SXUALITY RELATED BEHAVIORAL RISK TO HIV AIDS

EXAMINING THE EXPERIENCE OF PEOPLE ABUSING HOME MADE ALCOHOL BEVERGES

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RUNNING HEAD: BEHAVIORAL RISK TO HIV

Sexuality Related Behavioral Risk to HIV AIDS

Examining the Experience of People Abusing Home Made Alcohol Beverages

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APPROVED BY THE EXAMINIG BOARD

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Abstract

This paper looked at the experience of people abusing homemade alcohol with the intention of understanding sexual behavior related risk to HIV AIDS. The study was developed employing an in depth interview as a primary tool and ten participants were purposively selected to be interviewed. The study was developed in terms of qualitative inquiry with a descriptive purpose. Thematic categorization and content analysis is used for analyzing data. The key findings of this research point out that sexual risk taking, marked in different forms, is a general behavior pattern among participants. Participants also share common factors that predisposed them to both alcohol abuse and sexual risk taking behaviors in that they mentioned cognitive, affective, behavioral, socio cultural and situational factors. Commonalities regarding the conditions in which safe sex and unprotected sex occur were also observed. Hence they witnessed similar notions about the nature of sexual safety and risk. These findings suggest that interventions in the personal and socio cultural environment with the participation of families, women, religious institutions and service delivery system are indispensable for successful prevention outcomes. Interventions should also be aimed at empowering and enabling individuals and communities towards risk consciousness, risk prevention and promotion of healthy life style.

Key Words: Alcohol, Sexual behavior,

Sexuality Related Behavioral Risk to HIV AIDS

Examining the Experiences of People Abusing Home Made Alcohol Beverages

It is repeatedly heard that "sex is one of the very few pleasures that poor people can have especially because it is for free. (Steinith, 2007, p.11)." It is also stressed that for the large number of this people, long lasing costs of that pleasure is extremely high as poor people lack information, they are more often malnourished and more vulnerable to diseases such as malaria and tuberculosis (which make one more susceptible to HIV infection) and they lack all kinds of resources that promote well being (Steinith, 2007, p.11). This is why even though problems associated with people's sexual behavior are social threats that challenged the whole world, its gravity is much higher to the third world poor countries, such as ours where the majority of the population is below the poverty line (WHO, 2005).

For long now it becomes well known that risky sexual behavior related global disease burdens and associated complex socioeconomic problems are among the gravest problems of human kind (WHO, 2005, P.1). These contributions of sexual risk taking behaviors to the problems of the universal community are, furthermore, aggravated through the linkage that has been shown to exist between alcohol abuse and sexual risk taking behavior (WHO, 2005, P. Viii). The optimal manifestation of this condition is the prevalence of higher HIV infection and more, higher risk of infection for people abusing alcohol (WHO, 2005, p.9). Worldwide sexual risk taking behavior accounts for a large number of opportunities for acquiring HIV infection. To this end abuse of alcohol before or during sex has been shown to have a greater potential to promote unsafe sexual behavior and increase individuals risk to HIV infection (WHO, 2005, P.Vii). Cooper(2002) in explaining the relationship between alcohol abuse and sexual risk taking behavior made it clear that the association between alcohol and risky sexual behavior is strong

(p.105) and the ultimate result of this is an increased propensity to HIV AIDS and several sexually transmitted infections. This becomes a significant concern particularly for Sub Saharan African nations where sexual contact is almost the exclusive mode of contracting the disease (WHO, 2005.P.1).

WHO (2005) placed AIDS as the leading cause of death in sub Saharan Africa (p.vii). Ethiopia is one of the Sub Saharan African countries where there is high rate of HIV/AIDS infection next to South Africa and Nigeria. In the year 2000, it was estimated that there were about 2.6 million people infected with HIV and Over 6% of Ethiopia's adult population is believed to be HIV positive (Dereje Kebede etal,2005,p.2;WHO,2005,p. 7). Despite the absence of a context specific data, all indications are that the significant risk factors for HIV transmission in Ethiopia, like the case elsewhere in Africa, is unsafe heterosexual contact of different forms (HAPCO & GAMET, 2008, p.34).

Considering its gravity, it has been found critically important to come up with a way of dealing with this problem and to this end many interventions have been applied at national level (HAPCO & GAMET, 2008, p.39). Taking in to account the synergy between alcohol abuse and risky sexual behavior, however, the psychosocial dynamics that surround alcohol abuse and related sexual risk taking behaviors that augment vulnerability of people to HIV AIDS in diverse socio cultural settings necessitate a search for successful outcome (Steinith, 2007, p.12) hence the need for researches such as this.

