Running Head:MENTAL HEALTH PROBLEMS AND COPING MECHANISMS OF SEX WORKERS

Prevalance and Risk Factors of Mental Health Problems, Substance Abuse and Coping Mechanisms of Street Based Female Sex Workers in Addis Ababa, Ethiopia

By : Fasil Getachew

Advisor : Asmamaw Beyene (Ph.D)

ADDIS ABABA UNIVERSITY

DEPARTMENT OF SOCIAL WORK

POST GRADUATE PROGRAM IN SOCIAL WORK

June, 2018

Addis Ababa, Ethiopia

Prevalance and Risk Factors of Mental Health Problems, Substance Abuse and Coping Mechanisms of Street Based Female Sex Workers in Addis Ababa, Ethiopia

By: Fasil Getachew

A Thesis Submitted to the Department of Social Work, Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Art in Social Work

Approval Committee

I here by declare that this thesis is from the candidate student's own work and effort, and all that all sources used within the study have been appropriately acknowledged.

Prevalance and Risk Factors of Mental Health Problems, Substance Abuse and Coping Mechanisms of Street Based Female Sex Workers in Addis Ababa, Ethiopia

BY: Fasil Getachew

Approved by the Board of Examiners:

ADVISOR:	**SIGNATURE**	**DATE**
_____	_____	_____
EXAMINER		
_____	_____	_____
EXAMINER		
_____	_____	_____

Dedication

I would like to dedicate this paper to all Ethiopian female sex workers who became physically as well as psychologically impaired due to violent acts made against them.

Acknowledgments

First and foremost my utmost gratitude goes to the Almighty and Omnipresent God, who is my source of life, inspiration and strength.

I want to thank my advisor, Dr. Asmamaw Beyene, who shaped the title of my thesis and made critical remarks beginning from the early inception of this research all through the drafts of the thesis. The successful completion of this thesis would be difficult, if not impossible, had it not been for the unwavering assistance and intellectual guidance of my magnanimous advisor.

I want to express my respect to all female sex workers participated in this study for their sincere cooperation and willingness to answer the questions forwarded from the researcher patiently and with due respect.

In addition, I would like to express my profound appreciation to my friend; Atinkut Zewdu who always not only encouraged and motivated me throughout my study but also shared the burden of my responsibilities during the last three years. We had both thorny times and memorable episodes that couldn't forget easily. Without his assistance, I would not have come this far.

My special thanks and heartfelt gratitude to Mr. Gebrie G/hiwot who always inspired me and financial support to achieve my objective. Furthermore, I would like to thank my father Mr. Getachew Terefe, my mother, Mrs. Temerta Hailu My brothers and sister for their encouragement to conduct this research.

I am also grateful to all my colleagues for his wholehearted encouragement and intellectual supports while writing my thesis. I want to thank my classmates with whom I was sharing this time in Addis Ababa University. And I thank for all of those who were supporting me.

Table of Contents

page

Chapter Three

Methods of the Study

Chapter Four

Results of the Study

Chapter Five

Discussion

Chapter six

Summary, Conclusion and Recommendation

List of tables ***Page***

Acronyms and Abbreviations

APA	American psychologist Association
CSE	Committal sexual exploitation
DSM IV - TR	Diagnostic statistical manual of Mental Disorders Fourth edition Text Revision
FGD	Focus Group Discussion
FHI	Family Health International
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GO	Government Organization
HAPCO	HIV/AIDS Prevention and Control Office
MHI	Mental Health Inventory
NGO	Non-Governmental Organization
PTSD	Post Traumatic Stress Disorder
PTSDC	Post Traumatic Stress Disorder checklist
SSI	Simple Screening Instrument
SSI-AOD	Simple Screening Instrument for Alcohol and Other Drug Abuse
SSI-SA	Simple Screening Instrument for Substance Abuse
STD	Sexual Transmitted Disease
WHO	World Health Organization
UN	United Nation

Abstract

The purpose of the present study is to assess prevalance and risk facors of mental health problems, substance abuse and coping mechanisms among Addis Ababa Street based female sex workers. Mixed method explanatory research design was employed on 378 randomly selected street based sex workers in ten nominated hotspot areas in Addis Ababa. Mental Health Inventory (MHI)-38, simple screening instrument for substance abuse (SSI-SA) and Brief Coping-28 were employed for assessment. FGD and interviews were also utilized. Descriptive statistics, independent t-test, Pearson correlation and ANOVA were utilized to analyze the quantitative collected data.

As a result, the general lifetime prevalence of psychological distress and substance abuse disorder among street based sex workers was 35.4% and 75.1% respectively. Among the dimensions of mental health index, depression, anxiety and loss of behavioral/emotional state was observed respectively. Even higher prevalence of psychological distress and substance abuse disorder was found among divorced, illiterates, lower income, rural born, adolescence and sex workers who had a forensic history. As the cause to join the sex work, peer pressure, to improve personal and family life situation, poverty and poor life situation of the families, to search for better life and better paying job, to failure to succeed in educational endeavors, unemployment, to get initial capital to start a business, success of others, failed marriage and other reasons were highly reported major multifaceted determinant factors for joining street based commercial sex worker.

As contributing factors for psychological distress, forced self-degrading type of sex by clients, forced sex at knifepoint, physical assault, robbery, forced sex with multiple individuals at the same time. Sometimes clients refuse to pay for the service they received, insulting, some take them to an unknown place and torture them for more than 3 days while doing anything they want to them, and some injure them while they drunk were highly reported risk factors for developing psychosocial problem among street based sex workers. In this study, place of birth, forensic history, childhood history of sexual abuse, age, educational status, average monthly income and parent's living arrangement had a statistically significant effect on mental health index of street based sex workers.

Finally, the most frequently used adaptive coping mechanism by the sex workers were acceptance and religion respectively. Instrumental support, emotional support, planning, positive reframing, active coping and homer were also repeatedly reported adaptive coping mechanisms by sex workers in their due order. Concurrently, the most frequently used maladaptive coping mechanism by the sex workers were self-blame and substance use. Along with this, venting, Self-distraction, denial, behavioral disengagement were highly reported maladaptive coping mechanism by street based sex workers respectively. In conclusion, the life time prevalence rate of psychological distress and substance abuse disorder were very high. Therefore, mental health service providers shall consider in diagnosing and treating psychosocial problems of street based sex worker.

Key Word: Psychological distress, Psychological Wellbeing, substance abuse, sex work

CHAPTER ONE
INTRODUCTION

1.1 Background

In the last 20 years, the term sex worker has gained precedence over the term prostitute because people involved in the "profession" view it as less stigmatizing and as more descriptive of their work and life experience (Basu& Dutta cited in Margaret, Pam & Emma 2011). Sex work can be defined as a business transaction understood as such by the parties involved and in the nature of a short-term contract in which one or more people pay an agreed price to one or more other people for helping them attain sexual gratification by various methods (Perkins & Bennett cited in Margaret, Pam, & Emma, 2011).

According to Vanwesenbeeck (cited in Roxburgh, Degenhardt& Copeland, 2006), there is a long history of women engaging in the sex industry, both in developed and developing countries, and a large body of literature exists on the risks these women face in the course of their work.

Betsy (2010) also reported that women involved in sex work face a unique set of life circumstances that both influence their decision to enter the industry and affect them throughout their work. These individuals have higher rates of childhood physical and sexual abuse, as well as neglect and other forms of maltreatment. As sex workers, these individuals exist within a violent culture that is also rife with physical and sexual trauma. Because of the increased rates of violence that these women face, they are at a greater risk for posttraumatic stress disorder, dissociative disorders, substance abuse, and depression.

A study on Sydney street sex workers by Amanda, Louisa, Briony, & Jan (2005) revealed that from a total of 72 samples approximately half reported severe current depressive symptoms. In female sex worker populations, substance use could reasonably be considered the norm rather than deviant behavior (Jung, et al, cited in Betsy, 2010). Not only do these individuals have a high likelihood of having a traumatic history, they also are constantly in risky situations. For example, sex workers often do not know whether their next customer will be safe or violent. Drugs and alcohol not only serve as tools by which individuals can avoid or block out painful memories of traumatic pasts, but they also help these individuals numb their fear so that they can perform their services effectively (Kramer, cited in Betsy, 2010).

Local literatures done in this particular population reported that, commercial sex workers have been known in Ethiopia since ancient times, although there are no data as to when and where commercial sex first appeared in the country. Some sources associate the beginnings of commercial sex with the movement of kings, nobles and warlords, the establishment of cities and the development of trading (Andargachew, 2002).

Commercial sex work is not a legally recognized ‘‘profession’’ in Ethiopia. However, most of the establishments where the sex workers are based (hotels, bars/restaurants, nightclubs etc.) operate legally with working licenses (Family Health International (FHI)-Ethiopia, 2002).A study conducted in the city’s major sex trade centers of Mercato, Piazza, Arat Kilo, Kasanchis, Cherkos, Meshualekia and Kolfe involved a sample of 100 sex workers has revealed that the majority, 73% of the women started commercial sex as teenagers. Even though the women cited various factors that contributed to beginning to engage to commercial sex, the major factor that forced 63% of them was economic hardship (Betelehem, 2007).

Baardon’s (cited in Kevin, 2000) survey of 77 juvenile prostitutes in Addis Ababa found the mean age for starting prostitution was 14.7 years. Nineteen and a half per cent of the total sample were 12 years or younger when they entered prostitution. Extreme poverty was the major motivating factor for initiation into prostitution.

With regard to victimization, only 13% of Baardson’s sample reported that they had not been raped, sexually abused, or physically assaulted by customers. The most common reasons given for being assaulted was that the girls refused to engage in “deviant practices” specifically anal or oral sex. This abhorrence of any form of sexual contact other than peno-vaginal is also true of adult prostitutes in Addis Ababa. In a 1989 survey of 2,663 randomly selected female sex-workers, 98.1% reported practicing peno-vaginal sex only, 1.7% however occasionally practiced peno-rectal sex and 0.2% peno-oral sex (Mehret et al., cited in kevin, 2000).

Although very limited study has been done on the prevalence of mental health disorders among street sex workers in Ethiopia, there is a long history of women engaging in the sex industry, both in developed and developing countries, and a large body of literature exists on the risks these women face in the course of their work which results in psychosocial problems (Vanwesenbeeck cited in Amanda, Louisa, Briony, & Jan, 2005).

Many sex workers do not disclose their occupation to family and friends, which in turn leave them socially isolated. These factors in turn predispose them to psychopathology. Specific mental health disorders that are prevalent in the sex-worker population are anxiety disorders, post-traumatic stress disorder, mood disorders and substance abuse. Sex workers may also feel the need to use drugs or alcohol to feel confident in approaching clients in public or having sex with strangers. In South Africa, even the use of non-injecting drugs is likely to increase the risk of becoming HIV positive. These drugs have been shown to make people, including sex workers, less cautious and less aware of where they are. This means they are more likely to have risky sex (e.g. sex without a condom). However, it should be noted that the risks associated with binge drinking of alcohol are far greater than for illegal drug use in South Africa; due to the way it affects people and the fact that it is very common.

Sex work and drug use are both highly stigmatised activities in our society. When a person is linked with those activities, their social status is reduced, leading others to think they are less worthy of respect and good treatment, or even that they 'deserve' violence and abuse. Coping strategies is the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. An additional distinction that is often made in the coping literature is between active and avoidant coping strategies.

Coping mechanisms are used to manage an external situation that is creating problems for an individual. Coping styles can be problem-focused also called instrumental or emotion-focused. Problem-focused coping strategies are typically associated with methods of dealing with the problem in order to reduce stress, while emotion-focused mechanisms can help people handle any feelings of distress that result from the problem. Further, coping mechanisms can be broadly categorized as active or avoidant. Active coping mechanisms usually involve an awareness of the stressor and conscious attempts to reduce stress. Avoidant coping mechanisms, on the other hand, are characterized by ignoring or otherwise avoiding the problem.

Some coping methods, though they work for a time, are not effective for a long-term period. These ineffective coping mechanisms, which can often be counterproductive or have unintended negative consequences, are known as maladaptive coping. Adaptive coping mechanisms are those generally considered to be healthy and effective ways of managing stressful situations.

1.2 Statement of the problem

Female sex workers are frequently marginalized from society due to the lack social or moral approval for sex work. In addition to experiencing physical and sexual violence from their intimate partners, they can also experience violence from others in their personal and working lives, including clients, pimps, madams and the police (Tara, Parinita, Ramesh, Vandana, John, Shajy, … Stephen, 2010).

Many researches revealed commercial sex workers are exposed to numerous adverse conditions such as poor living conditions/housing, social stigma and sexually transmitted infections, including HIV. Literature on the rates of past and current violence in the lives of sex workers indicates that these individuals are exposed to intense and frequent traumatic incidents during their working lives. Types of violent encounters reported in the literature in the past include, but are not limited to, being raped, stabbed, forced to engage in degrading sexual acts, threatened with a weapon, kidnapped, stalked, verbally abused, tied up, tortured, beaten with objects, and run over by motor vehicles (Nixon et al, 2002).

In Ethiopia, sexual violence stands as one of the top public health problem. Though there is lack of country representative study in the general population in terms of magnitude and type of mental health problem among sex workers, small scale studies indicate that it is on the increase. For instance, out of 214 allegedly abused children under the age of 15 reported to one government hospital (Yekatit Hospital) during a period of one year, 74% suffered from sexual abuse.

In a study by Warr and Pyett (1999) of condom use in female indoor and street sex workers' personal romantic relationships in Victoria, Australia, researchers found that almost all 24 women did not use condoms in their private relationships in order to maintain a distinction between sex with clients and sex with private partners. All of the women reported tensions associated with working in the sex industry and having a private sexual relationship including issues of jealousy, resentment, disapproval and disrespect from partners due to the nature of their work. A recent study by Bilardi et al. (2011) based in Melbourne, Australia, examined female sex workers' job satisfaction but also briefly noted that women working in the sex industry reported problems in their personal relationships which stemmed from their work. Most participants reported that sex work interfered with their romantic relationships adversely due to issues of jealousy, guilt and safe sex practices. Seventy-five percent of

women stated that the job made it too difficult to sustain a relationship and 80% reported that sex work interfered with romantic relationships.

Previous studies that have touched on sex workers personal relationships as part of the broader study have also found sex work negatively affects personal relationships. In a study by Sanders (2005), which examined sex work from the perspective of risk management in England, it was found that negative emotions generated by the commodification of women's bodies through sex work affected their social identities and relationships, with women struggling to separate sex at work with sex for pleasure. In a further study by Rossler et al. (2010), examining the mental health of women in the sex industry in Switzerland, women stated relationships commonly failed because their partners could not separate out sex at work with sex at home even though the women themselves could.

To cope with these issues, sex workers commonly adopt behaviours to separate their work and personal lives (Sanders, 2005). Work/family border theory proposed by Clark (2000) argues that work and family influence each other.Work and home lives differ in terms of purpose as well as culture and have specific patterns of attitudes and behaviour for each. Some level of integration is necessary to balance the two spheres of an individual's life, but the degree to which this occurs varies between people. According to work/family border theory, borders are lines of segregation between domains, defining where a person's behaviours begin and end. A physical border defines where these take place, temporal borders define when the behaviours take place and psychological borders are defined by the individual, dictating when behaviours, thinking patterns and emotions are appropriate for each. The more flexible a border is, the more an individual can think about work while at home and home while at work.

In other case, it may be because of their avoidance behavior of substances like drugs, alcohol, 'chat' and cigarette which help them to develop self confidence. But other cases, specifically case No.1 is under a serious emotional problem. She induced electric shock to herself due to her instability.

According to the study findings, due to such related problems, all of sexually abused children, who participated in this study, have adopted different strategies to cope with the experience of abuse and its related problems. Supporting this Kelly (2001) identified, survivors are confronted with over whelming pains and experiences after abuse. In order to cope with extreme and intense emotions the detail, of what happened, and who hurt them they may try to convince themselves. This finding also goes in line with work of Munro (2000).

Coping skills were also in evidence, however, including spiritual sources of coping, maintenance of friendships with other Ethiopian women, and reassertion of one's cultural identity. Spiritual sources of coping were found to be an important coping mechanism among East African sex workers in Australia (Clark, 2000)

.

Sex work in Addis Ababa is usually linked to establishments such as restaurants, bars, hotels, nightclubs, and on selected streets waiting for clients. The rationale for examining street based sex workers in the current study is also empirically based, with previous studies suggesting that they are a more marginalized group, being more vulnerable to adverse violence, subject to physical assault, rape, kidnapping, and being threatened with a weapon and other objects. In addition, there are many reports related to crimes against sex workers at police stations and hospitals. Literature shows that sex workers are at high risk for developing violence related PTSD and other psychiatric disorders including depression and substance abuse (Betsy, 2010). Most of the studies done on sex work population were focused on HIV and condom use. Some other researches on commercial sex workers, conducted years back, have also attempted to explain the prevalence of mental health problems and substance abuse among sex worker. However, there is no recent literature on the subject and the scant literature available does not offer much in terms of explaining the relation between mental health problems, substance abuse and coping mechanisms. Therefore, the purpose of this study is to highlight the challenges of street based sex work life, including the risky work experience, and to look into the current state of affairs relating to the prevalence of memtal health problems and substance abuse among commercial sex workers and to establish a correlation between the mental health problem, substance abuse and coping mechanisms.

1.3 Research Questions

- What are the causes of street based female sex workers to join into sex work?
- What are the determinant factors that amplify the level of mental health problems of street based sex workers?
- What is the status of mental health conditions among Addis Ababa street based sex workers?
- What is the prevalence rate of substance abuse among street based sex workers?

- How do mental health conditions correlate with different background variables, specifically childhood history of sexual abuse, age, educational status and length of time having stayed in street-based sex work?
- Is there any relationship between substance use and mental health condition?
- What kinds of coping mechanism are commonly used by street based sex workers?

1.4 Objectives

1.4.1 General objective

The general objective of this study is to assess prevalance and risk facors of mental health problems, Substance abuse and coping mechanisms among Addis Ababa Street based female sex workers.

1.4.2 Specific objective

- To eplore the causes of street based female sex workers to join into sex work.
- To explain the determinant factors that amplify the level of mental health problems of street based sex workers.
- To assess the status of mental health conditions among Addis Ababa street based sex workers.
- To assess the prevalence rate of substance abuse among street based sex workers.
- To explain the relations between mental health conditions and different background variables, specifically childhood history of sexual abuse, age, educational status and length of time having stayed in street-based sex work.
- To analyze the relationship between substance use and mental health condition.
- To explain coping mechanism are commonly used by street based sex workers.

1.5 Significance of the study

The study seeks be significant for female sex workers, researchers, policy makers, governmental and non-governmental organizations and for the community as a whole in the following ways:

- The final report will be an important set of resources for mental health related policies, strategies and evidence based interventions regarding violence at sex work life, childhood sexual abuse, and its consequence for mental health problems.
- Agencies who are working directly with street based sex workers can benefit from the final recommendations.
- The final report will provide an important set of resources for any agency working to create awareness in the community about street sex workers' lives.
- It seeks to show the working environment of street based sex workers and the day-to-day traumatic experiences encountered, central and primary insights for any concerned body to take action.
- It facilitates organizations like the Ministry of Health and other government and civic institutions to work together in addressing the problem of sex workers as are an integral part of this society.
- In the long term, this group of stakeholders may all benefit from the results and findings of the research by incorporating them in to their project plans.
- It serve as the stepping-stone for further research

1.6 Delimitation of the study

This study gave emphasizes in assessing mental health problems among female street based sex workers in Addis Ababa. The population from which the sample drawn were female Street based sex workers in Addis Ababa in 2017/18.The study population were selected on 10 hot spot areas in each sub-cities of Addis Ababa which is identified by Federal HIV/AIDS Prevention and Control Office, Town-level HAPCO offices and Health Bureaus in 2014/15 where street-based sex workers worked regularly.

1.7 Operational Definition of terms

Street-based sex worker: Women who sell sex directly on the streets. They actively seek clients and are picked up on the street. They tend to work in the evenings from selected streets. They are not based at their residences.

Mental health Mental health refers to the capacity of individuals and groups to interact with one another in ways that promote subjective wellbeing, optimal development and the use of mental abilities (cognitive, affective and relational), and the achievement of individual and collective goals consistent with the law.

Mental health problems A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.

Wellbeing: The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition.

Mental illness: - disturbance of mood or thought that can affect behavior and distress the person or those around them, so the person has trouble functioning normally. They include anxiety disorder, depression and schizophrenia (National mental health commission, 2012). For the purpose of this study, mental illness incorporates all pathologies that are prevalent in West Shewa Mental health hospitals and clinics.

Substance Abuse: is the total score received on the Simple Screening Instrument for Substance Abuse. Over indulgence of alcohol and various other addictive drugs, including nicotine,

Coping Mechanism; Coping mechanisms are the strategies people often use in the face of stress and/or trauma to help manage difficult and/or painful emotions. Coping mechanisms can help people adjust to stressful events while maintaining their emotional well-being.

CHAPTER TWO

LITERATURE REVIEW

2.1 The Concept of Prostitution

Prostitution is variously described in the literature as sex work, violence against "women" or "slavery". The root meaning of "prostitute" implies a transaction. It follows that a prostitute performs some kind of sexual activity in exchanging for money. Prostitution cannot exist without customer who objectively and humanize themselves, the prostitution and human sexuality Work is any sexual performance carried out by a person for payment of certain amount of money or in exchange of goods and service. Child commercial sex worker is the use the child in sexual activities for remuneration or any other form of consideration (Flores, 2002).

Children who engaged in commercial sex work by many reasons such as, running away from home, child abuse and neglect, psychological and emotional difficulties, family -related risk factors, child -specific risk factors, socioeconomic related risk factors, environmental -related risk factors, poverty, personal life style and illiteracy. And children who engaged commercial sex works has it's awn consequence such as physical like victimization on the streets: beating, rape and murder, crime like delinquency and contact with the juvenile- justice system, health concern like HIV infection and other sexually transmitted disease and psychological disorders including depression and risks of suicide and substance abuse (As cited in Pollet, 2010)).

The children involve in commercial sex work experience negative effect. Sex work has been identified as the core group for remission of HIV/ AIDS and STD; thus, that face discrimination throughout the world (as cited in Zurita, 2012).

Child prostitution is growing in both urban and real area of Ethiopia in the capital city Addis Ababa the number of children victimized in committal sexual exploitation (CSE) is increased at an alarming rate. Numerous children migrate from rural areas in order to scope poverty. There are different types of child commercial sex work such as working on the street or alcohol houses working, in rented house/beds and working in rent places for chat & drugs (Huynh et.al., 1993)

2.1.1 FAMILY BREAKDOWN AND 'CUT OFF CARE

The consequences of family breakdown have been documented by studies which consider the links between institutionalised care services, vulnerability and chronic exclusion, in relation to sex work and wider social exclusion (Berelowitz et al., 2012). For example, Jeal and Salisbury (2004) in their study looking at on-street sex workers in Bristol, found that one third of the women they interviewed had been a 'looked-after' child and/or young person as a result of family breakdown. Additionally, nearly two-thirds of women reported they had experienced physical, sexual or emotional abuse during childhood, whilst a third had left school by 14; those in care left earlier. Other research has found that leaving care, prison, hospital, education and mental healthcare systems can lead to or exacerbate social exclusion (Tonybee hall, 2007; Fitzpatrick, Bramley and Johnsen, 2012).

