ሁለት፡ እውቀትን የሚያመላክቱ ጥያቄዎች

1. ኤች አይ ቪ ኤድስ ምን እንደሆነ ያውቃሉ? ሀ/ አውቃለሁ ለ/ አላውቅም
2. መልስዎ አዎ ከሆነ መረጃ ከምን ያገኛሉ?
   ሀ/ ከሬድዮ ለ/ከጋዜጣ ሐ/ ከቤተሰብ ወይም ከጓደኛ መ/ ከቴሌቪዥን
   ሠ/ ከማስታወቂያ ረ/ ከሌሎች
3. የኤች አይ ቪ ኤድስ መተላለፊያ መንገዶች የሆኑትን ይምረጡ ከአንድ በላይ መልስ መምረጥ ይችላሉ
   ሀ/ ልቅ የሆነ የግብረ ስጋ ግንኙነት
   ለ/ በኤች አይ ቪ የተበከለ ደምና የደም ውጤቶች ልገሳ ሲካሄድ
   ሐ/ ከእናት ወደ ጽንስ
   መ/ በመሳሳም
   ሠ/ በኤች አይ ቪ ኤድስ የተያዘ ሰው ሲስል ወይም ሲያስነጥሰው
   ረ/ የወባ ትንኝ ስትነድፈው
   ሰ/ ሽንት ቤት በጋራ በመጠቀም
   ሸ/ ስኒዎችን ብርጭቆዎችን በጋራ ስንጠቀም ቀ/ ሌሎች
4. የትኛዎችን ለኤች አይ ቪ ኤድስ የሚያጋልጡ ነገሮችን ያውቃሉ?

ሀ/ ከማንኛውም ሰው ገር ልቅ የሆነ የግብረ ስጋ ግንኙነት ማድረግ
ለ/ ሴተኛ አዳሪነትና ከሴተኛ አዳሪ ጋር የግብረ ስጋ ግንኙነት መፈጸም
ሐ/ በፊንጢጣና በአፍ የሚደረግ የግብረ ስጋ ግንኙነት
መ/ ብዙ የተቃራኒ ጾታ ጓደኛ ሲኖረን
ሠ/ አልኮል መጠጣት ወይም በሱስ መጠመድ
ረ/ ተደጋጋሚ የሆነ የጾታ ግንኙነት ማድረግ
ሰ/ ውርጃ
ሸ/ በሌሎች የአባላዘር በሽታዎች ቀ/ ሌሎች

5. የኤች አይ ቪ ቫይረስ ያለበት ሰው ምልክቶችን ሳያሳይ ለብዙ ጊዜ ሊኖር እንደሚችል ያውቃሉ?
ሀ/ አዎ ለ/ አላውቅም
6. የኤች አይ ቪ ቫይረስ ያለባቸው ሰዎች በኤድስ በሽታ ይሞታሉ? ሀ/ ይሞታሉ ለ/ አይሞቱም
7. የኤድስ በሽታ አስቀድሞ በትክክል ከታወቀ ይድናል? ሀ/ ይድናል ለ/ አይድንም
8. ለኤድስ በሽታ ክትባት ተገኝቶለታል? ሀ/ አዎ ለ/ አልተገኘለትም
9. አንድ በኤች አይ ቪ ኤድስ የተያዘ ሰው እስከ ሕይወት ፍጻሜው በሽታውን ማስተላለፍ ይችላል?
ሀ/ ይችላል ለ/ አይችልም
10. አንድን ሰው በማየት የኤች አይ ቪ ቫይረስ አለበት ማለት ይቻላል?
ሀ/ ይቻላል ለ/ አይቻልም
11. ምን ምን የኤች አይ ቪ ኤድስ በሽታ መከላከያ መንገዶችን ያውቃሉ?
ሀ/ ኮንዶም ለ/ መጠቀምመታቀብ ሐ/ አንድ ለአንድ መወሰን
መ/ በሌሎች የሰውነታችን ፈሳሾች የተበከሉ ቁሳቁሶችን ሙሉ በሙሉና በጥንቃቄ ማምከን/ነጻ ማድረግ ሠ/ ሌሎች