It can be expected that knowledge acquired through this course , in addition to highlighting the relevant preventive measures to be adopted, will bring out relevant research questions to be considered by further studies interested in addressing the problem of alcohol abuse and sexual behavior related HIV vulnerability.

Problem Statement

In the twenty first century substance abuse has become a universal health and social problem in the world (Atalay Alem, Derege Kebede, & Kullgren , 1999,p.3). Substance of abuse include prescribed or illegally used psychoactive drugs, industrially or homemade alcohol, and traditional drugs that affect the psyche of humans. Some of these substances are used for socially and medically accepted reasons. However, when use exceeds the norm, it is regarded as abuse. The question of where use ends and abuse begins has no easy answer. This is particularly true of alcohol because it is taken as part of a dietary intake by most people in the world and its use is as normative as food intake is in most cultures (Atalay Alem, Derege Kebede & Kullgren, 1999, p.3).

The American Psychiatric Association (APA, 1994) defined substance abuse as "a maladaptive pattern of use of psychoactive substances that act specifically on the central nervous system to alter thought processes, mood, cognition and behavior" (p.182). It sets out four conditions in which a person is said to be in the problem of substance abuse; when the person fails to fulfill his/her role at work, school or home, when s/he uses substances in places where it is hazardous, when s/he faces legal problems because of substance use and when s/he continues to use even when s/he faces recurrent social or interpersonal problems because of the problem. (APA, 1994, p.182)

Among the most abused substances of the world alcohol has been identified as one. The APA (1994) defines alcohol abuse as a maladaptive pattern of alcohol use leading to impairment of social, legal, interpersonal, and occupational functioning (P.182). The World Health Organization (WHO, 2004) reported that in the year 2004 there were 2 billion people around the

world who use alcohol and76.3 million with diagnosable alcohol use disorders. It is also reported that alcohol related diseases affect 5% to 10% of the world's population each year and accounted for 2% of the global burden of disease (p.1). In addition to the health related problems alcohol abuse poses, the social, psychological and economic costs incurred on the general public is vast (Sussman & Ames, 2008, p.vii; WHO, 2004, p.35). It could cause several dangers to the user. Yet the damage incurred by the abuse of alcohol is not limited to those who drink. Others also suffer the consequences because of drunk driving, family disruption, crime, and violence (Atalay Alem, et al., 1999, p.3).

Substance abuse is also a growing problem in restructuring countries (Abebaw Fekadu, Atalay Alem, & Hanlon, 2007, p.1). Likewise alcohol is one of the most abused substances and it has been associated with several psychological, social and health related problems. It is placed as one of the leading risk factor for disease burden in developing countries (Atalay Alem, et al., 1999, p.3).

Ethiopia is no exception to this. Alcohol is one of the major substances of abuse in the country. It is reported to be a major problem and also claimed to be increasing over time (Atalay Alem, et al., 1999, p.14; Abebaw Fekadu, et al., 2007, p.39). Homemade traditional alcohol drinks are used more often than industrially produced beverages. Production, consumption and retail of homemade alcohol in small alcohol shops or at home is an accepted norm, and its use is encouraged especially among men. These beverages, drunk during holidays and the numerous church festivities are part of the cultural fabric in many regions of the country (Atalay Alem, et al., 1999, p.6).These beverages are mostly brewed in rural and semi urban areas and are used more commonly by farmers and semi urban dwellers than by people who live in cities (Atalay Alem, et al., 1999, p.6). Also as indicated in Atalay Alem et al study (1999) there is a higher

prevalence of alcohol abuse among men and predominantly in the rural population where production of alcohol drinks from cereals and their consumption is most common (p.13). In cities, those who drink *Araki* and other homemade alcohol drinks regularly are predominantly people in a lower economic class or those who have become dependent upon alcohol and cannot afford to buy industrially produced alcohols (Atalay Alem, et al., 1999, p.7). Yet in recent years the increasing number of alcohol producing industries is raising alcohol consumption in urban areas leading to a growing prevalence of alcohol abuse in cities (Atalay Alem, et al,1999,p.6).

Regarding the multifaceted socioeconomic and health problems associated with alcohol abuse the available studies, even if limited, indicated that higher prevalence of mental distress and suicide attempts among those using alcohol in association with *Chat* (Atalay Alem, et al., 1999, p.14,). Economic and social costs, such as family disruption and lost productive hours as a result of alcohol related hangover, incurred on individuals, family and society at large are common problems in the country (Dereje Kebede ,et al., 2005, p.2; Atalay Alem,et al 1999, p.5).