Furthermore, neglect by either the family and/or the care system can lead to, or exacerbate, the vulnerability of some young people (Stein et al., 2009). An example of this type of neglect has been highlighted by the recent high-profile case in England of nine men in Oxford facing trial for various crimes relating to sexual violence and exploitation.1 In this case, British girls who were trafficked and prostituted by groups of men, tended to be young, vulnerable, in care or from chaotic households. They were coerced into sex work due to their vulnerable situations.

'Cut off care', the abrupt reduction or removal of institutional care systems and safety nets, can leave people vulnerable to exploitation from controllers and may result in engagement in sex work through necessity or habit. In many cases, those who have been discharged (cut off) from a particular care system may experience a lack of money, housing, employment, social capital and appropriate networks of support, which can drive people into greater social exclusion and may lead to engagement in sex work as a survival technique and/or as a way out (McNaughton and Sanders, 2007).

2.1.2 TYPES OF SEX WORK AND LEVELS OF EXCLUSION

The literature revealed several different types of sex work which are caused by, and can result in, varying states of vulnerability. Social exclusion is the leading cause of entrance into sex work and

exclusion is often deepened as a result of engaging in sex work. The severity of the exclusion tends to differ depending on the sex workers situation. Those who are most excluded are those who have been sex trafficked and enslaved in sex work. At the other end of the spectrum, there are those who become involved in sex work through non-coercive means making a particular lifestyle choice, such as the student sex workers described above (Scambler, 2007). The differences between the types of sex work and the severity of vulnerability will be examined below.

2.1.3 Theoretical Explanation for Prostitution

One possible explanation for these desires can be explained by the routine activities theory. This theory states a crime's likelihood is dictated by three elements: motivated (likely) offenders, available suitable targets, and lack of capable guardians (Cohen & Felson, 1979). This study focuses on the often over-looked motivated offender aspect of the routine activities theory and how it relates to the motivations of consumers as opposed to those of the prostituted woman. Up until now, many studies have not looked at motivated offenders simply because of the prevalence of crime. That is to say, why bother measuring motivation when it is obvious motivation exists in the presence of crime being committed.

If, as reported above, there are enough men being arrested for soliciting prostitution that there needs to be education programs for them, then it stands to reason that there are plenty of motivated offenders purchasing sex. Because of this, studying the attitudes consumers have towards prostitution is a vital step in understanding the motivation surrounding the purchasing of sex from prostituted women. Prior research has shown that men continue to purchase sex even when they know that it is an illegal activity (Kennedy et al., 2004).

In terms of available suitable targets, prostitution is an unusual criminal activity in that the targets, prostituted women, make themselves openly available despite the illegality of the act. There is a difference between being available and consenting to victimization however. Many prostituted women are forced to sell themselves by pimps or to feed a drug addiction; rarely is a woman prostituted of her own free will (Young et al., 2000).

Lacking of a capable guardian is the final necessary aspect, and it as much of an oddity as the availability of suitable targets. Much of the time a prostitute has a guardian, a pimp, but that guardian, by virtue of their title, is not capable of anything other than forcing women and children into selling themselves. In addition, prostituted women have no other guardians to help protect them. The community and law enforcement knowingly allow prostitution to continue while arresting the prostitutes at the same time and calling them criminals (Farley et al., 2007; Farley & Kelly, 2000).

This allows the criminal underground to use and abuse women as they wish with no recourse for the women victimized. This paradox creates a situation that helps to explain why prostitution runs rampant; two of the three necessary conditions are basically present by default, thus only leaving a motivated, sexually aroused, man to solicit a prostitute to complete the requisite elements (Monto & McRee, 2005).

While Johns are motivated anywhere prostitution exists, this study hypothesized that there are some ecological factors that increase the odds of offenders having higher motivation levels than others due to proximity to legal prostitution, and the hypersexuality of a city. This provides a distinct difference between cities like Reno and Las Vegas when compared to other cities in North America. It is possible that this increased desire for sex, related to the hypersexuality of a city, leads to an offender (John) that is more motivated due to the environment than a John in another city that has less sexual overtones.

2.1.4 POOR PHYSICAL AND MENTAL HEALTH

Sex workers suffer from a wide range of health and wellbeing issues. In the Bindel et al. study, 79 per cent of the women complained of physical and/or mental health problems, whilst it is possible that others may suffer from physical and/or mental health problems that have yet to be diagnosed or reported. Sex workers represent a high-risk group where communicable yet preventable diseases, including TB, HIV, other Blood borne Viruses and STIs, are common (Collinson, Straub and Perry, 2011). Furthermore, research into the mental health of sex workers in Switzerland found sex workers often suffered from mental health problems, including depression, anxiety and Post-Traumatic Stress Disorder (Rossler et al., 2010); which can also negatively impact on physical health.

Additionally, within the Bindel et al (2012) study, many claimed they were unable to envisage a life outside of sex work, particularly those who had begun selling sex before the age of. The combination of an inability to conceive of a life outside of sex work and other destructive behaviours, such as drug abuse, poses a particular challenge to hopes of stabilisation. Likewise, poor physical and mental health would make maintaining more formal forms of employment very difficult or in some cases, due to the severity of the problem, impossible.

2.1.5 SEXUALLY TRANSMITTED INFECTIONS

Due to the nature of the work, sexually transmitted infections are another inevitable risk which a number of outreach programmes aim to combat (Jeal, Salisbury and Turner, 2008). Whilst it is widely acknowledged that many sex workers still engage in risky behaviour, such as having sex without a condom, research suggests condom use amongst sex workers has increased over the last 30 years and incidents of HIV have decreased over the same period (Scambler and Paoli, 2008).

2.1.6 VIOLENCE

Physical, sexual and verbal violence are common experiences for many sex workers. The large majority of studies looked at in this report indicate that violence is a prominent feature in the lives of sex workers in almost all sex work settings. Some, such as Spice (2007), argue that physical violence is the single greatest threat facing sex workers. A study by Harding (2005), which examined the experiences of female sex workers in Nottingham, found that all of the women interviewed had experienced some form of violence, whether physical, emotional or sexual.

More recent studies also reveal high levels of violence. A study by Bindel et al. (2012), found that two-thirds of the sex workers they interviewed experienced violence, whilst another study by Sanders-McDonagh and Neville (2012) claims that many sex workers have experienced increasing levels of violence and complained of harassment by police. Reporting of violent crime is low among sex workers (for more detail, see below).

The consequences of physical violence can often lead to poor physical health, as well as poor mental health due to trauma (Rossler et al., 2004). At its most extreme, violence against sex workers leads to death. An example of this is the high profile case of Steve Wright who murdered five sex workers in the area of Ipswich around 2006. In addition, a study by Ward and Day (2006) which examined the

lives of 130 sex workers over a 15 year period discovered that two of their cohort had been murdered over the 15 year period.

Furthermore, the recording of violence against sex workers is problematic. As is discussed below, relationships between the police and sex workers is often poor and lacks trust and understanding on both sides. Additionally, whilst it is possible that victims of violence may visit A&E and other health services to receive treatment for injuries, it is unlikely that these incidents will be recorded in such a way that would identify the patient as a sex worker. There is no procedure amongst hospital staff for identifying sex workers and in most cases, sex workers would be reluctant to reveal their occupation to health staff for fear of stigmatisation (UKNSWP, 2009).

The legalization of prostitution is a matter of constant discussion as the implications are both moral and economic. Common rationale for legalization of prostitution includes health and safety issues as was the case in New Zealand in 2003 when prostitution was legalized (Farley, 2004). Unfortunately legalized prostitution at best only comprises about 10% of total prostitution conducted, leaving many young women and children in danger (Farley, Stewart, & Smith, 2007).

2.1.7 Risks Specific to Prostituted Women

Risk of Substance Abuse

The use of alcohol and other drugs is higher among prostituted women than the general population (Burnette, Schneider, Timko, & Ilgen, 2009). Sixty percent of prostituted women have sought out treatment for crack usage, 30% for cocaine, and nearly 20% for heroin with 40% of prostituted women admitting to intravenous drug use (Burnette et al., 2008).

Risk of Physical Harm

As with the rates of higher substance use, predictably so are the rates of sexual assault (Young, Boyd, & Hubbell, 2000). Research has found that 82% prostituted women have been the victim of a physical assault and 68% have been raped (Farley & Barkan, 1998). The risk of contracting sexually transmitted diseases is also a serious risk.

Risk of Psychological Harm

The risks to prostituted women are not contained to just physical harm, psychological harm is a serious risk as well. Farley and Barkan (1998) found that 68% of prostituted women met the criteria for post-traumatic stress disorder (PTSD). Burnette et al. (2008) found over 60% of prostituted women had depression, nearly 30% suffered from anxiety, and over 40% had attempted suicide at some point in their life with 14% recently attempting suicide.

2.1.8 Sex Work and Violence

There is a long history of women engaging in the sex industry, both in developed and developing countries, and a large body of literature exists on the risks these women face in the course of their work (Vanwesenbeeck cited in Amanda, Louisa, Briony, & Jan, 2005).

Women involved in sex work face a unique set of life circumstances that both influence their decision to enter the industry and affect them throughout their profession. These individuals have higher rates of childhood physical and sexual abuse, as well as neglect and other forms of maltreatment. As sex workers, these individuals exist within a violent culture that is also rife with physical and sexual trauma. Because of the increased rates of violence that these women face, they are at a greater risk for posttraumatic stress disorder, dissociative disorders, substance abuse, and depression (Betsy, 2010).

A study in Sydney by Amanda, Louisa, & Jan (2006) reported that all but one of the participants (99% of the sample) reported having experienced at least one traumatic event in their lifetime, with a large proportion (93%) reporting multiple traumas. More than half (53%) of the sample reported experiencing 6 or more traumatic events. Three quarters (75%) of the sample reported experiencing some form of sexual abuse before the age of 16 years, and the mean age of first occurrence was 7 years (range 1 to 15 years).

Approximately one quarter (26%) of the sample reported that the first incident occurred before the age of 6 years. Approximately half (51%) of the sample reported that someone had vaginal sex with them before they were 16 years. The majority of the sample (81%) reported having been raped while working or in their personal lives (44% of the sample reported being raped outside of work) and physically assaulted (81%), while 71% had witnessed someone being badly injured or killed. Among those exposed to trauma, the largest proportions reported rape (19%) and being threatened with a

weapon or being held captive (19%) as the most stressful of the traumatic events they had experienced.

2.2 Violence, Mental Health, and Sex Work

Though sex slave trafficking flourishes in modern Ethiopia most women who prostitute themselves in that country do so voluntarily in that they get into the business due to economic needs rather than physical coercion by others Evans et al., 1997). Given the large number of women involved, the welfare of sex workers constitutes a significant public health issue. By its very nature, sex work carries severe occupational risks, hazards that many authors have conceptualized as traumatic. The psychological impact of both entering the sex trade and the sex work itself, which often includes violence, drugs, deception, and forced captivity, among other risks, is presumed highly injurious with potentially lifelong consequences.

Studies have long demonstrated that mental health problems and treatment needs among sex workers and rates of mental disorders of prostitutes are higher than those of the general population. In addition, the mental health squeals of prostitution have been documented empirically in culturally diverse samples. These studies have reported a higher prevalence of distress, loneliness, isolation, and fear among street sex workers in Hong Kong (Ling et al., 2001); posttraumatic stress disorder (PTSD), and drug abuse in Sydney, Australia (Roxburgh, Degenhardt, & Copeland, 2006); drug and alcohol abuse in Mexico City (Gutierrez & Vega, 2003); depression and anxiety among street-based workers in Miami (Surratt, Steven, Weaver, &Inciardi, 2005); and PTSD and depression among trafficked women in Eastern Europe (Chudakov, Ilan, Belmaker, &Cwikel, 2002).

Only one study on the mental health of sex workers in India was found in a literature search. Kumar (1961) demonstrated that sex workers in India presented various psychological problems such as depression, amotivation, guilt, loneliness, and a host of psychosomatic symptoms. In contrast, only one study, which examined a sample from New Zealand, has found little difference between the psychological well-being of sex workers and non-sex worker controls (Romans, Potter, Martin, &Herbison, 2001).

The stress-inducing circumstances, for example, sexual and physical abuse, substance abuse, and poverty, which often give rise to women's entry into sex work and the hazards of the occupation, are typically cited as the general precipitating factors associated with the mental degradation that result from such stress (Gutierrez & Vega, 2003; Savin-Williams, 1994; Young, Boyd, &Hubbell, 2000). Although the literature has been very thorough in associating the social environment of prostitution to psychological well-being, few studies have attempted to determine specific variables that link the broad social context to psychological outcomes.

Surratt et al.,(2005) concluded that depression among sex workers is related to sexual and physical abuse associated with entry into sex work and the knowledge of the health risks, particularly STDs, involved in prostitution. Dominelli (1986) suggested that depression among sex workers results from stigmatization and due to negative social labels of sex work as *immoral* and *deviant*. According to this view, internalizing such stigma undermines women's sense of empowerment and leads to feelings of submissiveness and further self-degrading behavior.

2.2.1 Violence and Mental Health

The World Health Organization (2000) considered violence against women the leading cause of gender-related depression among women. Numerous studies among non-sex-worker women have linked violence, most notably intimate partner violence, to depression (Alsaker, Moen, &Kristoffersen, 2008; Helfrich, Fujiura, &Rutkowski- Kmitta, 2008; Ludermir, Schraiber, D'Oliveira, Franca, & Jansen, 2008). No study has been conducted to determine the empirical connections between workplace violence and depression among sex workers. Exposure to violence is among the more severe stressors confronting sex workers, and previous research estimates that half to more than 75% of sex workers report having been victimized by work-related violent acts (Church, Henderson, Barnard, & Hart, 2001). Rates of violence vary depending on the venue of the work: street-based workers, the subjects of the present study, face particularly high risks of violence due to the locations where they provide services and the nature of interaction with clients (Kurtz, Surratt, Inciardi, & Kelly, 2004). For example, getting into a car with a client and having sex have been associated with violent victimization among street workers (Roxburgh et al., 2006).

Violence is commonly experienced by sex workers in India and is an ever-present component in the web of stressors incumbent to their work. Violence has been associated with psychological problems such as PTSD, especially among trafficked women, at levels similar to soldiers in combat (Chudakov et al., 2002; Farley et al., 1998; Kaysen, Resick, & Wise, 2003; Ling, Wong, Holroyd, & Gray, 2007; Mayfield-Schwarz, 2007). In India, actual violence or the anticipation of violence is a daily occurrence among street-based sex workers. Clients are rarely trusted not to Rob, beat, burn, or rape the women who provide them sexual services. The risk of being harmed or even killed looms as a constant threat to a group that is offered little protection from family, friends, or the police who, in fact, are frequent perpetrators of violence against sex workers. Furthermore, female victims have virtually no recourse against their attackers; the stigma against sex workers is such that crimes against them are typically not taken seriously by police and the courts. Consequently, there are no reliable statistics on this form of gendered violence. There is general agreement, however, that the problem is widespread and constitute a core feature of the social fabric of street-based sex work (Jayasree, 2004; Samuels, Ravi, & George, 2006; Sinha, 2002).

2.3 Substance abuse and sex work

One of the prevalent psychiatric conditions among sex workers is substance abuse. A study by Amanda, Louisa, Briony, & Jan (2005) reported approximately half the sample reported injecting drugs prior to commencing sex work, and one-quarter reported commencing sex work within 3 years of injecting drug use initiation. Just over one-quarter of the sample reported starting sex work prior to injecting drug use, and approximately three-quarters reported that their drug use had increased since they started sex work.

In female sex working populations, drug use could reasonably be considered the norm rather than deviant behavior (Jung, Song, Chong, Seo, & Chae, 2007). Not only do these individuals have a high likelihood of having a traumatic history, they also are constantly in risky situations. For example, sex workers often do not know whether their next customer will be safe or violent. Drugs and alcohol not only serve as tools by which individuals can avoid or block out painful memories of traumatic pasts, but they also help these individuals numb their fear so that they can perform their services effectively (Kramer cited in Betsy, 2010). In addition, substance use in this career does not pose as severe a

threat as it may in other less stigmatized professions, as drug and alcohol use are often expected in sex workers.

Kramer (cited in Betsy, 2010) examined the motives for using substances in a group of 119 sex workers who were either incarcerated or working in an escort agency. In this study, 59% of the individuals sampled reported using drugs while engaging in prostitution and 28% reported using alcohol. In terms of motives, 70% of the respondents reported drug use to facilitate emotional detachment from the experience and 44% of the respondents said that they used substances to cope with the fear associated with engaging in sex work. Furthermore, 54% of subjects stated that they were unable to engage in sexual acts with a client unless they were high. These results not only indicate that drug and alcohol use helps sex workers perform their jobs, but they also indicate that many of these women are dependent on such substances.

2.3.1 **Formal Definitions of Substance Abuse**

Drug use pertains simply to the use of a drug. A drug may be injected (e.g., heroin and speed), smoked (e.g., crack cocaine, marijuana, speed, heroin, and cigarettes), sniffed (e.g., inhalants and cocaine), huffed (inhalants), swallowed (e.g., pills), or sometimes absorbed through the skin (e.g., the nicotine patch). Drug misuse means not using a drug in the manner in which it was intended (as appropriate, as instructed, or as prescribed). Drug abuse may be defined as the accumulation of negative consequences resulting from drug misuse (American Psychiatric Association [APA]; Newcomb & Bentler; Sussman, Dent, & Galaif, cited in Sussman & Ames, 2008).

A formal definition of substance abuse disorder is provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA, 2000). Drug abuse is a maladaptive pattern of drug use leading to clinically significant impairment or distress, as manifested by one or more of four symptoms or criteria in a 12-month period.

- Recurrent drug use may result in a failure to fulfill major role obligations at work, school, or home. Repeated absences, tardiness, poor performance, suspensions, or neglect of duties in major life domains suggests that use has crossed over into abuse.

- Recurrent drug use in situations in which it is physically hazardous is a sign of abuse. Operating machinery, driving a car, swimming, or walking in a dangerous area while under the influence indicates drug abuse.
- Recurrent drug-related legal problems, such as arrests for disorderly conduct or for driving under the influence, are indicative of abuse.
- Recurrent use despite having persistent or recurrent social or interpersonal problems, caused or exacerbated by the effects of the drug, is indicative of abuse. For example, getting into arguments or fights with others, passing out at others' houses, or acting inappropriately in front of others is indicative of abuse.

In summary, drug use that leads to decrements in performance of major life roles, dangerous action, legal problems, or social problems indicates substance abuse disorder.

There are seven other criteria that, if met, constitute substance dependence. A diagnosis of substance dependence, a more severe disorder, would subsume a diagnosis of substance abuse. The criteria for substance dependence provided by the DSM-IV-TR (APA, 2000) include a maladaptive pattern of drug use leading to clinically significant impairment of distress, as manifested by three or more of the following seven symptoms occurring in the same 12-month period:

- Tolerance is experienced. There is either a need for markedly increased amounts of the drug to achieve the desired drug effect or a markedly diminished effect with continued use of the same amount of the drug.
- Withdrawal is experienced. Either a characteristic withdrawal syndrome occurs when one terminates using the drug or the same or a similar drug is taken to relieve or avoid the syndrome.
- The drug often is taken in larger amounts or over a longer period than intended. For example, an alcohol-dependent man may intend to drink only two drinks on a given evening but may end up having fifteen drinks. Alternatively, he may decide to "party" over the weekend, however, the party lasts for 2 weeks, until he runs out of money.
- There is a persistent desire or unsuccessful effort to cut down or control drug use. For example, an alcohol-dependent man may decide to become a controlled drinker. He may intend to drink only two drinks every evening, however he ends up having fifteen drinks on some evenings, two drinks on some evenings, and twenty drinks on other evenings.

- A great deal of time is spent on activities necessary to obtain the drug, use the drug, or recover from its effects. For example, a person may travel long distances or search all day to "score" a drug, may use the drug throughout the night, and then may miss work the next day to recover and rest. In this scenario, two days were spent for one "high."
- Important social, occupational, or recreational activities are given up or reduced because of drug use. For example, the drug abuser may be very high, passed out, or hung over much of the time and thus may not visit family and friends like he or she did before becoming a drug abuser.
- Drug use continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or worsened by the drug. For example, someone who becomes very paranoid after continued methamphetamine use and is hospitalized but continues to use it after release from the hospital exhibits this last symptom.

2.4 Coping and resilience

Although still scarce, studies concentrating on sex workers' coping strategies and resilience are increasing. Qualitative and participatory studies reveal how stigma and the emotional challenges of sex work are dealt with by sex workers (e.g. Garofalo and Macioti, 2016). Among such strategies deployed by sex workers are: selective outing (disclosing to certain people in certain circumstances); identity management; peer support; pursuing increased autonomy at work; finding economic alternatives; self-care. Qualitative studies on expressions of resilience among FSW, found that protective factors such as education, social support and access to health care increase resilience which was in turn linked to better mental health. Conversely, higher levels of mental ill-health, homelessness, drug use, experience of victimisation were found to be negatively related to resilience (Buttram et al, 2014). Such studies point at the importance of valuing and building on sex workers' agency and resources for effectively supports the improvement of their mental health. They also show how coping skills and resilience depend on structural and situational factors (such as access to education and social support). Therefore, while recognising agency, they do not place the responsibility for healing and care solely on the individual sex worker.

2.4.1 Coping mechanism

The concept of coping mechanisms and/or strategies is closely related to the idea of survival, and threat. It is a key concept of emergency management. This is a working definition. Ask if participants agree with the statement or if they have other ones. Ask for examples from the participants.

2.4.2 Coping Mechanisms and Mental Health

The use of effective coping skills can often help improve mental and emotional well-being. People who are able to adjust to stressful or traumatic situations (and the lasting impact these incidents may have) through productive coping mechanisms may be less likely to experience anxiety, depression, and other mental health concerns as a result of painful or challenging events.

People who find themselves defaulting to maladaptive coping mechanisms and/or experience difficulty utilizing effective coping strategies may eventually see a negative impact on mental and emotional well-being. Consuming alcohol can often help people feel less stressed in the immediate moment, for example, but if a person comes to rely on alcohol, or any other substance, in the face of challenging situations, they may eventually become dependent on the substance over time.

A therapist or other mental health professional can often help people develop and improve their coping skills. Therapists can provide support and information about coping skills, and therapy sessions can be a safe, nonjudgmental environment for people to explore the coping methods they rely on and determine how they help or hinder stress management.

2.4.3 Vulnerability and Capacity to Cope

Illustrate and discuss. Vulnerability and Capacity to cope are the two facets of the same coin. The more one is vulnerable, the less one has the capacity to cope, and the more one tends to adopt coping mechanisms. Vulnerability and capacity to cope recognise three sets of causes: infra-structural, i.e. age, sex, environment, demographic structure of the community, etc., structural, e.g. individual socioeconomic status, services available to the community, etc., and super-structural, e.g. literacy/illiteracy, culture, beliefs, attitude of fatalism, etc.