ክፍል-3 የግንዛቤ ጥያቄዎች

1. የኤድስ በሽታ መኖሩን ያምናሉ? ሀ.አዎ ለ.አላምንም ሐ.ሃሳብ የለምኝም
2. የኤድስ በሽታን ይይዘኛል ብለው ይፈራሉ? ሀ/አዎ ለ/አልፈራም ሐ/ ሃሳብ የለኝም
3. የኤድስ በሽታን መከላከል ይቻላል? ሀ/አዎ ለ/አልፈራም ሐ/ ሃሳብ የለኝም
4. የኤደስ በሽታን በጣም አሰቃቂ ነው ብለው ያምናሉ? ሀ/አዎ ለ/አላምንም ሐ/ ሃሳብ የለኝም
5. ከብዙ ሰዎች ፆታዊ ግኑኝነት ማድረግ እንዲወገድ ይስማማሉ? ሀ እሰስማማለሁ ለ/አልስማማም ሐ/ሃሳብ የለኝም
6. ኮንደም ከ ኤች አይ ቪ ኤድስ ለመከላከል ጠቃሚ ነው ብለዉ ያምናሉ? ሀ/ አምናለሁ ለ/ አላምንም ሐ/ሃሳብ የለኝም
7. በኤድስ በሽታ ላይ ከጓደኛዎ ጋር መወያየትን ይፈልጋሉ? ሀ/አዎ ለ/አልፈልግም ሐ/ ሃሳብ የለኝም
8. አንድ ሰው ብዙ ገንዘብ ቢሰጡዎትና ያለኮንደም ግንኙነት እንፈጽም ቢሉዎት ፈቃደኛ ይሆናሉ? ሀ/ አዎ ለ/ አልሆንም ሐ/ ሃሳብ የለኝምሐ/ ሃሳብ የለኝም
9. ኤድስ በሽተኞች መገለል አለባቸው? ሀ/ እሰስማማለሁ ለ/አልስማማም ሐ/ሃሳብ የለኝም

10. የኤድስ በሽታ ይድናል ብለዉ ያምናሉ? ሀ/ አዎ ለ/ አይድንም ሐ/ሃሳብ የለኝም
11. መልስዎ አዎ ከሆነ በምን ይድናል? ሀ. በባህላዊ መድሃኒት ለ. በጠበል ሐ. በጾም እና በጸሎት መ. ሌሎች

ክፍል አራት -የተግባር ልምምድ ጥያቄ

1. ምንያህል ጓደኛ አለዎት? በቁጥር (……..)
2, በአብዛኛ ጊዜ ዕታዊ ግንኙነት የሚያደርጉት ከየትኞቹ ጋር ነው? ሀ/ ሹፌሮች ለ/ መንግስት ሰራተኞች ሐ/ ነጋዴዎች
መ/ ተማሪዎች ሠ/ ገበሬዎች
3. ኮንደምን ለምን ተግባር ነው የሚጠቀሙት?
ሀ/ ለአባላዘር ናለኤድሰው በሽታን ለ መከላከል ለ/ እርግዝናን ለመከላከል ሐ/ ግንኙነት ለመጠቀም ስናስብ አንጠቀም ስለሚሉኝ መ/ ሌላ ካለ ይጥቀሱ----------
4. የኮንደም አጠቃቀም ልምድዎት እንዴት ነው? ሀ/ ሁልግዜ ለ/ አልፎአልፎ ሐ / በጣም አልፎአልፎ
5. የአባላዘር በሽታ ይዞዎት ያውቃል? ሀ/ አዎ ለ/ አያውቅም
6. ለጥያቄ 5 መልስዎ አዎ ከሆነ ምን አየይነት ነበር? ሀ/ከብልት የሚፈስ ፈሳሽ ለ/ ከብልት አካባቢ መቁሰል ሐ/ ከንፈራት አካባበ ማበጥ መ/ ሌሎች--------
7. የ ኤችአቪ ምርመራ አድርገው ያውቃሉ? ሀ/ አዎ ለ/ አላውቅም
8.ከዚህ በፊት በህክምና ያልተፈቀደ ውረጃ አካሄደው ያውቃሉ? ሀ/ አዎ ለ/ አላውቅም ሐ/ ሃሳብ የለኝም