Risky sexual behavior, defined as any human sexual contact which posits individual's physical, social and psychological health at risk, on the other hand, is a nest for several problems. It accounts for all sexually transmitted diseases including HIV AIDS and psycho social problems such as altered self esteem, emotional instability, depression, impaired ability to form healthy long term relationships, infant and maternal poverty and growing birth rate (Malhotra, 2008, p.88).

Since early 1980s HIV AIDS get to be known as the leading threat to humanity (WHO, 2005, p.vii). It is a deadly disease that has taken many lives and still continues. Even though the developed nations has achieved a decent degree of control over the disease through preventive

and treatment measures, there still remains a large proportion of the world's population, particularly in developing nations, dying of the disease and even worse in a greater number, at risk of being infected(Gerald, 2010, p, 231). Of these, Sub Saharan nations constitute the greater proportion and it is reported unsafe sexual behavior to be an exclusive means of transmission (Dereje Kebede et al., 2005, p.2; WHO, 2005, p.7).

As suggested in the literatures, the relationship between alcohol abuse and risky sexual behavior has the potential to intensify this situation. Studies suggested that the synergy between the two enormously multiplies the potential risk for HIV as abuse of alcohol before or during sex has been shown to have a greater potential to make it an unsafe one and increase individuals risk to HIV infection (WHO, 2005, P.Vii).

Studies indicating the relation between alcohol abuse and high risk sexual behavior are numerous. These wide array of literatures indicating the association between the two see this relationship in two different ways. One approach to the interaction between alcohol abuse and high risk sexual behavior is from the cause and effect point of view (Cooper, 2002, pp.102). This constitutes one of the two most used models of explanation. This model assumes that the acute effects of alcohol intoxication cause one to take sexual risks that otherwise would not be taken (Cooper, 2002, pp.102).In support of this, studies indicated that female sex workers who report risky sexual behavior and symptoms of STIs also point out alcohol abuse and problem drinking before most sexual experiences (Atalay Alem, et al.,2003,p.9). Also in a Meta analysis of the association between alcohol intake and condom use, drinking at first intercourse was associated with decreased condom use (Derege Kebede,et al., 2005, p.7). The other model explaining the relationship between these two variables posits another third variable as an underlying predictor of the co occurrence of the two (Cooper, 2002, p.102). Some stable characters or a person's life

situation are thought to cause both drinking and risky sex. For example, thrill or sensation seeking needs, poor impulse control or coping mechanisms to negative emotions might lead one to involve in both drinking and risky sexual behavior (Cooper; Leigh & Stall, as sited in Cooper, 2002, p.102). These two models are the most commonly used explanations of the relationship between alcohol abuse and high risk sexual behavior.

The fact that problems posed by alcohol abuse and high risk sexual behavior independently get to be worse when they act together makes the subject a huge concern. In recent years after the cause and multidimensional consequences of HIV AIDS become well known, worldwide, the attention given to unprotected sexual practice is augmented. The virus's main means of transmission being sexual contact, particularly for poor countries such as Ethiopia, consideration of the issue was found vital. Taking the relationship between alcohol and risky sexual behavior in to account, several states have been applying different legislations, policies and programs to limit access to alcohol beverages to their citizens and prevent risky sexual behavior (Odejide, 2006, p.31; Gerald, 2010,p.231).Considering the strong association of alcohol abuse and risky sexual behavior, national programs and legislations deliberated at addressing HIV AIDS are also seen to include programs that focused on alcohol use as well.

Globally, for decades HIV/AIDS program planners have been developing prevention interventions to modify behaviors that put people at risk (Gerald, 2010, p.231).The fact that there is no cure or no vaccine and the drugs severe side effects and cattiness makes prevention more important(Gerald, 2010,p.231). At the national level as well, since the first national HIV /AIDS policy draft was approved in 1998, preventive measures have been given precedence (EFDRE, 1998,p. 24). Much resource has also been and is being devoted by different governmental as well as non governmental agencies working to the same concern.

Even though it is found difficult to estimate the exact outcome of prevention programs, a growing number of countries have documented the success of their prevention education efforts through careful program evaluations and surveys. Much also has been achieved through prevention education especially at the first two decades of the incidence of the epidemic (Gerald, 2010, p.231). However, despite this success attained so far, debates globally are that current prevention methods are failing. Absence of explanation for the annual two to three million people infected with the virus, of which gay people and substance users take the lion's share make the controversies even huge (Gerald, 2010,p.231). If effective ways are not devised to manage it in the near future, it is estimated that about 100 million people will be HIV infected by 2025 mostly through sexual transmission and nearly all in poor countries (Gerald, 2010, p, 231).