2.5 Conceptual framework

Various types of pushing and pulling factors lead to female sex workers for street based sex work but due to different types of abuse and exploitation, street based female sex workers develop various kinds of mental disorders and practice substance abuses which enventually require resort to coping mechanisms. The following framework shows the link among multidimensional factors leading to commercial sex work and then mental health disorder and substance abuse as a result of which female sex workers commonly use some coping strategies.

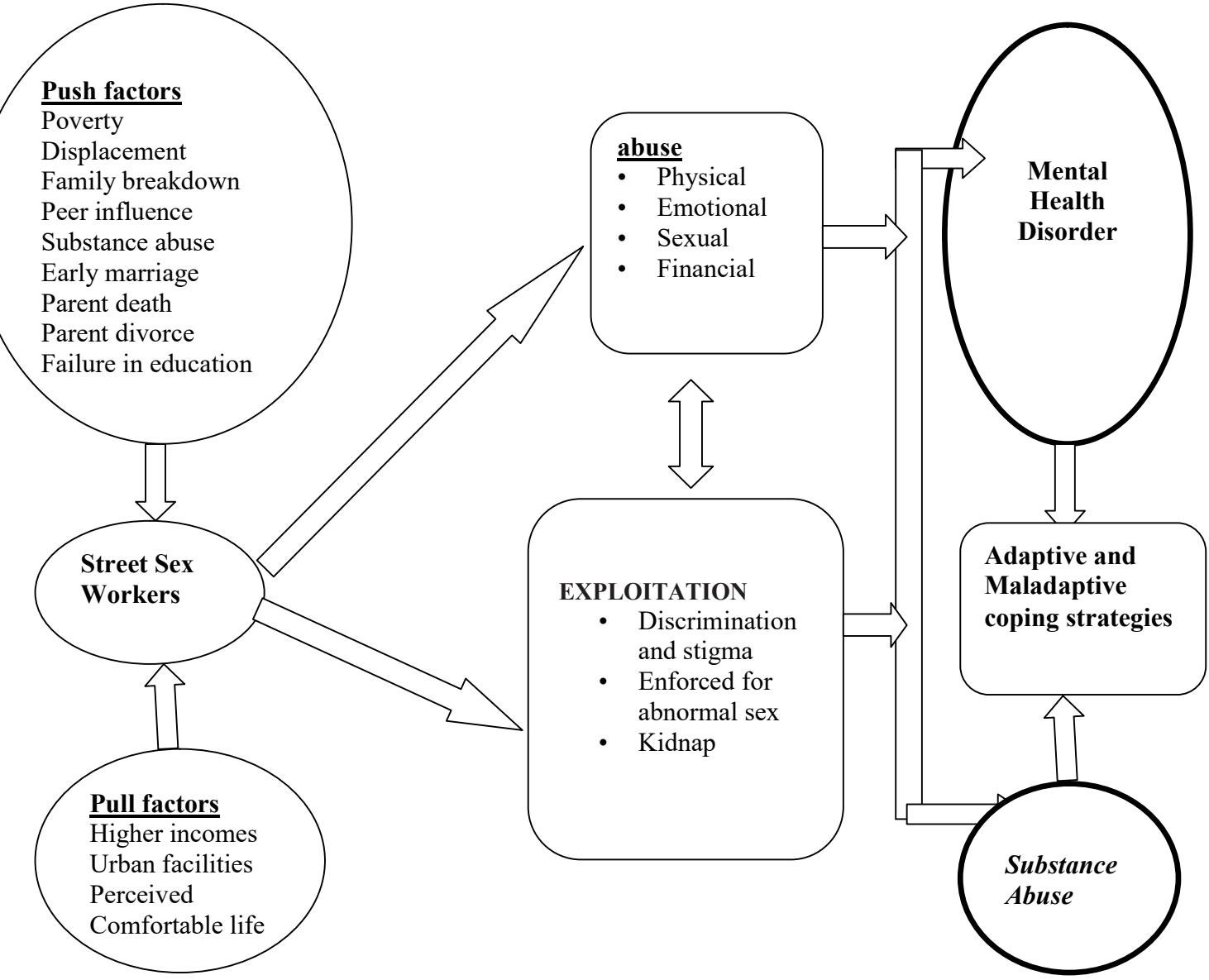

Figure 1: conceptual framework

CHAPTER THREE
METHODS OF THE STUDY

3.1 Study Design

This study employed a mixed method explanatory design consisting of quantitative and qualitative approaches in which priority was given to quantitative approach and the qualitative data were used to illustrate or further explain the quantitative findings. While the quantitative method was used to generate quantifiable data, the qualitative method of analysis was used to analyze the data obtained through interviewing key informants, recording special cases, and through direct observation of the lifestyle of the sex workers.

3.2 Study Area

This study was conducted on street based sex workers in 10 sub city of Addis Ababa. Addis Ababa is selected because the problem is more severe there and because sex work is practiced openly and due to many reasons such as modernization, the easily adaptability of the western culture, and relatively less stigma and discrimination connected with sex work than the case in the rest of the regional cities of the country.

3.3 Study Population

Population in this study was female street based sex workers in Addis Ababa. Participants were chosen based on one major inclusion/exclusion criteria: being female street-based sex worker. The reason for targeting this population was literature showing that street sex workers are at a higher risk for violence than indoors sex workers. Only females were chosen not because there are no male sex workers in Addis Ababa, but because male sex workers in the current study area are very few in number compared to female sex workers.

3.3.1 Inclusion Criteria

- ✓ Being female street-based sex worker in selected hot spot areas
- ✓ Any person whose age is beyond 13 years old.
- ✓ Permanent residents in Addis Ababa
- ✓ A person who is willing to give consent for participation.

3.3.2 Exclusion criteria

- ✓ Indoor sex workers
- ✓ All people with serious cognitive disorder and inability to communicate clearly.
- ✓ if the researcher considered participants to be too distressed or unwell to take part

3.4 Sampling and Sample Size Determination

In 2014, a study undertaken by Federal HIV/AIDS Prevention and Control Office, Town-level HAPCO offices and Health Bureaus reported that there were 10 hot spot areas in addis ababa sub-cities where street-based sex workers worked regularly. This report revealed that the average total number of street-based sex workers observed at the hot spot areas at 10 sub-cities of Addis Ababa were 1721.

According to Krejcie and Morgan (1970) work, if a population is around 1000 to 2000, approximately 20 % of the population should make up the sample. Therefore, in the current study the total population are around 1721 and 20% of them were approximately 344. However, considering the year gap and current living condition of the people an additional 34 participants were added for contingency. Thus, samples in this study were comprised of 378 participants used for this research, which is expected to be representative of the whole population.

Using the above sample size, the following samples were taken from each group based on proportional allocation formula:

$$nh = \frac{Nh}{N} n$$

Proportional allocation formula

N_h= population size in each stratum

h=Number of stratum

N= population size = 378

n=total sample size (N1 + N2 + N3 … + N10) = 378

Table 1: proportionate sample size across study sites

No	Study sites	Total study Population	Sample	Percent
1	Addis Ketema sub-city	923	203	53.63
2	Arada Sub-City	204	45	11.85
3	KirkosSub-City	256	56	14.88
4	Kolfe keranioSub-City	5	1	0.29
5	Akaki Sub-City	160	35	9.3
6	Bole Sub-City	48	11	2.79
7	Gulele Sub-City	5	1	0.29
8	Lideta Sub-City	50	11	2.9
9	Yeka Sub-City	18	4	1.05
10	Nifas silk Sub-City	52	11	3.02
Total		1721	378	100

Regarding to sampling techniques, because of the uneven distribution of street sex workers in Addis Ababa as shown in the table above and the need to have proportional representation, proportionate stratified sampling was employed to determine the number of participants from each sub-city. Simple random sampling was used to recruit respondents from each study sites. Besides, 5 core government stakeholders in different level, 20 street based sex workers, and 15 health service providers were also selected by using available sampling technique for key informant interview and FGD purpose.

3.5 Participants of the Study

Three hundred seventy eight participants were selected by using simple random sampling techniques. The research participants were identified as a sample frame from a list of work place. After selecting participants in different strata, samples were selected by using simple random sampling techniques.

3.6 Variables

3.6.1 Dependent variables:

Dependent variables were mental health and substance abuse of participants

3.6.2 Independent Variables:

The primary independent variable for this study is length of stay on sex work, age, marital status, educational status, social support, substance use and history of childhood sexual abuse of steet based sex workers.

3.7. Data Collection Instruments

Structured and semi-structured questionnaires & field observation were used as instruments for the assessment. Pre-established instruments that rate Mental Health condition of participants were used as instruments to gather the required data from samples. Before collecting the whole data, instruments were translated into Amharic. Then a pilot test was done using 80 street sex workers. Data collectors also play a key role by bringing some unique data from their observations that help define challenges and general situations related to the topic. In addition, special cases were documented to support the findings. Moreover, self-developed questions were used for to gather data from respondents through key informant interview and FGD.

3.7.1 Mental Health Inventory - 38 (MHI – 38)

Mental Health Inventory - 38 (MHI – 38) General Information The Mental Health Inventory - 38 (MHI – 38) is a consumer self-report tool designed to measure general psychological distress and well-being in the RAND Health Insurance Experiment (Veil & Ware, 1983), a study designed to estimate the effects of different health care financing arrangements on the demand for services as well as on the health status of the patients in the study. The RAND research group developed the MHI along side another measure (SF-36) used widely in population general health surveys. A number of questions were taken directly from the MHI to make up the mental health subscale of the SF-36. These five items have also been used as a free-standing scale in their own right, known as the MHI-5. Reflecting its roots in measurement in the general population, the measure includes positive aspects of well-being (such as cheerfulness, interest in and enjoyment of life) as well as negative aspects of mental health (e.g. anxiety and depression). The MHI can be completed either as a self-report measure or as part of an interview

3.7.2 Simple Screening Instrument for Substance Abuse (SSI-SA)

The Simple Screening Instrument for Substance Abuse (SSI-SA) was developed by the consensus panel of TIP 11, Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and

Infectious Diseases (Center for Substance Abuse Treatment 1994). The SSI- SA has previously been called the Simple Screening Instrument for Outreach for Alcohol and Other Drug Abuse; the Simple Screening Instrument (SSI); and the Simple Screening Instrument for AOD (SSI-AOD). To avoid confusion, the consensus panel suggests using "SSI-SA" (Simple Screening Instrument for Substance Abuse) when referring to this screening instrument.

As a government-supported document, the SSI-SA is in the public domain, can be used without charge or permission and can be reproduced without limit, including the instructions. It is a 16- item scale, although only 14 items are scored so that scores can range from 0 to 14. These 14 items were selected by the TIP 11 consensus panelists from existing alcohol and drug abuse screening tools. A score of 4 or greater has become the established cut-off point for warranting a referral for a full assessment.

Since its publication in 1994 the SSI-SA has been widely used and its reliability and validity investigated. A report by U.S. Department of Health and Human Services: Agency for Healthcare Research and Quality revealed that SSI-SA has high Internal Consistency (0.83) and Test- Retest (0.9) (Knight, Goodman, Pulerwitz, DuRant, 2000).

3.7.3 Brief Cope-28

According to Lazarus and Folkman (1984), coping mechanisms are constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.

The Brief cope was developed by Professor Charles S. Carver at the University of Miami which is one ofthe most commonly used coping measures and has been cited by more than 900 articles as of August 2011. It is the abridged version of the original COPE Inventory and assesses 14 coping types with 28 questions (2 questions per type) These include, for example, “active coping” (I have been taking action to try to make the situation better),“religion” (I have been praying or meditating), “venting” (I have been expressing my negative feelings), and “substance use” (I have been using alcohol or other drugs to make my self feel better) (Carver, 1997).

Participants rated their use of coping mechanisms on a four-point Likert scale ranging from “not at all” (1) to “a great deal” (4). High scores indicate a greater use of any particular coping strategy.

3.8 Data Collection Procedure

All the necessary data from the sample were collected by using structured and semi-structured questionnaire. Data collectors were also there for field observation in which challenges and general situations related to the topic will be assessed. A pilot test using 80 street based sex workers were done before the actual data collection. Short-term training was given to data collectors in order to familiarize them with the data collection tools and about the objectives and nature of the study. Fifteen key informants that consist of hotel owners, police, NGO coordinators, and some night customers were participated. Five psychiatric nurses who are experienced in interviewing psychiatric patients were recruited to collect the data. Data collectors were also very familiar with the 10 selected localities.

3.8.1 Report on Pilot Test

Pilot test was made to check the reliability and validity of the Mental Health Inventory - 38 (MHI – 38), Simple Screening Instrument for Substance Abuse (SSI-SA) and Brief Cope-28 instruments. Beside to the reliability and validity, clarity of instruction, items and language simplicity were also checked. The pilot study was conducted in Adama town. A pilot study was conducted by the researcher in October 2017 using 80 randomlyselected female prostitutes.

Face validity of the English and Amharic version of questionnaires were assessed by two psychologists from Ambo University at the same time, the feedback shows that the instruments had good face validity. The instrument translation's consistency was also examined by three language experts from Rift Valley University.

The participants of the pilot study were invited to complete the pre-settled questionnaire, which contained all the scales along with demographic questions used in the main study.It was clearly stated in the questionnaire and told the participants that confidentiality of information supplied by them would prevail at all times. In addition, the participants were informed that they could give their informed consent freely and voluntarily, and that they had full right to refuse to participate or to withdraw from participation in the study at any stage. Hence, some senior lecturers of sociology, social work and psychology at Ambo University were asked to comment on any item that they found ambiguous or difficult to understand. These queries did not reveal any major changes that needed to be made to any of the items.The items of all the completed instruments were evaluated for wording

and phrasing as well as for reliabilities to ensure that the resettled questionnaires were suitable for use in the main study.

Based on the comments and suggestions of the experts changes were made in wording of two Amharic versions of mental health inventory and three simple screening instruments for substance abuse items. No changes were made in the numbering and sequencing of the items. No items were deleted for lower rate of reliability. The reliability results of the Amharic version were assessed by Cronbach alpha. In the pilot study, the reliabilities of the tools were found to be 0.911, 0.943 and 0.901 for mental health inventory - 38 (MHI – 38), simple screening instrument for substance abuse (SSI-SA) and Brief Cope-28 respectively. In general, all the scales that were used in this study show good reliability and validity. Finally, the final instruments were developed after wording improvements and were used to gather the main data.

3.9 Data Analysis

After data collection, data analysis techniques were done in line with the research questions.

In the first research questions, simple descriptive statistical tools such as percentile, frequencies, mean and standard deviation were employed with in detail narration to see the status of mental health conditions of respondents. In the second and third research questions were analyzed qualitatively to assess the determinant factors for street based sex workers and to explain the determinant factors that amplify the level of psychosocial problems of street based sex workers.

In the fourth research question, independent t-test was computed to see mean difference between childhood histories of sexual abuse on mental health conditions. Moreover, one way ANOVA were computed to see whether there is a significant difference in prevalence of mental health conditions among participants in relation to their age, marital status, educational status, social support and the length of time having stayed in street-based sex work. Here, Bonferroni post hoc test will be computed to see the mean difference for the statistically significant differences more in detail in each category. In addition, Pearson correlation coefficients were used to analyze to relationship between substance abuse and mental health condition. Finally, one sample t –test were computed to see mean deference between coping mechanism used by participants. Statistical package (SPSS version 20) was used to analyze the data that could be quantified using statistical tools. The data that could not be presented numerically were described qualitatively using thematic analysis.

3.10 Ethical Considerations

In compliance with The Department of Social Work Program ethical requirements, informed consent from each participant to participate in this study were considered a first priority. Data collectors were given training on issues of ethics, confidentiality, and collection of data and other related procedures. Participants were requested to give genuine and full responses. In all phases of the data collection privacy of respondents were remained inviolate. The informed consent process was confirmed for each participant before data collection. Every effort was made to safeguard participants against any risk. Prior to the data collection, all participants were asked if they are willing to participate.

CHAPTER FOUR

RESULTS OF THE STUDY

This section presents finding of the research. demographic background of participants, contributing factors for mental health problem, general prevalence of mental health condition and substance abuse disorder, prevalence of mental health condition and substance abuse disorder across the independent variables (sex, age, Marital status, educational level, childhood sexual abuse and income), the mean difference between the prevalence of mental health condition and substance abuse disorder across the independent variables, the relationship between mental health condition and substance abuse disorder, the relationship between mental health condition and substance abuse disorder with length of stay in sex work, for FGD and interview findings were presented intermediately. Hence, coping mechanisms were presented. Finally, qualitative findings were analyzed in their due order.

4.1 Demographic characteristics

Table 2: Demographic Characteristics of the Respondents

Demographic Variable	Categories		Frequency	Percentile
Age	13-20 years (adolescence)		70	18.5
	21-29 years (early adult hood)		214	56.6
	30 & above (adulthood)		94	24.9
	Total		378	100
	Mean	SD	Minimum	Maximum
	24.65	4.624	16	40
Marital Status	Married		90	23.8
	Single		100	26.5
	Divorced		101	26.7
	Widow		87	23
	Total		378	100
Educational Status	Illiterate		195	51.6
	Grade 1-8		132	34.9
	Grade 9-12		43	11.4
	College diploma & above		8	2.1
	Total		378	100
Birth place	Rural		197	52.1
	Urban		181	47.9
	Total		378	100
Average family monthly Income	Lower income (≤ 1500 birr)		231	61.1

	Middle income (1501-3000 birr)	67	17.7
	Upper income (>3001 birr)	80	21.2
	Total	378	100
Parent's living arrangement	Mother and father live together	19	5
	Father and mother divorced	44	11.6
	Father passed away	118	31.2
	Mother passed away	70	18.5
	Both passed away	127	33.6
	Total	378	100

As can be seen from table 1, out of 378 respondents, most of the respondent's age 214 (56.6%) ranges between 21-29 years old, followed by 94 (24.9%) respondents whose age ranges from 30 years old and above and 70 (18.5%) were adolescence whose age ranged from 13-20 years old. The mean age of the respondents was 24.65 (SD =4.624) where the minimum and maximum ages were 16 and 40 respectively. With respect to marital status, 101 (26.7 %), 100 (26.5 %), 90 (23.8%) and 87 (23%) respondents were divorced, single, married and widow respectively.

Regarding to educational status, out of all respondents, 195 (51.6%) had found to be illiterates, followed by 132(34.9%) of respondents were 1 up to 8 graders. Also, 43 (11.4%) of respondents were 9-12 graders, followed by 8(2.1%) of respondents were college diploma and above completed. Of all the respondents, 197 (52.1%) respondents were born in rural place while 181 (47.9%) were born in urban place. Furthermore, with regard to the average monthly family income, out of all respondents, most 231 (61.1%) had found to be categorized as lower family income, followed by higher family income 80 (21.2%) and middle family income 67(17.7%). Finally, can be shown in table 1, most of the respondents 127 (33.6%) lost both father and mother; 118 (31.2%) lost their fathers while 70 (18.5%) lost their mother by death. About 44(11.6%) of respondents reported that their parents were divorced, and the rest 19 (5%) of respondents reported that their parents were currently living together.

4.2 Prevalence of Mental Health Condition and Substance Abuse among street sex workers

To assess the prevalence of common mental health disorder and substance abuse, two standardized scales (Mental Health Inventory & Simple Screening Instrument for Substance Abuse) were used.

In Mental Health Inventory, the Psychological Distress and Psychological Well-being global scales represent complementary summary scales with Psychological Distress indicating negative states of mental health and Psychological Well-being indicating positive states. Together, they use all 38 items to derive the scores (24 items for Distress, 14 items for Well-being) with no item overlap.

Table 3: Prevalence of Mental Health Condition and Substance Abuse among sex worker

Variable	Frequency	Percent
Mental health Inventory Score		
Psychological welling (143-226)	244	64.6
Psychological Distress(38-142)	134	35.4
Total	378	100.0
Substance abuse score		
0-3 normal state	94	24.9
4-14 substance positive	284	75.1
Total	378	100.0

The mental health inventory results in the table 2 indicate that out of the total of 378 respondents, 35.4% (134) of sex workers were psychologically distressed while the rest 64.6% (244) were psychologically healthy. For this reason, the general lifetime prevalence of psychological distress among street based sex workers was 35.4%. Among the dimensions of mental health index, depression, anxiety and loss of behavioral/emotional state was observed respectively. In addition, the prevalence of substance abuse among street based sex workers was checked using a simple screening instrument for substance abuse. As it is shown in the table 2, out of the total 378 respondents, 75.1% (284) of sex workers reported high risk of substance abuse, while the rest 24.9%(94) reported low risk of substance abuse.

Information from participant sex workers and key informants reported that most of street based sex workers have used one or more type of drug or alcohol as part of their daily lives. As interviewee sex

worker reported that much of the money they make from this work in the night will goes to buy substances in the day time. They use various types of substances to do their jobs effectively. Those frequently used substances include various drugs like cigarette, cannabis, chat, shisha, and alcohols like beer, draft, local drinks (tej, areke,).

They reported reasons for using substances, including help to avoid negative thoughts, to serve their client with relaxed mood. It also helps to cope with the night cold and windy environment, to stop the conflicts and negative thoughts about themselves and their work, to stop worrying about who will be their next client is (violent, abusive, aggressive, and other frightening types of clients). For other workers they are just addicted to it. One participant reported:

....First you start to use substances to feel relaxed and to work your job effectively but later it is the reverse, you work to satisfy your addiction….

Table 4: Prevalence of Mental Health Condition and Substance Abuse across demographic variables

Variable	Category	Mental Health Inventory				Substance abuse			
		Psychological Distress		Psychological Wellbeing		Substance positive		No substance abuse	
		N	%	N	%	N	%	N	%
Age	Adolescences (13-20 years)	90	67.2	28	11.5	160	56.3	21	22.3
	Early adulthood (21-29 years)	42	31.3	124	50.8	49	17.3	54	57.4
	Adulthood & above (≥30 years)	2	1.5	92	37.7	75	26.4	19	20.2
Educational Status	Illiterate	134	100	61	25	153	53.9	42	44.7
	Grade 1-8			132	54.1	90	31.7	42	44.7
	Grade 9-12			43	11.4	34	12	9	9.6
	College diploma and above			8	2.1	7	2.5	1	1.1
Average family Monthly Income	Lower Income Group	65	48.5	13	5.3	170	59.9	16	17
	Middle Income Group	54	40.3	166	68	51	18	61	64.9
	Higher Income Group	15	11.2	65	26.6	63	22.2	17	18.1
Marital status	Married	31	23.1	59	24.2	70	26.6	20	21.3
	Single	32	23.9	68	27.9	71	25	29	30.9
	Divorce	38	28.4	63	25.8	79	27.8	22	23.4
	Widow	33	24.6	54	22.1	64	22.5	23	24.5
Forensic history	Yes	134	100	79	32.4	167	58.8	46	48.9
	No	-		165	67.6	117	41.2	48	51.1
Birth place	Rural	134	100	63	25.8	154	54.2	43	45.7
	Urban	-	-	181	74.2	130	45.8	51	54.3

As can be depicted from table 3, out of the total 378 participants, high (67.2%) prevalence of psychological distress was found among participants whose age ranges between 13 – 20 years old (adolescence), followed by 31.3 % and 16.2 % of participants whose age ranges between 21-29 years old (early adulthood) and whose age ranges between 30 years old and above (middle adulthood) respectively. Whereas, in substance abuse , high prevalence of substance abuse disorder, similar to psychological distress, was found among (56.3%) participants whose age ranges between 13-20 years old (adolescences), followed by 26.4 % and 17.3% of participants whose age was 30 and above years (middle adulthood) and whose age ranges between 21-29 years old (early adulthood) respectively.