In Ethiopia the trend in HIV AIDS is that there has been shown a decline in the rate of infection (HAPCO & GAMET, 2008, p.83). However, recently there has been a new development regarding the trends of infection in the country. In contrary to what has been expected, the evidence from urban areas appears to indicate a generalized epidemic that is probably stabilizing or even declining in the major urban centers but increasing in the smaller towns (HAPCO & GAMET, 2008, p.16). Why this happens to be the case in these small towns is unfortunately not studied yet. Even though it hasn't been studied, the risk of STIs and HIV in these places are hypothesized to be the outcome of risky sexual behavior related with alcohol abuse (HAPCO & GAMET, 2008). It has been predicted that since these small towns serve as a market place where people from rural as well as urban place meet regularly and there are a number of alcohol shops with a potential prostitution involvement, there might be a strong and wide high risk sexual network in these places that predict a higher level risk to HIV infection (HAPCO & GAMET, 2008,p.8).

The epidemic potential in small towns, where there is the possibility of bridging the spread to rural communities, appears to be huge (HAPCO & GAMET, 2008, p.46). However, despite the indication that it deserves attention, there are seldom studies focusing on assessing this issue of concern. This fact is evident in that sufficient literatures could not be found with regard to the issue. Mindful of this lacking focus on the subject, this study tried to address the gap in knowledge on the subject and pave the way for further researches. The knowledge generated through this study as to the behavioral susceptibility to HIV among people abusing alcohol in these setting was found important to further improve social services, policies and public health programs in a way that gives a contextualized answer to needs.

Research Question

The study is aimed at answering the following questions

- To what extent individuals achieved a risk protected sexual behaviors in terms of abstinence, faithfulness (monogamy) condom use and VCT?
- In what kind of circumstances does safe sex happened to take place?
- In what kind of circumstances does unsafe sex happened to take place?
- What contextual situations have an influence on people's effort to take up a safe sexual behavior?

The Purpose Statement

The intent of this study was to assess sexual behavior related susceptibility to HIV AIDS among people abusing homemade alcohol in a semi urban community of *Chacha* using detailed experience of the participants. In the study, a phenomenological inquiry of the lived experience, attitude and opinion of the people have been studied using in depth interviews. In the overall

research process, a holistic contextual situations and needs of this community that influence sexual behavior as well as the context in which unsafe sex take place have been assessed.

Significance of the Study

This study was found important for several reasons. First, one of the huge national concern being health standard of the nationals particularly in relation to HIV, the knowledge generated through this study can inform policy makers and health program designers as to how to improve it in a way that responds to the situations on the ground. In view of the fact that high risk sexual behavior is the foremost means of transmission for HIV and substance users in general and alcohol abusers in particular are among high risk groups identified , the study could help in guiding intervention strategies, programs and policies towards effective control and prevention of the disease among this group. In a study the epidemic's potential in small towns and the possibility of bridging the spread of the epidemic to rural communities has been indicated (HAPCO &GAMET, 2008, P.46). These added with the knowledge gap in relation to the subject in the context of semi urban community and people abusing homemade alcohol, the need for studies like this remains apparent. Thus, this study is believed to have a significant role in further efforts to control and prevent HIV/STDs in these settings.

Delimitation and Limitation of the Study

By restricting the research design to interview, the study was focused on investigating susceptibility to HIV through unsafe sexual behavior among a semi urban community of homemade alcohol abusers. It was limited to the study of these phenomena among male, homemade alcohol beverage abusers of *Chacha Wereda* in East *Shewa Zone*. The study was also limited to the inquiry of the experience of ten individuals selected based on a purposeful

sampling technique. Because of this the generalizability of the study is limited. The nature of the study as a qualitative one also made it time and resource intensive.

Operational Definition of Terms

Alcohol abuse: - measured in terms of a self evaluated impairment of health, social, legal, interpersonal or occupational functioning in relation to using alcohol.

Safe sexual behavior: - any successful implementation by an individual of their chosen risk reduction strategy. It constitutes abstaining/delaying the age of sexual debut, avoiding casual sex, consistent use of condoms, faithfulness in a monogamous relationship and taking voluntary counseling and testing before sexual debut with a partner, abstinence or condom use while having an STD or with a partner who has an STD

Sexual intercourse: - all human sexual contact including oral sex, vaginal sex, anal sex, homo sexual and hetero sexual contacts

Sexual behaviors related risk to HIV: - having any of all risky sexual behaviors i.e. having multiple partners, having at risk or casual partners and failure to discuss risk topics and take safety measures prior to intercourse, failure to take protective actions such as use of condoms

Homemade beverages: - defined based on the most commonly used traditional drink in the area that includes *Tela, Tej* and *kundiftu(Araki)*

Casual sex: - sexual contact with a stranger or accidental partner and no stable partner

Review of Literature

Risky Sexual Behavior, Alcohol Abuse and Related Consequences

Risky sexual behavior is defined by different scholars. One mostly sited definition of risky sexual behavior conceptualize it as any behavior associated with sexual contact that involves a likelihood of any negative consequence including AIDS or other sexually transmitted disease (Copper, 2002,p.101). These behaviors are considered in two broad categories. The first category includes indiscriminate behaviors including having multiple partners, having at risk, casual or unknown partners. The second category includes failure to take protective actions such as use of condoms and discuss risk topics prior to intercourse (Copper, 2002, p102; WHO, 2005, p.1).

In addition to this, risky sexual behavior is also conceptualized to refer early sexual debut, the age early varying in different studies (Kebede et al, 2005, p.1).Early sexual initiation is considered as a risky behavior taking in to account claims suggesting that youths who begin early sexual activity are likely to have unprotected sex and multiple partners or less likely to use condom. Malhotra (2008) explained that for behavioral, psychological or physiological reasons early sexual debut is believed to increases adolescence risk for infection with HIV and other sexually transmitted diseases (p .88).

Relatively sufficient studies about risky sexual behavior are available particularly since the emergence of HIV AIDS. A lot of these literatures also suggest several social problems, psychological distresses and numerous sexually transmitted illnesses in association with this behavior (Malhotra, 2008,p 88; WHO, 2005, P.1; Gerald, 2010, p, 231) Also, since the emergence of HIV AIDS in the 1980s, one of the world's most killing diseases, there has been a

significant rise in the attention given to the issue. The fact that the rate of HIV AIDS infection is on the rise and it is being marginalized to developing countries makes it more of a concern to countries like ours (WHO, 2005, p.7). A recent UNAIDS/WHO estimate shows that in 2001 alone 5 million people were newly infected with HIV of which 3.4 million infections were in Africa. Furthermore, more than 70% of the world's population living with HIV/AIDS is in Africa while 78% of active AIDS cases and 68% of new infections occur in Sub-Saharan Africa nations alone. Statistics also shows that more than 80% of HIV positive women worldwide and 87% of children infected with HIV/AIDS are in sub Saharan Africa, as 95% of the world's AIDS orphans are. Similarly, 2.3 million deaths due to HIV/AIDS occur each year in Africa (WHO, 2004).

Ethiopia is one of the Sub Saharan African countries where there is high rate of HIV/AIDS infection next to South Africa and Nigeria (WHO, 2005, p. 7). In the year 2000, it was estimated that there were about 2.6 million people infected with HIV and over 6% of Ethiopia's adult population is believed to be HIV positive and as is the case elsewhere in Africa, transmission is almost exclusively through heterosexual contact (Dereje Kebede etal,2005,p.2;WHO,2005,p. 7).

On the other hand apart from being a problem by itself when abused, alcohol is associated with a number of psychological, social and economic problems (Denning, Little, Glickman, 2004 ; Obot, 2006). Alcohol was known to be one of the most contributors of the global disease burden as it causes many physiological and psychological disorders. It was reported that 76.3 million people worldwide had alcohol related disorders (WHO, 2004, p.1). Also it is indicated that alcohol related diseases affect 5% to 10% of the world's population each year and accounted for 2% of the global burden of disease. Fetal Alcohol Syndrome (FAS), a

birth defect resulting from drinking during pregnancy, has recently become a serious threat in the world (Atalay Alem, Dereje Kebede and Kullgren, 1999,p.3;WHO, 2004).

Irresponsible use of alcohol could cause several dangers to the user. However the damage incurred is not limited to those who drink as others also suffer the consequences because of drunk driving, family disruption, crime, and violence (Alem, Kebede and Kullgren, 1999,p.3).

In Ethiopia the production and consumption of alcohol predates modern civilization. It is claimed that the mountainous areas of Ethiopia were among the first centers in the world where plants were grown for alcohol production (Acuda, as sited in Abebaw Fekadu, et al., 2007). Alcohol has been identified as one of the two most commonly used substances in Ethiopia. Home brewed alcohols are part of the cultural fabric, widely available and acceptable (Abebaw Fekadu, et al.,2007,p.3). Drunk during holidays and the numerous church festivities, Tella is the most commonly home brewed alcoholic beverage, made from germinate barley and Gešho leaves (an evergreen shrub) and has an alcohol content of 2-4%. Tej is a traditional wine made from fermented honey and Gešho and contains 7-11% alcohol. Araki is a spirit distilled from fermented cereals with an alcohol content of up to 45%. Korefe, Shanti(, Borede and Katikala) are other traditional drinks made through similar processes. These traditional drinks are most prevalent in less modern and less expensive liquor houses in the country (WHO, 2004,p.4).