As it is revealed in table 3, out of all participants, higher prevalence of psychological distress were found among illiterate participants. On the other hand, substance abuse disorder was higher, similarly with psychological distress result among illiterate (53.9%) participants, followed by 1-8 graders (31.7%), 9-12 graders (12%) and college completed and above (2.5%) of participants.

In addition, regarding to monthly family income, out of the total 378 participant, higher prevalence of psychological distress was found among participants who came from lower family income groups (48.5%), followed by middle family income groups (40.3%), fewer but significant numbers of (11.2%) participants with psychological distress were found from the upper family income groups. Likewise, higher prevalence of substance abuse disorder was found among participants who came from lower family income group (59.9%), followed by 22.2% and 18% participants with substance abuse disorder were found from upper family income group and middle family income groups.

Regarding to marital status, out of the total participant, psychological distress was found more prevalent among divorced (28.4%) participants that was followed by widow (24.6 %), single (23.9%) and married (32.4 %) participants. Whereas, substance abuse disorder was found more prevalent, as similar to psychological distress result among divorced (27.8%) participants that was followed by married (26.6 %), single (25%) and widow (22.5 %) participants.

With regard to forensic history, out of the total participant, higher prevalence (100%) psychological distress was found among participants who a forensic history. Whereas, substance abuse disorder was found more prevalent (58.8%), as similar to psychological distress result among participants who had a forensic history.

Finally, regarding birth place, out of the total participant, higher prevalence (100%) psychological distress was found among participants whose birth place were rural. Correspondingly, substance abuse disorder was found more prevalent (54.2%), as similar to psychological distress result among participants whose birth place was rural.

In general, on one hand, out of the total participant, higher prevalence of psychological distress was found among divorced, illiterates, lower income, rural born , adolescence and sex workers who had a forensic history. On the other hand, by the same token with psychological distress, higher prevalence of substance abuse disorder was found among divorced, illiterates, lower income, rural born , adolescence and sex workers who had a forensic history.

4.3 Determinant Factors for Joining in Street based Commercial Sex Work

Table 5: Motivational factors listed by street based commercial sex worker

	Motivational factors for sex work	Frequency	%
1	Peer pressure	359	95
2	To improve personal and family life situation/living standard	348	92
3	Poverty of family and poor life situation	333	88
4	To search for better life and better paying job	317	83.8
5	Success of others	181	48
6	Unemployment	272	72
7	Failure to succeed in educational endeavors	302	80
8	Failed marriage	120	31.7
9	To get initial capital to start a business	257	68
10	Other reasons	7	1.85

The cause of joining in commercial sex worker can be seen in multifaceted ways. Similar to the global trend, the overall context of poverty, especially rural poverty, was the most important push factor. Socio-economic poverty was manifested in the form of a large and predominantly young rural population with limited access to means of production such as land, limited access to social services, including vocational and higher education, and limited employment opportunities. Interviewees reported that high rates of unemployment and low levels of earning stand out as key economic

reasons as well in all the study sites and by all categories of informants. Having the above description, the motivational factors for joining in commercial sex worker also presented as follows.

To understand the determinant factors for street based commercial sex worker, self-developed closed ended questionnaire were presented for respondents as it can be seen from table 4. Out of 378 sex workers, peer pressure (95%),to improve personal and family life situation (92%), poverty and poor life situation of the families (88%), to search for better life and better paying job (83.8%), to failure to succeed in educational endeavors (80%), unemployment (72%), to get initial capital to start a business (68%), success of others (48%), failed marriage (31.7%) and other reasons (1.85%) were highly reported major factors for joining street based commercial sex worker.

The interviewees reported that their career assist them for favorable economic conditions that enhance the living standards of their life and the life of their family. Sex worker also reported that their work had perceived significant comparative advantage in terms of better payment and living conditions.

Case stories depicting lack of job opportunities as one of the critical reason

> *I am the only woman to know as to how my extremely poor family's daily expense had been covered. I had a diploma but could not find a job. I tried to migrate to Middle East Country but I am deported after experiencing inhuman treatment from a destination country. I had been unemployed for 6 months here in Ethiopia. I tried to work various jobs however, what I need to support me and my family and what I gain have been completely non-compatible. So I join in street sex work to help my needy family. But my families have no idea what I am doing.*

Cases demonstrating how peer pressure enforce innocent female to join into this sex industry

> *……..I had a wrong role model who wears better clothes and leads their life with great freedom because money is not their problem; they can do whatever they want. Eventually I spent much of my time with them as a friend. And then I realized that the source of their income was selling their body for drunker, cheater husbands and irresponsible men as a prostitute. Consequently, because of their enforcement, I have joined the sex industry…..*

A key informant in Bole street (case)

…….I am coming from rural area of Desse in Amhara region. I went to Addis Ababa at the age of 19, without the knowledge of my family after interrupting my education. I had stayed with my old childhood friends who came to Addis Ababa before me. They were working as street based sex workers. They insist me to work like them. Finally, I started to work it…..

Case story indicating how poverty expose female for sex work

….I had been a waiter in café. I earned 300 birr per month. It was too hard to resist the work load at cafe. Employers didn't consider you as a human being rather they see you as untried slave who eat a lot and drink a lot. To sum up, employers don't care about you. Always my friends impose me to do this work for better life….

Case showing how wishes for better life and paying job influences them to join sex work

….I always saw the house in-front of our home which was built by our neighbor who is illiterate but went and worked to buy this house in Addis Ababa. We were forcing to migrate to Addis. We grew up through listening about better opportunities in the capital of the country and successful stories of relatives and neighbors who migrated to Addis; and thus, we decided to migrate to Addis through as a home maid to abide by the norm and help my family. I was 17 years old and I had nothing with home maid; I knew a girl who has worked as sex worker; with the help of her, I have adhered with this sex worker…..

FGD participants confirmed that significant number of sex workers could not be improved their quality of life. Most sex workers had been motivated by considering successful sex workers (see case)

'The reason why I engaged in sex work was for helping my mother. I was so impressed when I saw beautiful girls who had enough money having some property… But there was a real difference between what I think and the actual happening'

4.4 Contributing Factors for Mental Health Disorder among Street Based Sex Worker

Street based sex workers, police officers and other key informants had reported various kinds of violence and inhuman treatment that sex workers are always suffering with. These include forced self-degrading type of sex by clients, forced sex at knifepoint, physical assault, robbery, forced sex

with multiple individuals at the same time. Sometimes clients refuse to pay for the service they received, insulting, some take them to an unknown place and torture them for more than 3 days while doing anything they want to them, and some injure them while drunk. One respondent reported*:*

> *".....he drive me long road to unknown place of Addis, to his home, then he did everything various self degrading types of sex by force pointing knife at me. I was new to the job and the city and all what he did at me that night was very overwhelming, was very scary, and difficult to realize what was going on. When I walk to toilet there was bad smell and what I saw was so strange things on the garbage basket, including blood and a long hair and mini skirt, that has blood on it, which was definitely a woman... ohhhhhhhhhhhhhhh!!! ...then I do not remember how I went out from that home and place. And I stopped this work for more than a month because I was like mad, was experiencing night mare, frightening, sleeplessness, even after I start this work again I become suspicious, faced difficulty to converse with clients who took me with their car. But that's part of this life, you don't have choice.... you just continue.... yeah no choice..... What can you do?"*

Police officers reported that due to the nature of the job, street based sex workers are vulnerable to various kinds of violence by their clients, drunken persons, robberies, and owners of the houses they rent. The officers also said that even though these individuals do report a crime against them, they do not return to follow up the case against the perpetrator up to conclusion.

> *…….one of unforgettable events on my career life was that someone come to me and take me away with his car into somewhere else, at that time I had 500 birr and my client repeatedly threaten me to take my money. After taking the money, he attempted to kill me by crushing with his car because it was mid night, still I do remember the identification number* of the car…..

The interviewee counselor reposted that the society systematically excluded these sex workers in the normal life stream. Sex workers loss their social dignity and self regard because of their work. *…..the negative societal views of sex work and their psychosocial challenges force sex workers to conceal aspects of their identity and this leads to low self-esteem and self-worth. Many sex workers do not disclose their occupation to family and friends, which in turn leaves them socially isolated. These factors in turn predispose them to psychopathology…..*

4.5 Comparison of Mental Health Condition among sex workers' Demographic Variable

The Mental Health Index is a single score based on all 38 items designed as high level summary index of the person's mental health status. High scores on the Mental Health Index indicate greater psychological well being and relatively less psychological distress. Contrary, low scores on the Mental Health Index indicate greater psychological distress and relatively less psychological well being. The raw score range is 38-226.

Table 6: Mean Difference between sex workers' Demographic Variables on Mental Health

Variable	Category	N	M	SD	t-value	p-value
Place of birth	Rural	197	129.10	15.92	-21.742	0.000
	Urban	181	161.30	12.49		
Childhood History of Sexual Abuse	Yes	205	129.74	15.70	-21.747	0.000
	No	173	162.03	12.63		
Forensic history	Yes	213	130.50	15.88	-21.265	0.000
	No	165	162.61	12.64		

As can be revealed in table 5, the independent sample t-test result shows that there was a statistically significant mean difference in experiencing psychological distress between rural born and urban born street based sex workers ($t(376) = -21.742$, $p < 0.05$). Here, the mean score of mental health index for rural born respondents (M=129.10, SD=15.92) was lower than urban born respondents (M=161.30, SD=12.49). This implies that rural born respondents were more victim of psychological distress than their urban born counter parts. Along with this, there was a statistically significant mean difference between respondents who were sexually abused during their childhood and respondents who were not sexually abused during their childhood in experiencing psychological distress ($t(376) = -21.747$, $p < 0.05$). Moreover, the mean score of mental health index for those who were the victim of sexually abused during childhood (M=129.74, SD=15.70) was lower than mean score of mental health index for sexually not abused sex workers (M=162, SD=12.63).

NGO counselors and coordinators who are currently working with street sex workers reported that some of their clients (street sex workers who are getting economic and psychosocial support in their

organization) have had a history of one or more incident of childhood sexual abuse by their relatives, step fathers, neighbors, and other strangers or employers after coming Addis. Street sex workers who have had childhood sexual abuse also reported similar information.

One street sex worker reported that early childhood sexual abuse (a rape by her stepfather) influenced her to join sex work:

> **….** *I have no any sense of life; the only life I know is feeling high with various drugs and I do sex work with anybody whether he is safe or violent* **….** *I think nothing can hurt me anymore and I can do sex with whoever I wanted, because that person already distorted my life…*

Finally, table 3 also shows us that the mean score of mental health index for those who had a forensic history (M= 130.50, SD=15.88) were lower than forensic free sex workers (M= 162.61, SD= 12.64) and the difference was a statistically significant ($t(376) = -21.265$, $p < 0.05$).

One way ANOVA was employed to look-in to the mean difference in sex workers' mental distress based on age, educational status, average monthly income, marital status and Parent's living arrangement. The summaries of the findings were presented in table 6.

Table 7: ANOVA result of the effect of sex workers' age, educational status, average monthly income, marital status and parent's living arrangement *on mental health condition*

Variable	Category	N	M	SD	F	p-value
Age	Adolescences (13-20 years)	70	125.57	20.13	110.044	0.000
	Early adulthood (21-29 years)	214	141.85	14.47		
	Adulthood & above (≥30 years)	94	164.70	16.34		
Educational Status	Illiterate	195	128.70	15.40	318.112	0.000
	Grade 1-8	132	154.35	3.77		
	Grade 9-12	43	176.74	5.68		
	College diploma and above	8	194	4.84		
Average Monthly Income	Lower Income Group	67	124.94	18.33	82.346	0.000
	Middle Income Group	231	143.74	15.80		
	Higher Income Group	80	163.15	23.15		
Marital status	Married	90	143.79	21.23	0.630	0.596
	Single	100	146.90	21.43		
	Divorce	101	144.30	23.03		

	Widow	87	142.78	20.48		
Parent's living arrangement	Mother and father live together	19	188.68	6.52	654.388	0.000
	Father and mother divorced	44	169.11	8.83		
	Father passed away	118	153.47	2.88		
	Mother passed away	70	147.50	6.01		
	Both passed away	127	119.43	10.66		

As can be seen from table 7, the age of sex workers had a statistically significant effect ($F(3,374) = 110.044$, $p<0.05$) on mental health index. In the same fashion, the Bonferroni post hoc result demonstrated that highly significant psychological distress score mean differences were reported among adolescents (13-20 years) ($p < 0.05$) than early adulthood (21-29 years) ($p < 0.05$) and middle adulthood (30 years and above) ($p < 0.05$). The mean mental health index score of adolescents ($M=125.57$, $SD=20.13$) was lower than early adulthood ($M=141.85$, $SD=14.47$) and middle adulthood & above ($M=164.70$, $SD=16.34$). However, insignificant mental health index differences were obtained between early adulthood and middle adulthood and above sex workers ($p> 0.05$).

Furthermore, sex workers' educational status ($F(3,374) = 318.112$, $p<0.05$) had a statistically significant effect on their psychological distress. The Bonferroni post hoc multiple comparisons result displayed that illiterate sex workers demonstrated highly significant mean difference on psychological distress symptom as compared to 1-8 graders ($p < 0.05$), 9- 12 graders ($p < 0.05$) and college diploma and above completed ($p < 0.05$). Thus, the mean mental health index score of illiterate sex workers ($M= 128.70$, $SD=15.40$) was lower than 1-8 graders ($M=154.35$, $SD=3.77$), 9-12 graders ($M=176.74$, $SD=5.68$) and diploma & above completed ($M= 194$, $SD= 4.84$).

Moreover, table 5 shows us that average monthly family income of the sex workers had significant effect on psychological distress symptoms ($F(2, 375) = 82.346$, $p< 0.05$). Consistently, the Bonferroni post hoc multiple comparisons revealed that the psychological distress of sex workers with lower income had a statistically significant difference as compared to sex workers with middle income ($p<0.05$) and upper income ($p<0.05$). The mean mental health index score of sex workers with lower income ($M=124.94$, $SD=18.33$) was lower than sex workers with middle income ($M=143.74$, $SD=15.80$) and upper income ($M=163.15$, $SD=23.15$).

Additionally, table 7 also tell us that the univariant analysis of variance result showed that marital status had insignificant effect on psychological distress symptoms (F (4, 373) =0.630, p >0.05). Accordingly, the Benferroni post hoc multiple comparisons revealed that the psychological distress of single sex workers had no a statistically significant difference as compared to married sex workers (p>0.05) and divorced sex workers (p>0.05). The mean mental health index score of widow sex workers (M=142.78, SD=20.48) was slightly lower than married sex workers (M=143.79, SD=21.23), divorced sex workers (M=142.78, SD=20.48) and single sex workers (M=163.15, SD=23.15).

Table 7 also inform us that sex worker parent's living arrangement had a significant effect on psychological distress (F (4, 373) = 654.388, p <0.05). The Bonferroni post hoc multiple comparisons result demonstrated that significant mean difference on psychological distress score were observed on sex workers who lost both parents (p < 0.05) as compared to sex workers who lost their fathers(p< 0.05), sex workers whose parents were divorced (p< 0.05), sex workers whose parents were currently living together (p< 0.05) and sex workers who lost their mother (p< 0.05) respectively.

4.6 Correlations between Length of Stay in Sex Work on Substance Abuse and Mental Health Condition

The relationships between length of stay in sex work on substance abuse and mental health condition were computed with Pearson correlation coefficient and are presented as follows:

Table 8: Pearson correlation between length of stay on sex work and substance abuse and mental health condition

Independent variable		**Mental Health Score**	**Substance abuse score**
length of stay in sex work	Pearson Correlation	-0.542	0.632
	Sig. (2-tailed)	0.000	0. 019
	N	378	378

**. Correlation is significant at the 0.05 level (2-tailed)

To investigate the relationship between respondents' length of stay in sex work and their mental health, Pearson correlation coefficient was computed. As can be shown in table 7, the results show that there was a moderate negative correlation between length of stay on street sex work and mental health (r = -0.542, p<0.05). This means the longer street based sex workers stayed in street sex work was correlated the greater the severity of psychological distress.

In Table 8, the Pearson correlation coefficient results also revealed that there was a moderate positive correlation between length of stay in street sex work and prevalence of substance abuse (r = 0.632, p = < .05). This means the longer street based sex workers stayed in street sex work were correlated with the greater the severity of their substance abuse.

4.7 Correlations among Sex Workers' Mental Health Condition & Substance Abuse

To see the relationships among dependent variables (mental health & substance abuse), Pearson correlation coefficient were computed and are presented as follows:

Table 9: Pearson correlations among sex worker' mental health and substance abuse (N=378)

		Substance Abuse Score
Mental Health Score	Pearson Correlation	--0.742
	Sig. (2-tailed)	0.008

**. Correlation is significant at the 0.05 level (2-tailed).

As can be shown from table 8, the result of Pearson correlation coefficient shows that there was strong negative correlation between mental health score and substance abuse (r = --0.742, p < 0.05). This means that a lower mental health index score was correlated with a higher substance abuse scores.

4.8 Coping Mechanisms used by Street Based Sex Worker

As shown in table 9, out of the total 378 respondents, the most frequently used adaptive coping mechanism by the sex workers were acceptance (M=5.49, SD=1.74) and religion (M=5.12, SD=2.06) respectively. In addition, instrumental support (M=4.79, SD=2.02), emotional support (M=4.74, SD=1.99), planning (M=4.70, SD=1.94), positive reframing (M=4.672, SD=1.836), active

coping (M=4.66, SD=1.63) and homer (M=4.07, SD=1.93) were also repeatedly reported adaptive coping mechanisms by sex workers in their due order. Concurrently, the most frequently used maladaptive coping mechanism by the sex workers were self-blame (M=5.59, SD=2.03) and substance use (M=5.50, SD=2.06). Along with this, venting (M=4.96, SD=1.72), Self-distraction (M=4.76, SD=1.80), denial (M=4.47, SD=1.75), behavioral disengagement (M=5.42, SD=1.75) were highly reported maladaptive coping mechanism by street based sex workers respectively

As can be designated in table 9, one sample t-test result revealed that active coping(t (377) = 17.218, $p<0.05$), instrumental support(t (377) = 15.110, $p<0.05$), , Planning(t (377) = 14.867, $p<0.05$), acceptance(t (377) = 25.353, $p<0.05$), emotional support(t (377) = 14.837, $p<0.05$), homer(t (377) = 8.616, $p<0.05$), positive reframing(t (377) = 15.372, $p<0.05$) and religion(t (377) = 18.741, $p<0.05$) were found to be a statistically significant adaptive coping style of street based sex workers. Correspondingly, behavioral disengagement(t (377) = 14.632, $p<0.05$), denial(t (377) = 13.934, $p<0.05$), self-distraction(t (377) = 16.620, $p<0.05$), self-blame(t (377) = 22.723, $p<0.05$), substance use(t (377) = 21.497, $p<0.05$) and venting(t (377) = 19.700, $p<0.05$) had statistically significant effect on maladaptive coping style of street based sex workers.

Among the FGD participants, there was more discussion about how they had succeeded in resisting the work demands or coping with stressful situations. Most of them reported that washing once body, listening music, chewing chat, smoking, watching Soccer team, drinking alcohol and social support coping mechanisms were used to cope with stress.

> *……I discuss with intimate friends, family members and neighbors about the problems that faced me. They advised me. They also gave me insight as to how I could keep myself away from these problems. So, when I discussed with them about my problems with those people who are living with the disease. My stress was relieved.*

Table 10: Coping mechanisms used by street based sex workers

Coping style	**Coding item**	**N**	**Mean**	***SD***	***Df***	**Test value**	***t***	***P***
Adaptive coping style								
Active coping	2& 7	378	4.669	1.636	377	3.22	17.218	.000
Instrumental support	10&23	378	4.791	2.021	377	3.22	15.110	.000
Planning	14& 25	378	4.706	1.943	377	3.22	14.867	.006
Acceptance	20&24	378	5.492	1.742	377	3.22	25.353	.034
Emotional support	5&15	378	4.746	1.999	377	3.22	14.837	.000
Homer	18&28	378	4.079	1.939	377	3.22	8.616	.000
Positive reframing	12&17	378	4.672	1.836	377	3.22	15.372	.000
Religion	22&27	378	5.214	2.068	377	3.22	18.741	.000
Maladaptive coping style								
Behavioral disengagement	6&16	378	4.542	1.752	377	3.22	14.632	.000
Denial	3&8	378	4.476	1.752	377	3.22	13.934	.000
Self-distraction	1&19	378	4.761	1.803	377	3.22	16.620	.000
Self-blame	13&26	378	5.595	2.032	377	3.22	22.723	.000
Substance use	4&11	378	5.505	2.066	377	3.22	21.497	.000
Venting	9&21	378	4.963	1.720	377	3.22	19.700	.000

CHAPTER FIVE

DISCUSSION

The purpose of this study was to assess the prevalence, determinant factors for the mental health problems and coping mechanisms among female street-based sex workers in Addis Ababa, Ethiopia. Therefore, the findings of this study were looked in detail with the previous research findings on female street-based sex workers. The discussions were presented based on the research questions.

5.1 Prevalence of Mental Health Condition among Street Based Sex Workers

The purpose of this study was to assess prevalence and risk factors for mental health problem and coping mechanisms of street based sex workers. In this study, the general lifetime prevalence of psychological distress among street based sex workers was 35.4%. Among the dimensions of mental health index, depression, anxiety and loss of behavioral/emotional state was observed respectively. This result was supported with other similar studies.Studies that examine the prevalence of PTSD in samples of female sex workers have identified rates ranging from 17% (Chudakov, Ilan, Belmaker, Cwiken cited in Betsy, 2010) to 63% (Farley et al., 2003).Roxburgh, Degenhardt, and Copeland (2006) also found that 47% of their sample of 72 street-based sex workers in Sydney, Australia met criteria for posttraumatic stress disorder based on a diagnostic interview. Furthermore, of the women who met criteria for PTSD, 91% suffered from the chronic form of the disorder. This is much higher than the lifetime prevalence of PTSD in the general population which ranges from a low 0.3% to a high 6.1 % (WHO, 2008).

Farley and Barkan (1998) found that overall 68% met the criteria of PTSD which was attributed to past sexual assault by client. However Boyle et al. (1997b) and Romans, Potter, Martin and Herbson (2001) did not find that the overall levels of psychological distress reported by sex workers differed from female population.

Farley, Baral, Kiremire, and Sezgin (1998), for example, investigated the prevalence of Posttraumatic Stress Disorder (PTSD) among sex workers in South Africa, Thailand, Turkey, the United States, and Zambia. Overall, two-thirds of their sample of 475 prostitutes met the diagnostic criteria for PTSD, with no significant differences among countries. It was concluded that prostitution is an act that is

intrinsically traumatizing and that the harm of prostitution is not culture-bound. Farley et al. thus put forward prostitution per se as the explanatory factor for these high levels of psychological distress, and not the high prevalence of specific victimizing experiences, homelessness, and drug abuse as they were additionally documented in this very same study.