Apparently traditional alcohol production and consumption is widespread. Moreover in recent years the numbers of alcohol producing industries are increasing in the country. Unfortunately there is hardly a data available in the country on the prevalence of alcohol abuse and associated problems (Alem , Kebede and Kullgren, 1999, pp.12).

The available few studies suggest that alcohol abuse and related problems are not insignificant .WHO's (2004) global status report on alcohol reported that in Ethiopia the per capita consumption of alcohol was 0.91 liter recorded and 1.0 liter unrecorded (p.1). The prevalence of hazardous drinking (2.7%-3.7%) and alcohol dependence (1%-1.6%) in cities, selected rural sites and special population groups suggests that alcohol abuse is a widespread and significant problem (Abebaw Fekadu, etal.,2007,p.12)

Also few studies conducted in the country assessing the impact of substance abuse on health and overall functioning indicated that substance abuse is associated with psychological distress, suicide attempts, functional impairment, physical illness and risk taking behaviors. In Alem et al (1999) study conducted in Butajira among over 10, 000 adults, a higher prevalence of mental distress and suicide attempts were found in those using alcohol with Khat (p.13). An increased prevalence of suicide attempts was also reported in adolescents in Addis Ababa who drink alcohol (Kebede & Kestela, 1993,p.789). The use of alcohol in association with Khat has also been related with physical illness, injuries, under nutrition, mental distress, sleep disorders, heavy smoking as well as recurrent brief psychotic episodes with associated violent behavior (Alem & Shibre, 1997, p. 139; Belew et al., 2000, p. 22).

The respective contributions of alcohol and unsafe sex to the global burden of problems are furthermore strengthened through the linkage that has been shown to exist between the two (Cooper, 2002, p.102; Atalay Alem, et al., 2003, p.9). The ultimate manifestation of this is seen in the disturbingly wide spreading disease, HIV AIDS, particularly among substance abusers/alcohol abusers (WHO, 2005, p.1).

Alternative explanations for the link between alcohol abuse and risky sexual behavior

Most of the studies suggesting the relationship between high risk sexual behavior and alcohol abuse can be viewed from two commonly used theoretical models of explanations. Spurious model, one of the alternative models of explanation, calls for a third variable in to the picture that explains the occurrence of both alcohol abuse and risky sexual behavior. Different aspects of the individual or of his or her life situation are thought to cause both drinking and risky sex (Cooper, 2002, p.104). Studies by cooper in 1992 and Leigh and Stall (1993) (as sited in Cooper 2002,p.105) point out variables such as impulsivity , negative emotionality and some sort of life styles such as being single as factors that encourage both behaviors.

Acute causal effect of alcohol is another alternative explanation provided for the relationship between these two behaviors. This model assumes that the acute effects of alcohol intoxication cause one to take sexual risks that otherwise would not be taken (Cooper 2002, p.102). There are two different ways in which the effect of alcohol on sexual risk taking behavior can be explained. The first explanation gives emphasis to the interplay between inhibiting and instigating cues. Accordingly, alcohol by reducing the scope and efficiency of information processing, simple cues that instigate behaviors (eg sexual arousal) continue to be processed while complex cues that would ordinarily inhibit behavior(eg the chance of contracting AIDS) remain unprocessed and it ultimately leads to sexual intercourse . The second explanation posit individually held beliefs about alcohol effect on behavior prior to drinking as a determinant factor for engaging in high risk sexual behavior. Lang (1985) (as sited in Cooper. 2002, p.102) noted that people who believe that alcohol can affect their sexual behavior have a greater chance of engaging in high risk sexual behavior. In corroboration to the position held by these causal

models studies suggest alcohol abuse as one of the causes of high risk sexual behavior (Malhotra, 2008 p.88; Alem, Kebede, Mitike, Enqusellase, Lemma 2006,p.96).

Different studies supporting both of the above models are available and this fact makes it difficult to prefer one over the other (Cooper. 2002, p.104). While the competition of these models for better explanation in this regard remains unsettled, their significance in enlightening the association that can exist between alcohol use and high risk sexual behavior is fundamental.

Prevention Interventions Addressing HIV AIDS and Their Outcomes

Many countries, both in high and low economic category provide prevention interventions coupled with treatment services for HIV (Canning, 2006, p.129). In low income countries where resource are so tight that neither sufficient prevention nor treatment are being carried out, cost effectiveness analysis is needed as a way of setting priorities between the two. If the need for both treatment and prevention could be met, or if there were no resources constraint at all, priority setting would not be required. The fund that is available for spending on HIV/AIDS in low and middle income countries is however insufficient to meet all needs. Given this fact cost effectiveness analysis proved prevention is the best strategy (Canning, 2006, p.129).

Focusing on prevention is believed to bring large health gains, mainly in the form of infections avoided. Focusing on prevention particularly in the high mortality countries of Africa is said to reduce new HIV infections in the region by a significantly higher number as compared with an estimated outcome of antiretroviral therapy (Canning, 2006, p.133). Considering this, priority is bestowed to preventive efforts directing huge amount of funds and effort to the same efforts (Canning, 2006, p.133).

A number of prevention measures have been intended to lower or prevent the transmission of HIV/AIDS. One set of these measures focuses on reducing the rate of HIV transmission through nonsexual pathways, from mothers to children, and through blood transfusions. A second set of prevention measures focuses on promoting changes in sexual activity. Reducing the transmission of the HIV virus that occurs through sexual activity can be done either by reducing certain kinds of sexual activity or by making sexual activity less likely to transmit disease.

A number of interventions are believed to reduce transmission of HIV through this way. For instance, even though the effect of national campaigns, school based or peer lead education on behavior change is difficult to estimate since a control group is usually not available, evidence suggest that it has brought significant change in some communities. The ABC ,Abstain, Be Faithful, Use Condoms initiative in Uganda, for instance ,combined with a high level of political commitment to HIV prevention, was found to be successful in significantly reducing the prevalence of AIDS (Singh, Darroch, & Bankole,2004,p.129). This provides evidence that broad based and well supported efforts at behavior change can be effective prevention strategies. Voluntary counseling and testing for HIV is also widely available in several countries and has a role in prevention strategies. More significantly couple voluntary counseling and testing can play a great role in prevention by averting risky sexual activity and promoting safe sexual life style (Chippindale & French, 2001, p.1533).

A third set of prevention measures targets transmission rates per unprotected sex act through the treatment of other sexually transmitted diseases and the promotion of male circumcision (Canning, 2006, p.126).HIV transmission is higher while the presence of other sexually transmitted diseases as these diseases gives rise to open sores that allow entry of the

virus to the bloodstream. Such diseases and untreated sores are common in Sub Saharan Africa and treatment of these sexually transmitted diseases is simple and cheap and can significantly reduce risks for HIV infection (canning, 2006, p.128).Treatment of sexually transmitted infections (for general population) provided in primary care facilities, usually including drug treatment, counseling, advice on protection, and condom distribution is one strategy to reduce HIV transmission through sexual acts (Hogan, Baltussen, Hayashi, Lauer, Salomon,2005,p.1432).

Despite promising results in different trials, however, overall findings do not provide convincing evidence that these preventive measures always improves sexual behaviors and prevent HIV transmission. A review of studies in Africa, USA and some European countries on peer led education intervention, for instance, found no clear evidence that peer led sex education promotes condom use or reduces the odds of pregnancy or of having a new partner(Kim & Free, 2008, p.89). Conversely most of the studies found positive effects on measures of knowledge, attitudes and intentions (Kim &Free, 2008, p94).ABC educational interventions, in their many different forms, are not also without controversies about their success in bringing positive behavioral change. Although Uganda's huge success story has become virtually synonymous with this approach to HIV/AIDS prevention and, indeed, it is clear that some combination of important changes in all three of these sexual behaviors contributed both to Uganda's reduction in HIV/AIDS rate and to the country's ability to maintain its reduced rates through the second half of the 1990s (Cohen, 2004, p.132), in many trials the intervention hasn’t been found a simple way to reduction in HIVAIDS(Kim & Free, 2008, p.89).

In research conducted over the past several years, level of basic factual knowledge about AIDS has generally not emerged as a significant predictor of safer sex practices (Smith, 2004,

p.622). Behaviors don't change overnight by simply telling people to act differently than before. Complex, deep rooted and above all underlying issues such as alcoholism, gender inequality, and domestic violence , early marriage by girls, wife inheritance by a deceased man's brother, or having multiple sexual partners without the use of condoms must be addressed (Steinitz, 2007, p.12). These deep seated habits and cultural values touch upon issues of HIV prevention (Steinitz, 2007, p.20). It is argued that interventions must recognize the complexity of sexual relations, which embrace every facet of our lives, including issues of culture, tradition, power and status. Research indicates that attention must be directed to the social and interpersonal contexts of risk and these factors are many and complex. HIV prevention strategies, if they are to be effective in the immediate as well as the long term, need to be informed by researches, take account of this complexity and mobilize multi faceted responses involving the whole of society (Smith, 2004, p.622).