Despite the increased vulnerability to mental health disorders, the prevalence of depression among sex workers has varied in the international literature. Reported prevalence rates have varied from as low as 4.2% in Bangladesh, while a study in Australia reported no difference in prevalence compared with the general population, compared with a Swiss study in Zurich that found the lifetime prevalence of depression and anxiety to be 36.3% and 34.2% respectively (Rossler, Koch & Lauber, et al, 2010; Romans, Potter, Martin, et al., 2001; Hengartner & Islam, Haker, et al., 2015). Finally a study in Nepal reported the prevalence of depression to be as high as 84% in female sex workers (Sagtani, Battani & Adhikari, et al., 2013).

The fact that sex workers have higher rates of depressive symptoms than the general population is further supported by a study conducted by Roxburgh, Degenhardt, and Copeland (2006). Using the Beck Depression Inventory (BDI-II), the researchers found that 87% of their sample of 72 women reported symptoms indicative of at least mild depression. Furthermore, 54% of the subjects scored high enough on the BDI--II to indicate severe symptoms.

Dominelli (cited in Geetha, Allen, & Aylur, 2009) also suggested that depression among sex workers results from stigmatization and the view of sex work as immoral and deviant. According to this view, internalizing such stigma undermines women's sense of empowerment and leads to feelings of submissiveness and further self-degrading behavior. In addition to this, there have also been qualitative researchers who have examined depression in female sex workers. For example, Kramer (cited in Betsy, 2010) examined the emotional experiences of sex workers while performing acts of prostitution. The researcher asked 119 female sex workers to generate words that described their feelings while engaging in sexual acts with customers. Of these emotional words, 90% had negative connotations. The most frequently occurring words generated by these women included sadness, depression, undesirable, anger, resentment, detachment/disconnection, fear, and anxiety.

5.2 Prevalence of Substance Abuse among Street Based Sex Workers

In this study, 75.1% (284) of sex workers reported high risk of substance abuse, while the rest 24.9% (94) reported low risk of substance abuse. This result was supported with that of (Jung, Song, Chong, Seo, & Chae, 2007) who claimed that drug use could reasonably be considered the norm rather than deviant behavior in female sex working populations. In this study, most of street based sex workers use one or more types of drugs or alcohol as part of their daily lives. For many sex workers, much of the money they make from this work in the night will goes to buy substances during the day. They use different types of substances to do their jobs effectively. These frequently used substances include various drugs like cigarette, cannabis, hashish, khat, shisha, and alcohols like bear, draft, local drinks (tej, areke,). For most of them, the major reasons for using substances include was to avoid negative thoughts and to serve their client in a more relaxed mood. It also helps them to cope with the night cold and windy environment, to stop the conflicts and negative thoughts about themselves and their work, to stop worrying who their next client is and what he might do (violent, abusive, aggressive, and other fears of dangerous clients. For others addiction just solidifies the drug abuse. Therefore in this study, the prevalence of substance abuse among street based workers using a simple screening instrument for substance abuse revealed that out of the total 378 respondents 284 (75.1%) met the criteria for substance abuse. This result was supported by other similar studies which show that the rates of drug and alcohol use in female sex working populations ranged from 48% (Farley et al., 2003) to 94% (Roxburg, Degenhardt, & Copeland, 2006). Drugs and alcohol not only serve as tools by which individuals can avoid or block out painful memories of traumatic pasts, but they also help these individuals numb their fear so that they can perform their services effectively (Kramer cited in Betsy, 2010). This seems to accord with findings of previous studies. For instance Clarke, Clarke, Roe-Sepowitz & Fey (2015) and Patton et al. (2014) have revealed that alcohol and illicit drugs are significantly correlated with transactional sex.

5.3 Determinant Factors for Engaging for Street based Commercial Sex Worker

The present study found that interviewees reported various multifaceted determinant factors for engaging for street based commercial sex worker. Specifically, peer pressure, to improve personal and family life situation, poverty and poor life situation of the families, to search for better life and better paying job, to failure to succeed in educational endeavors, unemployment, to get initial capital

to start a business, success of others, failed marriage and other reasons were highly reported major factors for joining street based commercial sex worker. This result yields consistent with previous research findings of Pyett & Warr (1999) who found that 82% of the participants reported financial motivation while 52% stated for good money & flexible hours were the main reason reported for starting sex work. In addition, Buttram, Surratt and Kurtz (2014) in a sample of Australian sex workers, financial hardship was the main reason given for entering the sex industry. Less commonly, women reported they were unable to find another job (12%), they were using drug and needed money to pay for them (15%) they drifted in to it (18%), they were talked in to it (12%) and it was purely for survival (26%).

5.4 Risk factors for Psychosocial Problem among Street based Sex Workers

In this study, various risk factors for psychosocial problem were reported by street based sex workers, police officers and other key informants regarding to various kinds of violence and inhuman treatment that sex workers are always suffering with. These include forced self-degrading type of sex by clients, forced sex at knifepoint, physical assault, robbery, forced sex with multiple individuals at the same time. Sometimes clients refuse to pay for the service they received, insulting, some take them to an unknown place and torture them for more than 3 days while doing anything they want to them, and some injure them while drunk. This result yields consistent with Roxburgh, Degenhardt & Copeland (2006) & El-Bassel, Witte, Wada, Gilbert & Wallace (2001) who found that most women report being raped, physically assaulted, or threatened with a weapon during the course of prostitution. Not surprisingly, women involved in prostitution report an increased incidence of depression, 4 as many as 74% report lifetime suicidal ideation, 6 and 53% have attempted suicide (Gilchrist, Gruer & Atkinson, 2005; el-Bassel, Schilling, Irwin, Faruque, Gilbert, Von Bargen, Serrano and Edlin, 1997). Another studies have also suggested that female sex workers may experience workplace violence with estimates ranging from 65- 93% (Milman, 1980; Miller & Schwartz, 1995). Due to risk factors, compared with the general population, sex workers have poor mental health (Farley & Barkan, 1998; Chhudakov et al. 2002).

Several studies have indicated sexual violence leads to depression (Acierno et al., 2002; Clum et al., 2000; Golding, 1996) and anxiety (Siegel, Golding, Stein, Burnam, & Sorenson, 1990). Another reason leading to mental health symptoms among female involved in transactional sex of any form

(subsistence or consumptive) may be that being financially dependent, fear of infection, sex work per se, and shame and feelings of guilt (Rossler et al., 2010). The fact that in Ethiopian society sex work by university students is quite new and never acceptable by the society makes the sex work secret which makes getting social support in time of need very difficult for such female students.

Host (1999) suggested that 38.4% of sex workers from Brisbane had been victims of client- related assault and/ violence during the previous 12 months. This included 17.9% being physically assaulted, 35.9% being sexually assaulted and 46.2% both physically (Host, 1999). Ward et al. (1999) indicated that a sample of London street- based sex workers had a mortality rate of 5.93 per 1000 per year, which is 12 times higher than the expected rate for age matched women from the general community.

5.5 Association between Mental Health Conditions of Sex Workers with Different Background Variables

The present study result shows that there was a statistically significant mean difference in experiencing psychological distress between rural born and urban born street based sex workers. Here, the mean score of mental health index for rural born respondents was lower than urban born respondents.

Regarding to a history of childhood sexual abuse, there was a statistically significant mean difference between respondents who were sexually abused during their childhood and respondents who were not sexually abused during their childhood in experiencing psychological distress. Moreover, the mean score of mental health index for those who were the victim of sexually abused during childhood was lower than mean score of mental health index for sexually not abused sex workers. Somewhat consistent to findings of the present study a study by Monica et al. (2009 revealed that histories of past emotional, physical, and sexual abuse as correlates of current psychological distress using data from 916 female sex workers who were enrolled in a safer sex behavioral intervention in Tijuana and Ciudad (Cd.) Juarez, Mexico. These researchers found that history of sexual abuse was the strongest predictor of both depressive and somatic symptoms of the three abuse items. This suggests that history of sexual violence may be significantly associated with more serious mental health consequences. Along with this, Roosa, Reinholtz, and Angelini (cited in monica et al., 2009) also reported that for Mexican-American women, history of childhood sexual abuse accounted for more

variance in depression scores than the background variables of social class, family size, marital status, extent of child physical abuse, and teen pregnancy.

Other studies have examined the rates of childhood sexual abuse in populations that are highly correlated with current or future involvement in sex work. Vaddiparti et al. (cited in Betsy, 2010) examined the rates of childhood sexual assault in a group of 594 substance-using women, some of whom were involved in the sex trade. The authors found high rates of childhood sexual assault in both groups, with the sex-trading women having a significantly higher reported rate (46%) than women who had no experience in the sex trade industry (36%). Interestingly, this study indicated that childhood abuse histories were strongly correlatedwith later cocaine dependence, which in turn was correlated with subsequent involvement in the sex trade industry. According to Coy, (cited in Betsy, 2010), some theorists suggest that individuals who have experienced childhood trauma develop unhealthy coping habits, such as substance use and dissociation, which are later used to cope with the myriad of stressors that often accompany a profession in sex work.

The present study result shows that the age of sex workers had a statistically significant effect ($F(3,374) = 110.044$, $p<0.05$) on mental health index. In the same fashion, the mean mental health index score of adolescents was lower than early adulthood and middle adulthood & above. The present study finding was consistent with Bagley and Young (1987) study in Canada who found that the severity of sexual abuse before the age of 16 was a more important predictor of poor mental health than being involved in sex work was.

The present study result showed that sex workers' educational status ($F(3,374) = 318.112$, $p<0.05$) had a statistically significant effect on their psychological distress. Thus, the mean mental health index score of illiterate sex workers was lower than 1-8 graders, 9-12 graders and diploma & above completed. Qualitative studies on expressions of resilience among female sex workers, found that protective factors such as education, social support and access to health care increase resilience which was in turn linked to better mental health. Conversely, higher levels of mental ill-health, homelessness, drug use, experience of victimization were found to be negatively related to resilience (Buttram et al, 2014). In this study, average monthly family income of the sex workers had significant effect on psychological distress symptoms. This result was consistent with the finding of

Lindert et. al.,(2008). This study also indicates that worker parent's living arrangement had a significant effect on psychological distress.

5.6 Correlations between Length of Stay on Sex Work with Mental Health and Substance Abuse

There was general hypothesis that as street sex workers remain for longer periods in this work, their psychological distress also will increase. In this particular study, Pearson correlation coefficient revealed that there is a significant relationship between length of stay in sex work and dependent variables including mental health and substance abuse. The relationship between length of stay in sex work and there was **a** moderate negative correlation between length of stay on street sex work and mental health ($r = -0.542$, $p<0.05$). This means the longer street based sex workers stayed in street sex work was correlated the greater the severity of psychological distress. In addition, there was a moderate positive correlation between length of stay in street sex work and prevalence of substance abuse ($r = 0.632$, $p = < .05$). This means the longer street based sex workers stayed in street sex work were correlated with the greater the severity of their substance abuse. It is obvious that as street sex workers stay for longer periods with such persistent traumatic and distressing events, their mental health condition will worsen. This is supported by Jung, Song, Chong, Seo, and Chae (2007) who explored the relationship between length of time engaging in sex work and experience of psychological distress. Similar to the present study finding, Mroczek and Almeida (2004) found that the risk for a mental disorder increases with the period of time that someone has been part of this industry.

5.7 Correlations among Mental Health and Substance Abuse

The current study tried to examine the relationships between mental health and substance abuse. To investigate these relationships among themselves Pearson correlation coefficient was computed. The result shows that there was strong negative correlation between mental health score and substance abuse ($r = --0.742$, $p < 0.05$). This means that a lower mental health index score was correlated with a higher substance abuse scores.

There are also limited studies that examine relationships between Psychological distress and current substance abuse related to this population. However, Najavits; Najavits, Weiss, & Shaw, (cited in

Betsy, 2010) reported that although alcohol and drug use is a problem that is seen independently of trauma, comorbidity rates between substance abuse and trauma related pathologies are high. This is generally thought to be because alcohol and drug use provide a way for traumatized individuals to avoid the triggering stimuli they encounter in their day-to-day lives or to numb the persistent distress that they experience.

Several authors have attempted to explain why substance abuse rates are so high among sex workers. For example, in their sample of 113 former prostitutes, Jung, Song, Chong, Seo, and Chae (2007) found that problematic drinking and smoking were positively correlated with the frequency that these women experienced depression symptoms. There is an empirical study limitation to find the exact correlation results reported between depression and substance abuse. However, some researchers report their general analysis on it. For example, according to Hong et al.,; Fang et al., (cited in Qing, Xiaoming, & Bonita, 2010), the secrecy and stigmatization associated with illegal commercial sex have created stress, conflict, and fear among female sex workers. Stressors include depression, internalized stigma, needs to hide their situation from family and friends, socioeconomic pressures and diminishing hope for the future. Therefore, drinking among female sex workers may serve as self-medication or a maladaptive attempt to cope with economic disadvantage, an impoverished life style, and stressful work.

5.8 The Most Commonly Used Coping Mechanism Used by Street based Sex Workers

With regard to the coping mechanism, the most frequently used adaptive coping mechanism by the sex workers were acceptance and religion respectively. In addition, instrumental support, emotional support, planning, positive reframing, active coping and homer were also repeatedly reported adaptive coping mechanisms by sex workers in their due order. Concurrently, the most frequently used maladaptive coping mechanism by the sex workers were self-blame and substance use. Along with this, venting, Self-distraction, denial, behavioral disengagement were highly reported maladaptive coping mechanism by street based sex workers respectively. Research in the Netherlands found, among others, relatively high levels of emotion-directed coping, dissociation, and denial among sex workers, which, in turn, were strongly associated with more psychosomatic complaints and social insecurity (Vanwesenbeeck et al., 1995).

Chapter six
Summary, Conclusion and Recommendation

6.1 Summary

Various bodies of literature show that street based sex workers are highly at risk of developing violence related psychological disorders including depression and substance abuse. Therefore, this paper examines investigate the determinant factors for the psychosocial problems of street-based female sex workers in Addis Ababa, Ethiopia and their associations with demographic variable and length of stay in sex work among Addis Ababa female street-based sex workers. It also investigates the relationships among mental health index and substance abuse. In addition, the study also examines the risk factors for developing psychosocial problems among street based sex workers. Hence, the present study tried to investigate the determinant factors for engaging in street based commercial sex work.

Mixed approach explanatory design was implemented in which quantitative data was collected with standardized instruments, including a Mental Health Inventory-38, a simple screening instrument for substance abuse (SSI-SA), and Brief Coping-28 supported by qualitative data. In this study a systematic random sample of 378 participants drawn from various hotspot areas, Besides, 5 core government stakeholders in different level, 20 street based sex workers, and 15 health service providers will be also selected by using available sampling technique for interview and FGD purpose. The pilot study was conducted in Adama town before the actual data collection in October, 2017 using 80 randomly selected street based sex workers. Ethical practices were also strictly followed. The quantifiable data was analyzed using Statistical Package for Social Science (SPSS) version 20, with statistical tools including descriptive statistics, t-test, Pearson correlation, and one way-ANOVA. Data that could not be quantified was described qualitatively using thematic analysis.

The majority of the sex workers reported different kinds of violence while they were working on the streets. A history of childhood sexual abuse was common among this population. The mental health inventory results indicate that out of the total of 378 respondents, 35.4% (134) of sex workers were psychologically distressed. Among the dimensions of mental health index, depression, anxiety and loss of behavioral/emotional state was observed respectively. In addition, using a simple screening

instrument for substance abuse, more than 75.1 % of the samples met the criteria for substance abuse. The crosstab result shows that even higher prevalence of psychological distress and substance abuse disorder was found among divorced, illiterates, lower income, rural born, adolescence and sex workers who had a forensic history.

To understand the determinant factors for street based commercial sex worker, self-developed closed ended questionnaire were presented for respondents. The result shows that out of 378 sex workers, peer pressure (95%),to improve personal and family life situation (92%), poverty and poor life situation of the families (88%), to search for better life and better paying job (83.8%), to failure to succeed in educational endeavors (80%), unemployment (72%), to get initial capital to start a business (68%), success of others (48%), failed marriage (31.7%) and other reasons (1.85%) were highly reported major factors for joining street based commercial sex worker respectively.

In this study, various risk factors for developing psychosocial problem were reported by street based sex workers, police officers and other key informants regarding to various kinds of violence and inhuman treatment that sex workers are always suffering with. These include forced self-degrading type of sex by clients, forced sex at knifepoint, physical assault, robbery, forced sex with multiple individuals at the same time. Sometimes clients refuse to pay for the service they received, insulting, some take them to an unknown place and torture them for more than 3 days while doing anything they want to them, and some injure them while they drunk

Regarding to the association between mental health conditions and demographic variables, the independent sample t-test result shows that birth place ($t(376) = -21.742$, $p < 0.05$), childhood sexual abuse ($t(376) = -21.747$, $p < 0.05$) and forensic history ($t(376) = -21.265$, $p < 0.05$) had a statistically significant effect on mental health index of sex workers. Correspondingly, the ANOVA result depicted that age, educational status, average monthly income and parent's living arrangement had a statistically significant effect on mental health index of street based sex workers.

Pearson correlation coefficient result show that there was **a** moderate negative correlation between length of stay on street sex work and mental health ($r = -0.542$, $p<0.05$). This means the longer street based sex workers stayed in street sex work was correlated the greater the severity of psychological distress. Also, there was a moderate positive correlation between length of stay in street sex work

and prevalence of substance abuse (r = 0.632, p< .05). This means the longer street based sex workers stayed in street sex work were correlated with the greater the severity of their substance abuse. In addition, strong negative correlation between mental health score and substance abuse (r = --0.742, p < 0.05) were observed. This means that a lower mental health index score was correlated with a higher substance abuse scores.

With regard to the coping mechanism, the most frequently used adaptive coping mechanism by the sex workers were acceptance and religion respectively. In addition, instrumental support, emotional support, planning, positive reframing, active coping and homer were also repeatedly reported adaptive coping mechanisms by sex workers in their due order. Concurrently, the most frequently used maladaptive coping mechanism by the sex workers were self-blame and substance use. Along with this, venting, Self-distraction, denial, behavioral disengagement were highly reported maladaptive coping mechanism by street based sex workers respectively.

6.2 Conclusion

The main purpose of this study was to investigate the determinant factors for the mental health problems of street-based female sex workers in Addis Ababa, Ethiopia. With mixed approach design both quantitative and qualitative data were collected and analyzed using descriptive and inferential statistics. The following conclusions can be drawn:

- The general lifetime prevalence of psychological distress among street based sex workers was 35.4%. Among the dimensions of mental health index, depression, anxiety and loss of behavioral/emotional state was observed respectively. In addition, nearly three fourth of sex workers reported high risk of substance abuse.
- Even higher prevalence of psychological distress and substance abuse disorder was found among divorced, illiterates, lower income, rural born, adolescence and sex workers who had a forensic history.
- The present study tried to investigate the determinant factors for engaging for street based commercial sex worker. The result shows that peer pressure, to improve personal and family life situation, poverty and poor life situation of the families, to search for better life and better paying job, to failure to succeed in educational endeavors, unemployment, to get initial capital to start a business, success of others, failed marriage and other reasons were highly reported major multifaceted determinant factors for joining street based commercial sex worker.
- Many of the female street-based sex workers who participated in this study reported complex histories of trauma, and the majority reported experiencing work-related violence. Mental health problems were prevalent, and history of childhood sexual abuse among this population is very common.
- In this study, various risk factors for developing psychosocial problem were reported by street based sex workers, police officers and other key informants regarding to various kinds of violence and inhuman treatment that sex workers are always suffering with. These include forced self-degrading type of sex by clients, forced sex at knifepoint, physical assault, robbery, forced sex with multiple individuals at the same time. Sometimes clients refuse to pay for the service they received, insulting, some take them to an unknown place and torture them for more than 3 days while doing anything they want to them, and some injure them while they drunk.

- The result of this study shows that place of birth, forensic history, childhood history of sexual abuse, age, educational status, average monthly income and parent's living arrangement had a statistically significant effect on mental health index of street based sex workers.
- This study also tried to examine if there was a relationship among length of stay, mental health index and substance abuse symptoms one with the other. The relationship between length of stay in sex work and there was a moderate negative correlation between length of stay on street sex work and mental health index. This means the longer street based sex workers stayed in street sex work was correlated the greater the severity of psychological distress. In addition, there was a moderate positive correlation between length of stay in street sex work and prevalence of substance abuse. This means the longer street based sex workers stayed in street sex work were correlated with the greater the severity of their substance abuse

- The current study tried to scrutinize the relationships between mental health and substance abuse. The result shows that there was strong negative correlation between mental health index score and substance abuse. This means that a lower mental health index score was correlated with a higher substance abuse scores.
- The most frequently used adaptive coping mechanism by the sex workers were acceptance and religion respectively. In addition, instrumental support, emotional support, planning, positive reframing, active coping and homer were also repeatedly reported adaptive coping mechanisms by sex workers in their due order. Concurrently, the most frequently used maladaptive coping mechanism by the sex workers were self-blame and substance use. Along with this, venting, Self-distraction, denial, behavioral disengagement were highly reported maladaptive coping mechanism by street based sex workers respectively

6.3 Limitations of the Study

In conducting this study, the usage of a structured instrument, trained data collectors and supervised field workers to collect data from randomly selected street female sex workers decreases the likelihood of the occurrence of bias in the study. This study has three limitations.

- The first limitation of this study was related to the generalizability of the results. Those findings in this study were specific to low-income Ethiopian and African women exposed to various kinds of suffering in the work area and thus might not be applied to populations which differ in demographic characteristics; ethnicity, race, socio economic status, type of trauma exposure, culture, societal attitude, stigmatization, type of drugs they use, and the support they receive from police following violence.
- The second limitation was determining the total population and sampling. The current study depends on the report of base line assessment of sex workers in Addis Ababa, which was done back in 2014. However, due to many local and global economic changes the life situation now more complicated for the low-income earner societies in recent years. Therefore, for the last six year its expected increase on the number of street based sex workers.
- The third limitation was due the sensitive nature of studying this population (conducting research about such stigmatized and disrespected type of work) and the complex research methodological challenges specially sampling techniques, most of similar researches were computed using descriptive statistics. Therefore, the current researcher found it difficult to compare the current quantifiable findings with other similar studies. This can limit the generalizability of the current study findings. Similar researches with inferential statistics should be done in the future.

6.4 Recommendations

Following the above conclusion, the researcher has forwarded the following major recommendations to the concerned bodies, to see improved the psychosocial and quality of life among street based sex workers.

- Mental health service providers shall consider in diagnosing and treating psychological distress among sex workers. The psychosocial service shall be taken place in all sub cities in Addis Ababa.
- All concerned governmental, non-governmental and civil society stakeholders shall work hand in hand to improve the sex workers' mental health problem.
- Agencies shall address the mental health issues among street-based sex workers, particularly psychological distress and substance abuse. They should also be aware of the potential existence of trauma histories among street-based sex workers, especially child sexual abuse.
- Mental health care should be advocated for this population and special care should be given to those who were sexually abused at childhood period.
- Various GO's and NGO's who are working directly with sex workers shall deliver psychosocial support including psychotherapy for substance abuse. Side by side, since poverty is one of the reasons to turn to street sex work, GO's and NGO's should offer and promote education and training. These may include basic knowledge such as writing and reading, vocational training, home economics, life skills training programs shall be established that target empowering these women, by providing funding for them to start working outside the sex service area.
- Agencies should work to reduce the stigma and discrimination these women are suffering from which may help them at least reduce the level of psychological distress and may them develop enough sense of their worth that they can work with a mental health professional to improve their life.
- Agencies who are interested to work in changing the lives of this population shall go down to their work place and persuade them to join their programs. That would increase the awareness of sex workers about the possibility of setting assistance to leave sex work.

- For those who continue doing sex work, police and women affair shall work together with other agencies to reduce the level of violence and make their working situation safer, as they are part of the community.
- Mental health professionals, NGO and GO workers who are working with street based sex workers should display their respect for the identity of sex workers and avoid any sign of stigma, to meet their goals in assisting them.
- The researcher noticed family breakdown by death or divorce seems to create an emotional burden for children that is a factor later in them choosing to do sex work. Therefore, community, government, NGO's, local traditional institutions, and other agencies throughout the country should look to assist those children who have lost their parents before they go out on the streets. In addition, bringing awareness about the causes, risk factors, and consequences of child sexual abuse in both rural and urban communities is vital to reducing the incidence of girls later becoming sex workers.

Reference

Amanda, R. Louisa, D. & Jan C. (2006). Posttraumatic stress disorder among Female Street based sex workers in the greater Sydney area, Australia: Biomed central psychiatry.

Amanda, R., Louisa, D. Briony, L., & Jan, C. (2005). Mental health, drug use, and risk among female street-based sex workers in greater Sydney: NDARC Technical Report, No, 237.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders: (4th ed.). Washington, DC

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders: (4th ed.). Text Revision. Washington, DC.

Bagley, C., & Young, L. (1987). Juvenile prostitution and child sexual abuse: A controlled study. *Canadian Journal of Community Mental Health*, *6,* 5–26.

Berelowitz, S.m Firmin, C., Edwards, G. and Gulvurtlu, S. (2012) *"I thought I was the only one. The only one in the world." The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups – Interim Report*. London: The Office of the Children's Commissioner.

Bethelehem, T. (2007). Poverty and the Social Context of Sex Work in Addis Ababa: Forum for social studies.

Betsy, L. (2010). Trauma Symptomatology in Female Sex Workers: A Review of Recent Literature. School of Professional Psychology, 132.

Binghamtom, NY: The Haworth Maltreatment & Trauma Press.

Boyle, F., Glennon, S., Najman,J., Turrel, G., Weatern, J., & Wood, C. (1997b). Psychological distress among female sex workers. Australian, New Zealand Journal of Public Health, 21(6), 643-646

Brewis, J., &Linstead, S. (2000). The worst thing is the screwing. 1: Consumption and the management of identity in sex work. *Gender, Work, and Organization*, *7,* 84 96.

Buttram, M., Surratt, H., and Kurtz, S. (2014). Resilience and syndemic risk factors among African-American female sex workers. Psychology, health and medicine, 19(4), 442-452.

Chudakov B, Ilan K, Belmaker RH, Cwikel J. The motivation and mental health of sex workers. *J Sex Marital Ther* (2002) 305–15. doi:10.1080/00926230290001439

Chudakov Host,L. (1999). Assaults against Queensland Sex Workers: A situational Prevention Analysis. Unpublished Mastersthesis, GrifiithUniversity

Clark SC.(2000) Work/Family Border Theory: A New Theory of Work/Family Balance. HumanRelations. 53(6):747–70.

Cusick L, Martin A, May T. Vulnerability and involvement in drug use and sex work. London: Home Office, 2003.

Davis, J. (2004) *off the streets: Tackling homelessness among female street-based sex workers.* 21 London: Shelter.

El-Bassel N, Schilling RF, Irwin KL, Faruque S, Gilbert L, Von Bargen J, Serrano Y, Edlin BR. Sex trading and psychological distress among women recruited from the streets of Harlem. *Am J Public Health*. 1997;87(1):66-70.

El-Bassel N, Witte SS, Wada T, Gilbert L, Wallace J. Correlates of partner violence among female street-based sex workers: substance abuse, history of childhood abuse, and HIV risks. *AIDS Patient Care STDS*. 2001;15(1):41-51.

Family Health International (FHI). (2002). Mapping and census of female sex workers in Addis Ababa, Ethiopia.

Farley M, Cotton A, Lynne J, Zumbeck S, Spiwak F, Reyes ME, Alvarez D, Sezgin U. Prostitution and trafficking in nine countries: an update on violence and posttraumatic stress disorder. In: Farley M, ed. *Prostitution, Trafficking, and Traumatic Stress.* New York, NY: Haworth Maltreatment & Trauma Press; 2003:33-74.

Farley, M. & Barkan, H. (1998). Prostitution, violence, and posttraumatic stress disorder. Women and Health, 27:37-49.

Farley, M., Baral, I., Kiremire, M., &Sezgin, U. (1998). Prostitution in five countries: Violence and post-traumatic stress disorder. *Feminism and Psychology*, *8,* 405 426.

Farley, M., Cotton, A., Lynne, J., Zumbeck, S., Spiwak, F., Reyes, M. E., et al. (2003). Prostitution and trafficking in nine countries: An update on violence and posttraumatic stress disorder. Prostitution, Trafficking, and Traumatic Stress (pp.33--74).

Farley,M., and Barkan,H. (1998) .prostitution, violence, and posttraumatic stress disorder. Women and Health,27(3),37-49

Garofalo Geymonat, G., and Macioti, PG. (2016). Ambivalent Professionalisation and Autonomy in Workers' Collective Projects: The Cases of Sex Worker Peer Educators in Germany and Sexual Assistants in Switzerland. Sociological Research Online, 21(4),

Geetha, S., Allen, F., & Aylur, K. S. (2009). An Assessment of the Mental Health of Street Based Sex Workers in Chennai, India. Journal of Contemporary Criminal Justice, 25, 186-201. Doi:10.1177/1043986209333590.

Gilchrist G, Gruer L, Atkinson J. Comparison of drug use and psychiatric morbidity between prostitute and non-prostitute female drug users in Glasgow, Scotland. *Addict Behav*. 2005;30(5):1019-1023.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Harcourt, C. and Donovan, B, (2005) The many faces of sex work, *Sex Tansm Infect*, 81: 201 206.

Hersen, M., Turner, S. M., & Beidel, D. c. (2007). Adult Psychopathology and Diagnosis:(5th ed). New Jersey: John Wiley & Sons, Inc.

Hutton HE, Lyketsos CG, Zenilman JM, Thompson RE, Erbelding EJ. Depression and HIV risk behaviors among patients in a sexually transmitted disease clinic. Am J Psychiatry 2004; 161:912–914.

Jullan, D. F. (2009). Posttraumatic stress disorder science and practice. United kingdom: Elsevier Inc.

Jung, Y. E., Song, J. M., Chong, J., Seo, H. J., & Chae, J. H. (2007). Symptoms of posttraumatic stress disorder and mental health in women who escaped prostitution and helping activists in shelters. Yonsei Med J, 49(3), 372--382

Jung Y, Song J, Chong J, et al. Symptoms of post-traumatic stress disorder and mental health in women who escaped prostitution and helping activists in shelters. Yonsei Med. J. 2008; 49(3):372–82.

1. Kenneth, J. R., Kevin, D. B., Joseph, R. S. & Aline, E. R. (2003) Psychometric Properties of the PTSD Checklist-Civilian Version: Journal of Traumatic Stress, 16(5), 495 502.
2. Kevin, L. (2000). The Victimization of Juvenile Prostitutes in Ethiopia, International Social Work, 43 (2), 227-242.

Knight, J. R., Goodman, E., Pulerwitz, T., Durant, R. H. (2000). Reliabilities of short substance abuse screening tests among adolescent medical patients. Pediatrics, 105, 948-953.

Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. Educational and psychological measurement, 30, 607-610.

Lemma, A. (1997). Introduction to psychopathology: London: Alessandra SAGE Publications.

Lindert, J., Brähler, E., Wittig, U., Mielck, A.,& Priebe, S.(2008)Depression, anxiety and posttraumatic stress disorders in labor migrants, asylum seekers and refugees. A systematic overview.*PsychotherPsychosom Med Psychol.* 2008 Mar-Apr;58(3 4):10 22. doi: 10.1055/s- German 2008-1067358.

Margaret, H., Pam, N. & Emma, K. (2011). Risk and Risk Management for Australia Sex Workers. Quality health press, 21, 386.

Mark, J. H. & Daniel L. S. (2004). Comprehensive handbook of psychological assessment: New Jersey: John Wiley & Sons, Inc.

Miller,J.,&Schwartz,M.(1995).Rape myths & violence against street prostitutes. Deviant Behavior: An interdisciplinary Journal,16(1-23).

Milman,J(1980). New Rules for the oldest profession: should we change the laws? HrvardWomens Law Journal,3,1-82

Monica, U. Shirley, J. S., Swati, R., Steffanie, A. S., Miguel, A. F., Jesus, B.,…Thomas, L. P. (2009). History of Abuse and Psychological Distress Symptoms among Female Sex Workers in Two Mexico-U.S. Border Cities. NIH public access, Violence Vict. 2009; 24(3): 399–413.

Mroczek and Almeida (22). This possibility also implies that the risk for a mental disorder increases with the period of time that someone has been part of thisindustry.

Mroczek DK, Almeida DM. The effect of daily stress, personal-ity, and age on daily negative affect. *J Pers* (2004) **72**(2):355–78. doi:10.1111/j.0022 3506.2004.00265.

Nixon, K., Tutty, L., Downe, P., Gorkoff, K., & Ursel, J. (2002). The everyday occurrence: Violence in the lives of girls exploited through prostitution. Violence against Women, 8, 1016-1043.

Paul, B. (2006). Abnormal and Clinical psychology an introductory textbook: (2nd ed). England: Open University press.

Priscilla A. (1998). Sex Work & Health: A Question of Safety in the Workplace. JAMWA, 53, 2.

Pyett,P.,&Warr,D.(1999). Women at risk in sex work: strategies for survival. Journal of sociology,35(2),183-197

Qing, L. Xiaoming, L. & Bonita, S. (2010). Alcohol Use among Female Sex Workers and Male Clients: An Integrative Review of Global Literature, 45, 188–199.

Rachel, J. S. (2008). Predicting comorbid ptsd & depression over time among victims of intimate partner violence. UMI microform. 315905

Raymond, W. L., Erin, E. M., & Richard, P. S. (2005). Assessment Scales in Depression Mania and Anxiety: United Kingdom: Taylor & Francis Group.

Romans SE, Potter K, Martin J, Herbison P. The mental and physical health of female sex workers: a comparative study. *Aust N Z J Psychiatry* (2001) 75–80. doi:10.1046/j.1440-1614.2001.00857.x

Rössler W, Koch U, Lauber C, Hass AK, Altwegg M, Ajdacic-Gross V, et al. The mental health of female sex workers. *Acta Psychiatr Scand* (2010) **122**(2):143–52. doi:10.1111/j.1600-0447.2009.01533.x

Roxburgh A, Degenhardt L, Copeland J. Posttraumatic stress disorder among female street-based sex workers in the greater Sydney area, Australia. *BMC Psychiatry*. 2006;6:24.

Roxburgh A, Degenhardt L, Copeland J. Posttraumatic stress disorder among female street-based sex workers in the greater Sydney area, Australia. BMC Psychiatry 2006;6:24.

Sagtani RA, Bhattarai S, Adhikari BR, Baral D, Yadav DK, Pokharel PK. Violence, HIV risk behaviour and depression among female sex workers of eastern Nepal. *BMJ Open* (2013) e002763.

Sanders T.(2005) 'It's Just Acting': Sex Workers' Strategies for Capitalising on Sexuality. Gender, Work and Organisation. 12(4):319–41.

Surratt H, Kurtz S, Weaver J, Inciardi J. The connections of mental health problems, violent life experiences, and the social milieu of the ‘‘stroll’’ with the HIV risk behaviors of female street sex workers. Journal of Psychology & Human Sexuality 2005;17:23–44.

Sussman, S. & Ames, S.L. (2008). Drug abuse concept, prevention, and cessation: United States of America: Cambridge University press.

Tara, S. B., Parinita, B., Ramesh, B. M., Vandana, G., John, A., Shajy, I.,… Stephen, M. (2010). Violence against female sex workers in Karnataka state, south India: impact on health, and reductions in violence following an intervention program. Biomed central public health. 10:476.

Vanwesenbeeck (21), who stressed that substance use appears to be a causal risk factor forsex work only in specific subgroups of street-working FSW, such as homeless youths, but not in other FSW subgroups.

Vanwesenbeeck I. Another decade of social scientific work on sex work: a review of research 1990-2000. *Annu Rev Sex Res* (2001) **12**:242–89.

Vanwesenbeeck, I. (1994). *Prostitutes' well being and risk*. Amsterdam: VU University Press.

Vanwesenbeeck, I., de Graaf, R., van Zessen, G., Straver, C. J., &Visser, J. H. (1995). Professional HIV risk taking, levels of victimization,

Ward, H., Day, S., &Weber,J. (1999). Risky business: Health and safety in the sex industryover a 9 year period. Sexually Transmitted Infections,75(5),340-343.

Wong S. What are the mental health seeking behaviors of female sex workers [dissertation]. Northampton, MA: Smith College School for social work; 2009.

Warr DJ, (1999) Pyett PM. Difficult Relations: Sex Work, Love and Intimacy. Sociology of Health and Illness. 21(3):290–309.

Yacoubian GS, Urbach JB, Larsen KL, et al. A comparison of drug use between prostitutes and other female arrestees. J Alcohol Drug Educ. 2002;46(2):12–25.

Yemataw, W. Workie, Z., Biruk, T., Konrad, R., & Harry, S. (2011). The psychosocial consequence of child sexual abuse in ethiopia: a case-control comparative analysis. Journal of interpersonal violence, 26(10), 2025-2041.

Appendices A
English Version

ADDIS ABABA UNIVERSITY

DEPARTMENT OF SOCIAL WORK

POST GRADUATE PROGRAM IN SOCIAL WORK

General information

This questionnaire is designed to assess determinant factors for the psychosocial problems among Addis Ababa female street-based sex workers. The instrument has four sections. Section one is about the demographic variables concerning participants. In the second section, Mental Health Inventory - 38 (MHI – 38) is used to assess the most commonly observed mental health problems among Addis Ababa female street-based sex workers. In the third section, Simple Screening Instrument for Substance Abuse (SSI-SA) is used for assessing the practice of substance dependency. Finally, Brief Cope-28 is employed to assess the most commonly used coping mechanisms. As a result, you are kindly requested to give your truthful responses to each item of the questionnaire. Hence, your answers will be kept confidentially and would be used only for research purpose. To maintain anonymity, you are not required to write your name.

Thank you Very Much for your cooperation!!

By: Fasil Getachew

Appendix One

Background Information

Instruction: below is a list of questions which checks participants' demographic characteristics, please read each one carefully and respond the right answer which represents you. Put (√) symbol for questions with box choice.

1. Age _____
2. Marital status ☐ married ☐ Divorced
   ☐ Single ☐ Widowed
3. Educational status ☐ Illiterate
   ☐ Elementary school
   ☐ Secondary school
   ☐ College/ university
4. Ethnicity _____
5. Place of origin _____
6. Average household income in birr _____
7. Family situation
   ☐ Father and mother live together ☐ Mother passed away
   ☐ Father and mother divorced ☐ Both passed away
   ☐ Father passed away

8. Onset _____
9. Length of time working as a sex worker _____
10. In your childhood, has anyone abused you sexually?

    Yes ☐ No ☐

11. If your answer is YES, how old you were that time? _____
12. If your answer is "yes" for question 12, how many times you got abused? _____
13. If your answer is "yes", for question 12, who was the abuser? _____
14. Ever-experienced violence while working?

    Yes ☐ No ☐

15. If your answer is yes, mention the type of violence you frequently experiencing

    _____

    _____

    _____

16. Ever reported these incidents to police?

    Yes ☐ No ☐

Appendix TWO

Mental Health Inventory (MHI-38)

Instruction: Please read each question and tick the box by the one statement that best describes how things have been for you during the past month. There are no right or wrong answers.

1. How happy, satisfied, or pleased have you been with your personal life during the past month? (Tick one)
   - 1□ Extremely happy, could not have been more satisfied or pleased
   - 2□ Very happy most of the time
   - 3□ Generally, satisfied, pleased
   - 4□ Sometimes fairly satisfied, sometimes fairly unhappy
   - 5□ Generally dissatisfied, unhappy
   - 6□ Very dissatisfied, unhappy most of the time
2. How much of the time have you felt lonely during the past month? (Tick one)
   - 1□ All of the time
   - 2□ Most of the time
   - 3□ A good bit of the time
   - 4□ Some of the time
   - 5□ A little of the time
   - 6□ None of the time
3. How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month? (Tick one)
   - 1□ Always
   - 2□ Very often
   - 3□ Fairly often
   - 4□ Sometimes
   - 5□ Almost never
   - 6□ Never
4. During the past month, how much of the time have you felt that the future looks hopeful and promising? (Tick one)
   - 1□ All of the time
   - 2□ Most of the time
   - 3□ A good bit of the time
   - 4□ Some of the time
   - 5□ A little of the time
   - 6□ None of the time
5. How much of the time, during the past month, has your daily life been full of things that were interesting to you? (Tick one)
   - 1□ All of the time
   - 2□ Most of the time
   - 3□ A good bit of the time
   - 4□ Some of the time
   - 5□ A little of the time
   - 6□ None of the time
6. How much of the time, during the past month, did you feel relaxed and free from tension? (Tick one)
   - 1□ All of the time
   - 2□ Most of the time
   - 3□ A good bit of the time
   - 4□ Some of the time
   - 5□ A little of the time
   - 6□ None of the time
7. During the past month, how much of the time have you generally enjoyed the things you do? (Tick one)
   - 1□ All of the time
   - 2□ Most of the time
   - 4□ Some of the time
   - 5□ A little of the time

3□ A good bit of the time 6□ None of the time

8. During the past month, have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? (Tick one)
   1□ No, not at all
   2□ Maybe a little
   3□ Yes, but not enough to be concerned or worried about
   4□ Yes, and I have been a little concerned
   5□ Yes, and I am quite concerned
   6□ Yes, I am very much concerned about it
9. Did you feel depressed during the past month? (Tick one)
   1□ Yes, to the point that I did not care about anything for days at a time
   2□ Yes, very depressed almost every day
   3□ Yes, quite depressed several times
   4□ Yes, a little depressed now and then
   5□ No, never felt depressed at all
10. During the past month, how much of the time have you felt loved and wanted? (Tick one)
   1□ All of the time 4□ Some of the time
   2□ Most of the time 5□ A little of the time
   3□ A good bit of the time 6□ None of the time
11. How much of the time, during the past month, have you been a very nervous person? (Tick one)
   1□ All of the time 4□ Some of the time
   2□ Most of the time 5□ A little of the time
   3□ A good bit of the time 6□ None of the time
12. When you have got up in the morning, this past month, about how often did you expect to have an interesting day? (Tick one)
   1□ Always 4□ Sometimes
   2□ Very often 5□ Almost never
   3□ Fairly often 6□ Never
13. During the past month, how much of the time have you felt tense or “high-strung”? (Tick one)

   1□ All of the time 4□ Some of the time

   2□ Most of the time 5□ A little of the time

   3□ A good bit of the time 6□ None of the time

14.During the past month, have you been in firm control of your behaviour, thoughts, emotions or feelings? (Tick one)

   1□ Yes, very definitely 4□ No, not too well
   2□ Yes, for the most part 5□ No, and I am somewhat disturbed
   3□ Yes, I guess so 6□ No, and I am very disturbed

15. During the past month, how often did your hands shake when you tried to do something? (Tick one)

1□ Always
2□ Very often
3□ Fairly often
4□ Sometimes
5□ Almost never
6□ Never

16. During the past month, how often did you feel that you had nothing to look forward to? (Tick one)

1□ Always
2□ Very often
3□ Fairly often
4□ Sometimes
5□ Almost never
6□ Never

17. How much of the time, during the past month, have you felt calm and peaceful? (Tick one)

1□ All of the time
2□ Most of the time
3□ A good bit of the time
4□ Some of the time
5□ A little of the time
6□ None of the time

18. How much of the time, during the past month, have you felt emotionally stable? (Tick one)

1□ All of the time
2□ Most of the time
3□ A good bit of the time
4□ Some of the time
5□ A little of the time
6□ None of the time

19. How much of the time, during the past month, have you felt downhearted and blue? (Tick one)

1□ All of the time
2□ Most of the time
3□ A good bit of the time
4□ Some of the time
5□ A little of the time
6□ None of the time

20. How often have you felt like crying, during the past month? (Tick one)

1□ Always
2□ Very often
3□ Fairly often
4□ Sometimes
5□ Almost never
6□ Never

21. During the past month, how often have you felt that others would be better off if you were dead? (Tick one)

1□ Always
4□ Sometimes

2□ Very often 5□ Almost never

3□ Fairly often 6□ Never

22. How much of the time, during the past month, were you able to relax without difficulty? (Tick one)

1□ All of the time 4□ Some of the time

2□ Most of the time 5□ A little of the time

3□ A good bit of the time 6□ None of the time

23. How much of the time, during the past month, did you feel that your love relationships, loving and being loved, were full and complete? (Tick one)

1□ All of the time 4□ Some of the time

2□ Most of the time 5□ A little of the time

3□ A good bit of the time 6□ None of the time

24. How often, during the past month, did you feel that nothing turned out for you the way you wanted it to? (Tick one)

1□ Always 4□ Sometimes

2□ Very often 5□ Almost never

3□ Fairly often 6□ Never

25. How much have you been bothered by nervousness, or your "nerves", during the past month? (Tick one)

1□ Extremely so, to the point 4□ Bothered some, enough to notice

where I could not take care of things

2□ Very much bothered 5□ Bothered just a little by nerves

3□ Bothered quite a bit by nerves 6□ Not bothered at all by this

26. During the past month, how much of the time has living been a wonderful adventure for you? (Tick one)

1□ All of the time 4□ Some of the time

2□ Most of the time 5□ A little of the time

3□ A good bit of the time 6□ None of the time

27. How often, during the past month, have you felt so down in the dumps that nothing could cheer you up? (Tick one)

1□ Always 4□ Sometimes

2□ Very often 5□ Almost never

3□ Fairly often 6□ Never

28. During the past month, did you think about taking your own life? (Tick one)

1□ Yes, very often

2□ Yes, fairly often

3□ Yes, a couple of times

4□ Yes, at one time

5□ No, never

29. During the past month, how much of the time have you felt restless, fidgety, or impatient? (Tick one)

1□ All of the time 4□ Some of the time

2□ Most of the time 5□ A little of the time

3□ A good bit of the time 6□ None of the time

30. During the past month, how much of the time have you been moody or brooded about things? (Tick one)

1□ All of the time 4□ Some of the time

2□ Most of the time 5□ A little of the time

3□ A good bit of the time 6□ None of the time

31. How much of the time, during the past month, have you felt cheerful, lighthearted? (Tick one)

1□ All of the time 4□ Some of the time

2□ Most of the time 5□ A little of the time

3□ A good bit of the time 6□ None of the time

32. During the past month, how often did you get rattled, upset or flustered? (Tick one)

1□ Always 4□ Sometimes

2□ Very often 5□ Almost never

3□ Fairly often 6□ Never

33. During the past month, have you been anxious or worried? (Tick one)

1□ Yes, extremely to the point of being sick or almost sick

2□ Yes, very much so 5□ Yes, a little bit

3□ Yes, quite a bit

4□ Yes, some, enough to bother me

6□ No, not at all

34. During the past month, how much of the time were you a happy person? (Tick one)

1□ All of the time

2□ Most of the time

3□ A good bit of the time

4□ Some of the time

5□ A little of the time

6□ None of the time

35. How often during the past month did you find yourself trying to calm down? (Tick one)

1□ Always

2□ Very often

3□ Fairly often

4□ Sometimes

5□ Almost never

6□ Never

36. During the past month, how much of the time have you been in low or very low spirits? (Tick one)

1□ All of the time

2□ Most of the time

3□ A good bit of the time

4□ Some of the time

5□ A little of the time

6□ None of the time

37. How often, during the past month, have you been waking up feeling fresh and rested? (Tick one)

1□ Always, every day

2□ Almost every day

3□ Most days

4□ Some days, but usually not

5□ Hardly ever

6□ Never wake up feeling rested

38. During the past month, have you been under or felt you were under any strain, stress or pressure? (Tick one)

1□ Yes, almost more than I could stand or bear

2□ Yes, quite a bit of pressure

3□ Yes, some more than usual

4□ Yes, some, but about normal

5□ Yes, a little bit

6□ No, not at all .

Appendix THREE

Simple Screening Instrument for Substance Abuse (SSISA)

Instruction: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you using "√ ''. Answer the questions in terms of your experiences in the past 6 months. In this study the term alcohol represents all types of alcohol but the term drug represents cigarette, cannabis, shisha, and khat.

During the last 6 months

NO	Question	YES	NO
1	Have you used alcohol or other drugs?		
2	Have you felt that you use too much alcohol or other drugs?		
3	Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4	Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		
5	Have you had any health problems? For example, have you:		
5.a	Had blackouts or other periods of memory loss?		
5.b	Injured your head after drinking or using drugs?		
5.c	Had convulsions, delirium tremens ("DTs")?		
5.d	Had hepatitis or other liver problems?		
5.e	Felt sick, shaky, or depressed when you stopped?		
5.f	Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?		
5.g	Been injured after drinking or using?		
5.h	Used needles to shoot drugs?		
6	Has drinking or other drug use caused problems between you and your family or friends?		
7	Has your drinking or other drug use caused problems at school or at work?		
8	Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)		

9	Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10	Are you needing to drink or use drugs more and more to get the effect you want?		
11	Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12	When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?		
13	Do you feel bad or guilty about your drinking or drug use?		
14	Have you ever had a drinking or other drug problem?		
15	Have any of your family members ever had a drinking or drug problem?		
16	Do you feel that you have a drinking or drug problem now?		

Appendix FOUR

Brief coping scale

Instruction:This part is about your cope mechanisms with the stress in your life. Please read each item carefully and respond by writing a √ mark on the place provided. Choose one of the following where

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

No	Questions	**1**	**2**	**3**	**4**
1	I've been turning to work or other activities to take my mind off things.				
2	I've been concentrating my efforts on doing something about the situation I'm in.				
3	I've been saying to myself "this isn't real."				
4	I've been using alcohol or other drugs to make myself feel better.				
5	I've been getting emotional support from others.				
6	I've been giving up trying to deal with it.				
7	I've been taking action to try to make the situation better.				
8	I've been refusing to believe that it has happened.				
9	I've been saying things to let my unpleasant feelings escape.				
10	I've been getting help and advice from other people.				
11	I've been using alcohol or other drugs to help me get through it.				
12	I've been trying to see it in a different light, to make it seem more positive.				
13	I've been criticizing myself.				
14	I've been trying to come up with a strategy about what to do.				
15	I've been getting comfort and understanding from someone.				
16	I've been giving up the attempt to cope.				
17	I've been looking for something good in what is happening.				
18	I've been making jokes about it.				
19	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				

20	I've been accepting the reality of the fact that it has happened.				
21	I've been expressing my negative feelings.				
22	I've been trying to find comfort in my religion or spiritual beliefs.				
23	I've been trying to get advice or help from other people about what to do.				
24	I've been learning to live with it.				
25	I've been thinking hard about what steps to take.				
26	I've been blaming myself for things that happened.				
27	I've been praying or meditating.				
28	I've been making fun of the situation				

Appendix FIVE

Question for key informants

Instruction: you are kindly requested to respond the fact that you witnessed or heard about street-based sex workers real experience, and for the choice questions please put this symbol(√).

1. Do you think street sex workers at risk for violence during work time, particularly physical, emotional, and sexual abuses?

   Yes ☐ NO ☐

2. If yes, mention some of the type of violence that you noticed _____

   _____

   _____

3. For question no 1, who are frequently assumed to be the abusers?

   _____

   _____

   _____

4. Do you think street sex workers are suffering from psychological disorders?

   Yes ☐ NO ☐

5. If yes, can you give us your opinion why they develop psychological disorder from your understanding?

   _____

   _____

   _____

6. Do you think street sex workers often use substances (drugs and alcohol) as part of their daily life?

   Yes ☐ NO ☐

7. If yes, please mention what kind substance frequently used

   _____

   _____

   _____

8. Anything you want to say about street sex workers

   _____

   _____

   _____

Appendix SIX

Interview Guide for Street-based Sex Workers

The interview guide for participants has four parts and a total of twelve items. The interview guide is open-ended, thereby allowing for participants to freely tell their stories.

- **Interview guide Part I**
  - ✓ Could you tell me your age, religion and rigon
  - ✓ What were your educational background, marital status and employment status before joining this career, and your current status?
  - ✓ Tell me about your family situation. Are they living together? What do you say about their income?
- **Interview guide Part II**
  - ✓ Tell me about your reason to join in this career: who was involved in assisting you to join this career?
  - ✓ What do you think about the determinant factors for street based sex workers?
- **Interview guide Part III**
  - ✓ Tell me about your work experience in detail.
  - ✓ Tell me the determinant factors that amplify the level of psychosocial problems of street based sex workers
  - ✓ Tell me about your typical experience in the history of your career life with your customers.
  - ✓ Tell me any challenges and advantages you have experienced during your job.
- **Interview Guide Part IV**
  - ✓ What were your expectations before you join in this career? What actually did happen?
  - ✓ What is your advice to potential street-based sex workers?
  - ✓ Can I call you if I need to ask you further questions?

Thank you for your cooperation!!!

Appendix SEVEN

Questions for FGD

Discuss and explain the following discussion points based on your groups

1. How do you join this career? Who support you?
2. How do you see the cause street-based sex workers?
3. How you had succeeded in resisting customers' typical demand or coping with?
4. How do you see the status of mental health conditions of street based sex workers?
5. Tell me the typical experiences that expose you for any danger in your career life.
6. What are the determinant factors that amplify the level of psychosocial problems of street based sex workers?
7. What do you think about the attitude of the community towards street based sex workers?
8. Have you used any substance for any purpose? If so, tell me more
9. What kinds of coping mechanism are commonly used by street based sex workers?
10. What do you think about the future?

Appendaix B

Amharic version

በአዲስ አበባ ዩኒቨርስቲ
የድህረምረቃ ትምህርት ፕሮግራም
የሶሻል ወርክ ትምህርት ክፍል

አጠቃላይ መረጃ

ውድ የዚህ ጥናት ተሳታፊዎች የዚህ መጠይቅ ዋና አላማ ጎዳናን መሰረት አድርገው በሚሰሩ የፆታ-ንግድ ተዳዳሪዎች ላይ ከሥራው ጋር በተያያዘ ሊከሰቱ የሚችሉ የሥነልቦናና የማህበራዊ ችግሮች ካለ መፈተሽ ነው፡፡ ከዚህ ጥናት የሚገኘው መረጃ የችግሩ መጠን ምን ያክል እንደሆነ የሚያመላክት ይሆናል፡፡ ጥናቱም ችግሩ በቀጥታ ለሚመለከተው የመንግስትም ሆነ መንግስታዊ ያልሆኑ ድርጅቶች ቀርቦ የመፍትሄ አቅጣጫ ለመቅረፅ ይረዳቸዋል ፡፡ በተጨማሪም የችግሩ ተጠቂዎች በቀጥታም ሆነ በተዘዋዋሪ የጥናቱ ተጠቃሚ ይሆናሉ ተብሎ ይገመታል ፡፡ ጥያቄዎችን በትኩረት አምብቦ ትክክለኛውን መልስ መስጠት የጥናቱን አላማ ከዳር ለማድረስ ይረዳል ፡፡ ለጥያቄዎቹ የሚሰጡት መልስ በሚስጥር የሚያዙና ለጥናቱ አላማ ብቻ የሚውሉ ይሆናሉ፡፡ በዚህ መጠይቅ ውስጥ የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ይሆናል፡፡ ስም መግፍ አያስፈልግም፡፡

ስለ ትብብርዎ በቅድሚያ አመሰግናለሁ !!!

ፋሲል ጌታቸው

የጥናቱ ባለቤት

ተቀፅላ ክፍልአንድ

የግል መረጃዎች

መመሪያ፡- ከዚህ በታች የተዘረዘሩት ጥያቄዎች የዚህ መጠይቅ ተሳታፊዎችን የግል መረጃ የሚዳስሱ ናቸው፡፡ በጥንቃቄ ካነበብሽ በኋላ እኔን ይወክላል ብለሽ የምታስቢውን መልስ ስጭ እንዲሁም ሳጥን ላላቸዉ ጥያቄዎች(√) ምልክት አስቀምጭ ፡፡

1.እድሜ _____

2.የትዳር ሁኔታ

1 አግብቻለሁ ☐ 3 አግብቼ የፈታሁ ☐
2 አላገባሁም ☐ 4 ባሌን በሞት ያጣሁ ☐

3 . የትምህርትደረጃ

1 ምንም ያልተማረች ☐ 3 ሁለተኛ ደረጃ ☐
2 አንደኛ ደረጃ ☐ 4 ኮሌጅ /ዩንቨርሲቲ ☐

4. ብሄር_____

5. የትዉልድ ቦታ ፡- 1 ገጠር ☐ 2 ከተማ ☐

6.አማካኝ የቤተሰቦችሽ የገቢ ደረጃ በወር ብር ----------

7.የቤተሰቦችሽ የአኗኗር ሁኔታ

1 አባትና እናቴ አብረው የሚኖሩ ☐ 4 እናቴ በሞት የተለየች ☐
2 አባትና እናቴ የተፋቱ ☐ 5 ሁለቱም በሞት የተለዩ ☐
3 ☐ቴ በሞት የተለየ

8.ወደ ያታ-ንግድ ተዳዳሪነት ሥራ መቸ ገባሽ ?_____

9.ምን ያህል ጊዜ በያታ-ንግድ ተዳዳሪነት ሥራ ላይ ቆይተሻል ?_____

10.በልጅነትሽየወሲብ ጥቃት ደርሶብሽ ያውቃል ?

1 ☐ አዎ ☐ 2 አልደረሰብኝም

11.መልስሽ አዎ ከሆነ የስንት ዓመት ልጅ እያለሽ ?____

12.ለጥያቄ ቁጥር 12 መልስሽ አዎ ከሆነ ለምን ያህል ጊዜ ?_____

13.ለጥያቄ ቁጥር 12 መልስሽ አዎ ከሆነ ጥቃቱን ማን ነበር ያደረሰብሽ ?_____

14.በወሲብ ንግድ ሥራ ላይ ከገባሽ በኋላ ጥቃት ወይም ወንጀል ተፈፅሞብሽ ያውቃል ?

1 ☐ አ☐ 2 የለም

15.መልስሽ አዎ ከሆነ ምን አይነት ጥቃት ብዙ ግዜ ደረሰብሽ? _____
_____
_____

16. ለፖሊስ ሪፖርት አድርገሽ ታውቂያለሽ ? 1 አዎ ☐ 2 የለም ☐

ተቀፅላ ክፍልሁለት

መመሪያ፡ ከዚህ በታች የተዘረዘሩት ጥያቄዎች የአንችን ከቅርብጊዜ ወዲህ ያለውን የአዕምሮ ጤና ሁኔታ ለመለካት የተዘጋጁናቸው ፡ በጥንቃቄ ካነበብሽ በኋላ ይወክለኛል ብለሽ የምታስቢውን መልስ በማክበብ ምልክት አስቀምጭ ፡

1. ላለፉት ወራቶች በግል ህይወትሽ ምን ያህል ደስተኛ፣ የረካና ህይወት የተስማማውሰው የሆንሽ ያህል ተሰምቶሻል፡ ፡
   1. እጅግ በጣምደስተኛ ነኝ ከዚህ በላይ ደስተኛ የምሆን አይመስለኝም
   2. ብዙ ጊዜ ደስተኛ ነኝ
   3. በአጠቃላይ በግል ህይዎቴ ደስተኛ ነኝ
   4. አልፎአልፎ ደስተኛ ነኝ አልፎአልፎምደስተኛ አይደለሁም
   5. በአጠቃላይ ደስተኛ አይደለሁም
   6. በአጠቃላይ በግል ህይዎቴ በጣምደስተኛ አይደለሁም
2. ላለፉት ወራቶች ለምን ያህል ጊዜ የብቸኝነት ስሜት ተሰምቶሻል፡ ፡
   1. ሁልጊዜ
   2. ለብዙጊዜ
   3. ቀላል ለማይባል ጊዜያቶች
   4. አልፎ አልፎ
   5. ለጥቂት ጊዜያት
   6. የለምተሰምቶኝ አያውቅም
3. ባለፉት ወራቶች አንችን የሚያስደስት ነገር ወይምያልተጠበቀ ሁኔታ ሲያጋጥምሽ ለምን ያህልጊዜ የብስጭት/የመበርገግ ስሜት ተሰምቶሻል፡ ፡
   1. እጅግ በጣም ሁልጊዜ
   2. በጣምብዙጊዜ
   3. ቀላል ለማይባል ጊዜያቶች
   4. አልፎ አልፎ
   5. በጣምበጥቂቱ
   6. በፍፁም
4. ባለፉት ወራቶች ስለ ወደፊቱ ስታስቢ ህይወትሽ ምን ያህል ብሩህና በተስፋ የተሞላ ያህል እንደሆነ ይሰማሻል
   1. ሁልጊዜ
   2. ለብዙጊዜ
   3. ቀላል ለማይባል ጊዜያቶች
   4. አልፎ አልፎ
   5. ለጥቂት ጊዜያት
   6. የለምተሰምቶኝ አያውቅም
5. ባለፉት ወራቶች ለምን ያህልጊዜ የቀንተቀን ህይወትሽ አንችን በሚያስደስቱነገሮች የተሞሉ እንደሆነ ይሰማሻል፡ ፡
   1. ሁልጊዜ
   2. ለብዙጊዜ
   3. ቀላል ለማይባል ጊዜያቶች
   4. አልፎ አልፎ
   5. ለጥቂት ጊዜያት
   6. የለምተሰምቶኝ አያውቅም
6. ባለፉት ወራቶች ለምን ያህል ጊዜ መልካምየሆነ የመዝናናት ስሜት ወይምከጭንቀትሽ ነፃ የሆንሽ ያህል ተሰምቶሻል፡ ፡
   1. ሁልጊዜ
   2. ለብዙጊዜ
   3. ቀላል ለማይባል ጊዜያቶች
   4. አልፎ አልፎ
   5. ለጥቂት ጊዜያት
   6. የለምተሰምቶኝ አያውቅም
7. ባለፉት ወራቶች ለምን ያህል ጊዜ በህይወትሽ በየቀኑ በምትፈፅሚያቸውተግባራት በአጠቃላይ የደስታ ስሜት ተሰምቶሻል፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

8. ላለፉት ወራቶች ከመልካምየአዕምሮ ጤናሽ ውጭ(የእብደት ስሜት)እየሆንሽ እንደሆነ ወይምየምትሰሪውን፣ የምታወሪውን፣ የምታስቢውን፣ የሚሰማሽንና የምታስታውሽውን ለማሰተዋል/ለመቆጣጠር በሞተገርሽ ምክንያት በራስሽ ለመደነቅ ምክንያት አግኝተሽ ታውቂያለሽ፡፡
   1.የለምአላስታውስም
   2.ምናልባት በጥቂቱ
   3.አዎ ግን ያን ያህል አስጨናቂኝ አያውቅም
   4.አዎ የተወሰነ አሳስቦኛል
   5.አዎ ይመለከተኛል
   6.አዎ በጣምይመለከተኛል

9. ባለፉት ወራቶች የድብርት ስሜት ተሰምቶሻል፡፡
   1.አዎ ይደብረኛል እንደውምበወቅቱ ለቀናት ስለምንምነገር ግድ አይሰጠኝምነበር፡፡
   2.አዎ በጣምይደብረኝ ነበር ሁልጊዜ በሚባል ደረጃ (በየቀኑ ይደብረኝ ነበር)
   3.አዎበጣምብዙጊዜይደብረኛል
   4.አዎ በተወሰነ ደረጃ አሁንምአሁንምይደብረኛል
   5.የድብርት ስሜት ተሰምቶኝ አያውቅም
10. ባለፈውወራት ለምን ያህል ጊዜ የተወዳጅነ ትና የተፈቃሪነ ት ስሜት ተሰምቶሽ ያውቃል፡፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
11. ባለፈውወራት ለምን ያህል ጊዜ አዕምሮውበጭንቀት የተወጠረ ሰውሁነ ሽ ነበር፡፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
12. ባለፈውወራት ለምንያህልጊዜ ጠዋት ከእንቅልፍሽ ስትነሽ ደስ የሚል ብሩህ የሆነ ቀን እንደምታሳልፊ ጠብቀሽ ታውቂያልሽ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
13. ባለፈውወራት ለምን ያህልጊዜ የአዕምሮ ውጥረት ወይምከፍተኛ የመረበሽ ስሜት ተሰምቶሻል፡፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም

14. ባለፈውወራት ስሜትሽን፣ አስተሳሰብሽንና ባህሪሽን በደንብ ለመቆጣጠር ሞክረሻል፡ ፡
    1. አዎ በጣምበትክክል
    2. አዎ አብዛኛውን ነገሮች
    3. አዎ ይመስለኛል
    4. የለምብዙምአልነበረም
    5. የለምአልነበረምበተወሰነ ደረጃ ተረብሸ ነበር
    6. የለምአልነበረምእጅግ በጣምተረበሸ ነበር
15. ባለፈውወራት የሆነ ተግባር ለመፈፀምስትሞክሪ ለምን ያህል ጊዜ እጅሽ ይንቀጠቀጣል፡ ፡
    1. ሁልጊዜ በየቀኑ
    2. ብዙጊዜ
    3. በአብዛኛውጊዜ
    4. አልፎአልፎ
    5. ብዙምአይደለምበሚባል ደረጃ
    6. በፍፁምአይንቀጠቀጥም
16. ባለፈውወራት ለምን ያህል ጊዜ ነውበህይወትሽ ወደፊት የምትጠብቂውምን ምተስፋ እንደሌለዉየተሰማሽ፡ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
17. ባለፈውወራት ለምን ያህልጊዜ ነውየመረጋጋትና የሰላምስሜት የተሰማሽ፡ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
18. ባለፈውወራት ለምን ያህል ጊዜ ነውበጥልቅ ስሜት ውስጥ የሰከነ / የተረጋጋ ስሜት የተሰማሽ፡ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
19. ባለፈውወራት ለምን ያህል ጊዜ በነገሮች የጨለምተኝነትና የትካዜ ስሜት ይሰማሽ ነበር፡ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
20. ባለፈውወራት ለምን ያህል ጊዜ የማልቀስ/የማዘን ስሜት ተሰምቶሽ ነበር፡ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ
    3. ቀላል ለማይባል ጊዜያቶች
    4. አልፎ አልፎ
    5. ለጥቂት ጊዜያት
    6. የለምተሰምቶኝ አያውቅም
21. ባለፉት ወራት ለምን ያህልጊዜ ነውየአንች አለሞር (መሞት) ሌሎችን ደስተኛ ሊያደርግ እንደሚችል የተሰማሽ፡ ፡
    1. ሁል ጊዜ
    2. ለብዙ ጊዜ

3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

22. ባለፉት ወራት በነገሮች ያለ ምንምችግር የተዝናናሽው/የተደሰትሽውለምን ያህል ጊዜ ነበር፡፡
1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

23. ባለፉት ወራት ለምን ያህል ጊዜ ነዉየፍቅር ግንኙነ ትሽ ማለትምማፍቀርና መፈቀርሽ የተሟላና የተሳካ ያህል የተሰማሽ፡፡
1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

24. ባለፈውወራት ለምን ያህል ጊዜ ነዉበህይወትሽ ነገሮች አንች በምትፈልጊው መንገድ በፍፁምሊቀየሩ እንደማይችሉ የተሰማሽ፡፡
1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

25. ባለፈውወራት ለምን ያህል ጊዜ አዕምሮሽ ምክንያት በሌላቸውነገሮች እየተወጠረ/እየተጨነቀ ተቸግረሻል፡፡
1. እጅግ በጣምነገሮችን መቆጣጠር ከምችለውበላይ
2. በጣምተቸግሬነበር
3. ጨንቆኝ ተቸግሬነበር
4. ሊታወቅ በሚችል ደረጃ የተወሰነ ጨንቆኝ ነበር
5. በጥቂቱ ጨንቆኝ ትንሽ ተቸግሬነበር
6. ምንምአልጨነቀኝምነበር

26. ባለፉት ወራቶች ለምን ያህል ጊዜ በህይወት ሞኖር ለአንች በስቃይ ውስጥአስደሳች የሆነ ያህል ተሰምቶሻል፡፡
1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

27. ባለፉት ወራቶች ለምን ያህል ጊዜ ህይወትሽ ወደ ታች ዝቅ እንዳለና ምንም የሚያስደስትነገር እንደሌለ ተሰምቶሻል፡፡
1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

28. ባለፈውወራት ስለ ግል ሕይወትሽ ለሌሎች ለማማከር ምን ያህል አስበሻል፡፡
1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

29. ባለፉት ወራት ለምን ያህል ጊዜ ነውየረፍት አልባ፣ የድካምወይምትዕግስት የማጣት ስሜት የተሰማሽ፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

30. ባለፉት ወራት ለምን ያህል ጊዜ በነገሮች በቀላሉ የመበሳጨት፣ ተለዋዋጭስሜትና የሙተከዝ ስሜት ተሰምቶሻል፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

31. ባለፈውወራት ለምን ያህል ጊዜ የደስተኝነት፣ ፍልቅልቅ ያለ የተዝናና የደስታ ስሜት ውስጥ ያለሽ ያህል ተሰምቶሻል፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

32. ባለፉት ወራት ለምን ያህል ጊዜ ደንግጠሻል፣ ፈርተሻል፣ ተበሳጭተሻል፣ ወይምግራ ተጋብተሻል፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

33. ባለፈውወር ለምን ያህል ጊዜ ተጨንቀሻል፣ ተሸብረሻል፣ ሰግተሻል፡ ፡

1. አዎ እጅግ በጣምአሞኝ ነበር
2. አዎ በጣም
3. አዎ አብዛኛውን ጊዜ
4. አዎ በጥቂቱ
5. በተወሰነ መልኩ
6. አልጨነቅም

34. ባለፈውወራት ለምን ያህል ጊዜ ደስተኛ ሰውነበርሽ፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

35. ባለፈውወራት ለምን ያህል ጊዜ ራስሽን የተረጋጋ ሰውሁነ ሽ አግኝተሽዋል፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

36. ባለፉት ወራት ለምን ያህል ጊዜ በመንፈስ መድከምወይምበሞራል ከፍተኛ ውድቀት አጋጥሞሻል፡ ፡

1. ሁል ጊዜ
2. ለብዙ ጊዜ
3. ቀላል ለማይባል ጊዜያቶች
4. አልፎ አልፎ
5. ለጥቂት ጊዜያት
6. የለምተሰምቶኝ አያውቅም

37. ባለፈውወራት ለምን ያህልጊዜ ነውየታደሰና መልካምየእረፍትስሜት ይዘሽ ጠዋት ከእንቅልፍሽ የተነሳሽው ፡

1. ሁል ጊዜ በየቀኑ
2. በየቀኑ በሚባል ደረጃ
3. አብዛኛውን ቀናቶች
4. የተወሰኑ ቀናቶች ግን አብዛኛውን ጊዜ አይደለም
5. በጣምጥቂት ቀናቶች
6. የእረፍት ስሜት ተሰምቶኝ አያውቅም

38. ባለፈውወራት በህይወትሽ ውስጥ ጭፍ የሚፈጥር፣ አዕምሮሽን በጭንቀት የሚወጥር ወይምደጋግሞየሚያሳስብሽ ነገር ነበር፡ ፡

1. አዎ ልገልፀውከምችለውበላይ
2. አዎ የተወሰነ ጭፍ በሚፈጥር ደረጃ
3. አዎ ከሁልጊዜውበተለየ
4. አዎ የተወሰነ ግን ከመደበኛውየተለየ አልነበረም
5. አዎ በጥቂቱ
6. የለምምንምነገር አልነበረም

ተቀፅላ ክፍልሦስት

መመሪያ፡- ከዚህ በታች ያሉት ጥያቄዎች የአልኮልና ሌሎች ዕፅ ተጠቃሚነትን የሚለኩ ናቸው፡፡ መልስሽ በሚሰጥር የሚያዝ መሆኑን ደግሚ አሳስባለሁ፡፡ እኔን ይገልፀኛል ብለሽ የምታስቢውን መልስ (√) ምልክት አድርጊ፡፡ መልስሽ ላለፉት 6 ወራት የነበረሽን ስሜት ይዎክላል፡፡

መግለጫ፡- በዚህ ጥናት **አልኮል** የሚለው ቃል ማንኛውንም አልኮል ሲሆን **ዕፅ** ግን ***ሲጋራን ፣ ሀሽሽን ፣ ሺሻን እና ጫትን*** ያካትታል፡፡

ላለፉት 6 ወራት

ተ/ቁ	ጥያቄ	አዎ	የለም
1	አልኮል ወይም ሌላ የእፅ አይነት ተጠቅመሽ ታዉቂአለሽ?		
2	ከልክ በላይ የአልኮል ወይም የዕፅ ተጠቃሚ ሆኛለሁ ብለሽ አስበሽ ታዉቂአለሽ?		
3	የአልኮል ወይም የእፅ ተጠቃሚነትን ለመቀነስ ወይም ለማቆም ሞክረሽ ታዉቂአለሽ?		
4	በአልኮል ወይም ዕፅ ተጠቃሚነትሽ የተነሳ እርዳታ ለማግኘት ፈልገሽ ታዉቂአለሽ? (ለምሳሌ፡- አልኮል አኖኒመስ (የአልኮል ሱሰኞች በጋራ እየተገናኙ የሚዎያዩበት ግሩፕ) ፣ የምክር አገልግሎት መስጫ፣ ማእከላት ወይም ሌላ የህክምና ቦታ)		
5	**አንዳንድ የጤና ችግሮች ነበሩብሽ? ለምሳሌ**		
5.a	የሃንጐበር እና ለተወሰነ ግዜ የማሰታወስ ችግር		
5.b	የጭንቅላት አካባቢ ግጭት በአልኮሉ ወይም ዕፁ የተነሳ		
5.c	አንቀጥቅጦ መጣል፣ለአጭር ጊዜ የሚቆይ ያለሽበትን ቦታ፣ ሠዓትና ሰዎችን መለየት አለመቻል፣ቅዠት፣ እንቅልፍ ማጣት		
5.d	የጉበት ማቃጠልና ሌሎች ተያያዥ የጉበት ችግሮች		
5.e	የህመም ስሜት፣ብርክብርክ ማለት፣ ወይም ድብርት ልክ አልኮሉን ወይም ዕፁን እንዳቆምሽ		
5.f	አንዳንዴ ዕፁን እንዳቆምኩ ከቆዳየ ውስጥ የሚሄድ ነገር ያለ መስሎ ይታየኛል		
5.g	ከጠጣሁ ወይም ዕፁን ከተጠቀምኩ በኋላ ጉዳት አጋጥሞኛል		
5.h	ዕፁን ለመውሰድ መርፊ ተጠቅሜ አውቃለሁ		
6	የመጠጥ ወይም ዕፅ ተጠቃሚነትሽ ከቤተሰቦችሽ ወይም ጓደኞችሽ ጋር አጋጭቶሽ ያውቃል?		
7	መጠጥ ወይም ዕፅ ተጠቃሚነትሽ በትምህርትሽ ወይም በስራሽ ላይ ችግር ፈጥሯል?		
8	ታስረሽ ታወቂያለሽ ወይም ሌላ የህግ መተላለፍ አጋጥሞሽ ያውቃል?		
9	ሥሜትሽን መቆጣጠር አለመቻል ወይምንትርክ /ክርክር/ አምባጓሮወይም ጠብመጠጥወይም ዕፅ ከተጠቀምሽ በኋላይታይብሻል?		
10	የምትፈልጊውን ያህል እርካታ ለማግኘት ብዙ መጠጣት ወይም ዕፁን በብዛት መውሰድ አለብሽ ?		
11	ብዙ ሠዓት አልኮሉን ወይም ዕፁን ስለማግኘት እያሰብሽ ጊዜ ታቃጥያለሽ ?		
12	በጠጣሽ ቀን ወይም እፅ ስትወስጅ አላስፈላጊ ነገሮችን ታደርጊያለሽ ? ለምሣሌ ህግና ደንብ መጣስ፣ ጠቃሚ እቃዎችን መሸጥ፣ጥንቃቄ የጎደለው ወሲብ መፈፀም?		

13	በመጠጣትሽ ወይም እፅ በመጠቀምሽ ፀፀትወይምመጥፎ ስሜት ይሠማሻል?		
14	መጠጥ ወይም ዕፅ ጋር በተያያዘ ችግር አጋጥሞሽ ያውቃል ?		
15	ከቤተሰቦችሽ መካከል ከመጠጥ ወይም ዕፅ ጋር በተያያዘ ችግር ያለበት አለ?		
16	በአሁኑ ሰዓት ከመጠጥና ዕፅተ ጠቃሚነት ጋር በተያያዘ ችግር አለብኝ ብለሽ ታስቢያለሽ?		

ተቀፅላ ክፍልአራት

የ አ ዕ ምሮ ጤና መቃወስ ን መቋ ቋ ሚያ ስ ኬል

መመሪያ፡- **ባለፈው ሳምንት የተሰማሽን ስሜት መሰረት በማድረግ የሚከተሉትን ሀሳቦች ካነበብሽ በኋላ የምትስማሚበትን ቁጥር (√) ምልክት አስቀምጭ፡፡**

1. **እ ኔ ይህ ን ነ ገ ር ምን ም አ ላ ደ ር ግ ም**
2. **እ ኔ ይህ ን ነ ገ ር እ ስ ካ ሁን በ ት ን ሹ አ ደ ር ገ ዋ ለ ሁ**
3. **እ ኔ ይህ ን ነ ገ ር እ ስ ካ ሁን በ ጣ ሙ አ ደ ር ገ ዋ ለ ሁ**
4. **እ ኔ ይህ ን ነ ገ ር እ ስ ከ አ ሁን ለ ብ ዙ ጊ ዜ አ ደ ር ጌ ዋ ለ ሁ**

ተ.ቁ	ጥ ያ ቄ ዎ ች	1	2	3	4
1	ችግሩን ለመርሳት ሌላ ስራ ወይም ተግባር እሰራለሁ ?				
2	ስላለሁበት ችግር በአትኩሮት ለመስራት እጥራለሁ?				
3	የሆነውን ነገር እውነት እንዳልሆነ ለአዕምሮየ እነግረዋለሁ ?				
4	ነፃነት እንዲሰማኝ አልኮል ወይም ሌላ መደሃኒት እጠቀማለሁ?				
5	ከሌሎች ሰዎች የማበረታቻ ድጋፍ እፈልጋለሁ ?				
6	ከችግሩ ጋር መጋፈጡን አቆማለሁ ?				
7	ሁኔታውን የተሻለ ለማድረግ የሆነ ድርጊት እተገብራለሁ ?				
8	ነገሩ እንዳልሆነ ወይም ምንም እንዳልተፈፀመ አምናለሁ?				
9	የያዘኝ መጥፎ ስሜት እንዲለቀኝ የሆነ ነገር እናገራለሁ?				
10	ከሌሎች ሰዎች እርዳታ /ምክር / አገኛለሁ /እፈልጋለሁ?				
11	ከሁኔታው ለመላቀቅ አልኮል ወይም ሌላ መድሃኒት እጠቀማለሁ?				
12	ነገሩን አወንታዊ /ጠቃሚ ለማድረግ ከተለያየ አቅጣጫ አስባለሁ				
13	ራሴን እወቅሳለሁ ?				
14	ምን ማድረግ እንዳለብኝ ስትራቴጅ /ዘዴ እነድፋለሁ ?				
15	ሌሎች ሰዎች ሁኔታውን እንዲቀበሉኝና እንዲረዱኝ አደርጋለሁ?				
16	ሁኔታውን ለመቋቋም ርምጃ አልወስድም ?				
17	በሆነው ነገር ውስጥ መልካም ነገር ይሆናል ብየ እፈልጋለሁ?				
18	ስለሁኔታው እቀልዳለሁ?				
19	ነገሩን ቀላል ለማድረግ ፊልም ፣ ቴሌቪዥን እመለከታለሁ አነባለሁ፣ እተኛለሁ፣ህልም አያለሁ?				
20	የሚሆነውንና የሁኔታውን እውነታ አምኜ እቀበለዋለሁ ?				
21	ስለ ሁኔታው ያለኝን አሉታዊ ስሜት እገልፃለሁ?				
22	ራሴን በሀይማኖት ወይም በመንፈሳዊ እምነቶች አፅናናለሁ ?				
23	ምን ማድረግ እንዳለብኝ ከሌሎች ሰዎች ምክር ወይም እርዳታ እጠይቃለሁ /አገኛለሁ?				
24	ከሁኔታው ጋር ተለማምጄ እኖራለሁ ?				
25	ምን አይነት እርምጃ መውሰድ እንዳለብኝ ከልቤ አስባለሁ?				
26	ለሆኑት ነገሮች ሁሉ ራሴን ተጠያቂ አደርጋለሁ ?				

27	እፀልያለሁ ወይም ተመስጦ አደርጋለሁ?				
28	በሆነው ነገር እደሰትበታለሁ ?				

ተቀፅላ ክፍል አምስት

መመሪያ ፡- መልስዎ በትክክል ጎዳናን መሰረት ያደረጉ ሴተኛ አዳሪዎች ያጋጥሟቸዋል ብለው ያዩትን፣ የሰሙትን በግልፅ ይዘርዝሩልን፣ እንዲሁም ለምርጫ ጥያቄዎች (√) ምልክት ያሥቀምጡልን ፡፡

1. በእርስዎ አመለካከት ጎዳናን መሰረት ያደረጉ ሴተኛ አዳሪዎች ለተለያዩ ጥቃቶች በተለይም አካላዊ፣ ሥነ-ልቦናዊ፣ እንዱሁም ለወሲብ ጥቃት የተጋለጡ ናቸው ብለው ያምናሉ?

   ☐ አዎ ☐ አላምንም

2. መልሥም "አዎ" ከሆነ ካዩት ወይም ከሠሙት ውስጥ ዋና ዋናዎችን የጥቃት ዓይነቶች ቢገልፁልን _____

   _____

   _____

   _____

3. ለመጀመሪያ ጥያቄ መልሥዎ "አዎ" ከሆነ ብዙ ግዜ እነማን ናቸው ጥቃቱን የሚያደርሱት ብለው ያሥባሉ? _

   _____

   _____

   _____

4. በእርስዎ አመለካከት ጎዳናን መሰረት ያደረጉ ሴተኛ አዳሪዎች ለስነ ልቦና ችግር የተጋለጡ ናቸው ብለው ያስባሉ?

   ☐ አዎ ☐ አላስብም

5. መልስዎ "አዎ" ከሆነ በእርስዎ አመለካከት እነዚህ ችግሮች እነዴት እንደሚያጋጥሟቸው ቢገልፁልን::

   _____

   _____

   _____

6. በእርስዎ አመለካከት አነዚህ ሴተኛ አዳሪዎች በብዛት አልኮል ወይም አንዳንድ ዕፆችን ይጠቀማሉ ብለው ይሰባሉ?

   ☐ አዎ ☐ አላስብም

7. መልስዎ "አዎ" ከሆነ ምን አይነት ዕፆችን እንዲሁም የአልኮል አይነቶች በብዛት ይጠቀማሉ? _____

   _____

   _____

8. ጐዳናን መሠረት አድርገው ስለሚሰሩ ሴተኛ አዳሪዎች ሌላ የቀረ የሚነግሩን ነገር ካለ ቢገልፁልን _____

   _____

ተቀፅላ ክፍል ስድስት

የቃል መጠይቅ

ቃለ መጠይቁ ለትሳታፊዎች 4 ክፍሎችና በአጠቃላይ 12 ጥያቄዎች አለት እንዲሁም ግልፅና የማያሻማ ነው ስለዚህ በግልፅ ታሪኩን እንድታብራሩ እጠይቃለሁ.

ቃለ መጠይቅ ክፍል 1

1. እድሜሽን ሃይማኖትሽን እና ክልል---
2. የትምህርት ዝግጅትሽ የጋብቻ ሁኔታና የስራ ሁኔታ የጾታ-ንግድ ስራ ከመጀመርሽ በፊት ምን ይመስል ነበር አሁንስ ያለሽበት ሁኔታ ምን ይመስላል
3. ስለቤተሰቦችሽ የኑሮ ሁኔታ ልትነግሪኝ ተችያለሽ አንድ ላይ ነው የምትኖሩት የገቢ መጠናችውስ ምን ያህል ነው

ቃለ መጠይቅ ክፍል 2

1 ለምን ወደ ዖታ-ንግድ ስራ ለመግባት ወሰንሽ ወደ እዚህ ስራ እንድትገቢስ ማን ገፋፋሽ

2 ለጎዳና የዖታ-ንግድ ስራ የሚያጋልጡ ዋና ዋና ምክናያቶች ምንድን ነው ብለሽ ታስቢያለሽ

ቃለ መጠይቅ ክፍል 3

1 ስለ ጎዳና ዖታ-ንግድ ስራ ህይወት በጥልቀት ልትነግሪኝ ትችያለሽ ---ስላጋጠመሽ ነገር

2 በጎዳና ላይ በዖታ ንግድ የሚታዳደሩ ሴቶች በስነ-ልቦናና ማህበራዊ ችግሮች የሚጠቁበት ዋና ምክንያት ልትነግሪኝ ትችያለሽ

3 በጎዳና የዖታ-ንግድ ስራ ህይወት የማትረሽው የተለየ ገጠመኝ ካለ---

4 በስራሽ ዉስጥ የገጠመሽን አስቸጋሪና መልካም ሁኔታዎችን ልትነግሪኝ ትችያለሽ

ቃለ መጠይቅ ክፍል 4

1 ወደ እዚህ ስራ ከመግባትሽ በፊት ምን ነበር ስለ ስራው የምትጠብቂው (የምታስቢዊው) ምንስ ገጠመሽ

2 ማድረግ ለሚችሉ በጎዳና ላይ የዖታ-ንግድ ስራ ለሚሰሩ ሴቶች የአንች ምክር ምንድን ነው

3 ተጨማሪ ጥያቄዎች የሚኖሩኝ ከሆነ መደወል እችላለሁ

ስለ ትብብርዎ በጣም አመሰግናለሁ

ተቀፅላ ክፍል ሰባት

በቡድን የመወያያ መሪ ጥያቄዎች

የሚከተሉትንየውይይትሃሳቦችበቡድናችሁውስጥተወያዩበት

1. እንዴት ወደ ዖታ ንግድ ስራ ገባሽ እንድትገቢ የገፋፋሽስ ምክንያት ምንድን ነው
2. በጎዳና ላይ የተሰማሩ የዖታ ንግድ ተዳዳሪዎችን በስራው ላይ የሚያጋጥማቸው ችግርን እንዴት ታይዋለሽ
3. የደንበኞችን የተለየ ፍላጎት ለማሳካት የሚፈፀም ድርጊት ካለ እንዲሁም ችግር ሲያጋጥም የምትወስዱት መፍትሔ ካለ
4. በጎዳና የዖታ ንግድ የሚተዳደሩ ሴቶች የአዕምሮ ጤና ሁኔታ ምን ይመስላል
5. በስራ ዘመናችሁ ህይወትን ለአደጋ የሚጥል የተለየ አደገኛ አጋጣሚ ካለ
6. በጎዳና ላይ ንግድ የሚተዳደሩ ሴቶች በሰነ-ልቦናዊና ማህበራዊ ችግሮች የሚጠቁበት ዋናው ምክንያት ምንድን ነው
7. በዖታ ንግድ በሚተዳደሩ ሴቶች ላይ ያለው የህብረተሰቡ አስተሳሰብ ዙሪያ ምን ታስቢያለሽ
8. ማንኛውንም እፅ ወይም አልኮል ለየትኛውም አላማ ተጠቅመሽ ታውቂያለሽ ;
   አዎ ካልሽ እንዴት እንደተጠቀምሽ ልትነግሪኝ ትችያለሽ
10. በዖታ ንግድ የሚተዳደሩ ሴቶች አብዛኛውን ጊዜ ምን አይነት ችግርን የመቋቋሚያ መንገዶች ይጠቀማሉ
11. ስለ ወደፊቱ ምን ታስቢያለሽ

ስለ ትብብራችዎ በጣም አመሰግናለሁ

Post Hoc Tests for Educational status

Multiple Comparisons

Dependent Variable: summhi

Bonferroni

(I) educationalstatus	(J) educationalstatus	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
illitrate	primary school	-25.646*	1.296	.000	-29.08	-22.21
	secondary school	-48.042*	1.937	.000	-53.18	-42.90
	college/university	-65.797*	4.148	.000	-76.80	-54.80
primary school	illitrate	25.646*	1.296	.000	22.21	29.08
	secondary school	-22.396*	2.019	.000	-27.75	-17.04
	college/university	-40.152*	4.187	.000	-51.26	-29.05
secondary school	illitrate	48.042*	1.937	.000	42.90	53.18
	primary school	22.396*	2.019	.000	17.04	27.75
	college/university	-17.756*	4.427	.000	-29.50	-6.01
college/university	illitrate	65.797*	4.148	.000	54.80	76.80
	primary school	40.152*	4.187	.000	29.05	51.26
	secondary school	17.756*	4.427	.000	6.01	29.50

*. The mean difference is significant at the 0.05 level.

Post Hoc Tests for Marital status

Multiple Comparisons

Dependent Variable: summhi

Bonferroni

(I) maritalstatus	(J) maritalstatus	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
	single	-3.111	3.141	1.000	-11.44	5.22
married	divorced	-.508	3.133	1.000	-8.82	7.80
	widow	1.007	3.250	1.000	-7.61	9.63
	married	3.111	3.141	1.000	-5.22	11.44
single	divorced	2.603	3.049	1.000	-5.48	10.69
	widow	4.118	3.169	1.000	-4.29	12.52
	married	.508	3.133	1.000	-7.80	8.82
divorced	single	-2.603	3.049	1.000	-10.69	5.48
	widow	1.515	3.162	1.000	-6.87	9.90
	married	-1.007	3.250	1.000	-9.63	7.61
widow	single	-4.118	3.169	1.000	-12.52	4.29
	divorced	-1.515	3.162	1.000	-9.90	6.87

Post Hoc Tests for Living Arrangement

Multiple Comparisons

Dependent Variable: summhi

Bonferroni

(I) towhomyouarelivingwith	(J) towhomyouarelivingwith	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
with father and mother	separeted father and mother	19.571*	2.104	.000	13.63	25.51
	only father died	35.218*	1.894	.000	29.87	40.57
	only mother died	41.184*	1.982	.000	35.59	46.78
	both father and mother died	69.259*	1.885	.000	63.94	74.58
separeted father and mother	with father and mother	-19.571*	2.104	.000	-25.51	-13.63
	only father died	15.648*	1.354	.000	11.83	19.47
	only mother died	21.614*	1.474	.000	17.45	25.78
	both father and mother died	49.688*	1.341	.000	45.90	53.47
only father died	with father and mother	-35.218*	1.894	.000	-40.57	-29.87
	separeted father and mother	-15.648*	1.354	.000	-19.47	-11.83
	only mother died	5.966*	1.156	.000	2.70	9.23
	both father and mother died	34.041*	.980	.000	31.27	36.81
only mother died	with father and mother	-41.184*	1.982	.000	-46.78	-35.59
	separeted father and mother	-21.614*	1.474	.000	-25.78	-17.45
	only father died	-5.966*	1.156	.000	-9.23	-2.70
	both father and mother died	28.075*	1.141	.000	24.85	31.30
both father and mother died	with father and mother	-69.259*	1.885	.000	-74.58	-63.94
	separeted father and mother	-49.688*	1.341	.000	-53.47	-45.90
	only father died	-34.041*	.980	.000	-36.81	-31.27
	only mother died	-28.075*	1.141	.000	-31.30	-24.85

*. The mean difference is significant at the 0.05 level.

Declaration

I, declare that ‘determinant factor for the psychosocial problems of street-based female sex workers in Addis Ababa Ethiopia’ is my original work and that all sources used within the study have been appropriately acknowledged. This work has not been published.

Declared by:

Name: Fasil Getachew

Signature: _____

Date: _____

Confirmed by advisor:

Name: Dr Asmamaw

Signature: _____

Date: _____