Trends in HIV in Ethiopia

Despite the absence of much local data, all indicators are that the significant risk factors for HIV transmission in Ethiopia are much the same as other countries in the Africa, unsafe heterosexual contact of different forms being the most important one (HAPCO & GAMET, 2008, p.34). A review of the available studies indicated that behavioral factors associated with a high risk of HIV infection include a high number of lifetime partners and the rate of partner change as well as the well known risky behaviors of casual relationships and sex with commercial sex workers (HAPCO & GAMET, 2008, p.34).

The country has been implementing HIV/AIDS prevention, control and treatment programs under the supervision of different ministerial offices and bureaus (HAPCO &

GAMET, 2008, P.39). Among these, preventive interventions of different kind and content were implemented having a priority since the beginning phase of the epidemic in the country. The most prominent are Information, Education and Communication (IEC), Behavioral Change Communications (BCC), Condom Promotion and Distribution, Voluntary Counseling and Testing (VCT), Management of Sexually Transmitted Infections, Blood Safety, Universal Precaution, Prevention of Mother to Child Transmission and Care and Support. These responses to the AIDS epidemic in Ethiopia has been a collective effort of the government, multilateral and bilateral donors, national and international nongovernmental organizations, community based organizations, and faith based organizations, the private sector, associations of PLHIV and individuals. These efforts have taken different shape and intensity during the course of the epidemic (World Bank, 2008, p.77).

Available data also indicate that there does appear to be a decreasing level of high risk behaviors, comparing the data from the 1993 large scale behavioral survey with the results of the 2000 and 2005 demographic and health survey (HAPCO & GAMET, 2008, p.34). However, while HIV infection and risky sexual behavior appears to have increased markedly in the 1990's and leveled off or even decreased slightly since then, a substantial proportion of the adult and youth population still continues to engage in risky sexual behavior(HAPCO&GAMET, 2008, p.36). This means that regardless of continued focus on prevention, there is still a huge potential that the epidemic may continue to be a threat to public health in Ethiopia.

Evidence from both the most recent antenatal care and demographic and health survey indicate that the epidemic may be less severe, less generalized and more heterogeneous than previously believed. It seems to have stabilized or even declined mostly in major urban centers (HAPCO & GAMET, 2008, p.8). Contrary to expectations, however, the small towns involved in

the demographic and health survey exhibited a higher than estimated prevalence of HIV compared to the bigger towns (HAPCO & GAMET, 2008, p.8). One likely conclusion is that there are high risk sexual networks operating in these small towns. There are a number of possibilities as to why there might be high risk sexual networks in small towns. Small towns often are market places where rural and urban people meet regularly. Many of the small town residents may be mobile populations, including traders and businessmen, and as a market and commercial point, there would be bars and local drink houses that would attract sex workers and customers both from urban and rural areas (HAPCO & GAMET, 2008, p.8).

The scale of the epidemic in rural areas cannot be fully described due to lack of data, and the available data provide ambivalent findings (HAPCO & GAMET, 2008, p.46). However evidences suggest a huge urban rural differential since the advent of HIV in the country, with urban areas disproportionately more affected than rural areas (World Bank, 2008, p.46).

It has been suggested that because of the heterogeneity of the epidemic, HIV/AIDS programs should not be based on national level statistics, but need to be more focused geographically, and directed to those regions, districts or communities exhibiting higher prevalence rates (World Bank, 2008, p.46). This will necessitate conducting research and disaggregating data to the district level in order to identify hot spots and communities at higher risk as well as predisposing factors as sexual behaviors are determined by a number of socio economic and cultural factors, including, but not limited to, traditional practices and norms supporting high risk behavior, gender roles, alcohol abuse, poverty, population movement, urbanization, war and conflict etc. There is lack of recent and reliable data that could help to unravel which of these communities and factors are of primary importance in Ethiopian context

and it is this heterogeneity of HIV risk factors that calls for a contextualized understanding of each community if effective response is sought (HAPCO & GAMET, 2008, p.38).

The epidemics potential in small towns, where there is the possibility of bridging the spread to rural communities, appears to be huge and has not been given enough attention as the focus was on larger city centers (HAPCO & GAMET, 2008, p.46).This study by focusing on a semi urban (small town) dwellers of homemade alcohol abusers, tried to fill this gap.

Conceptual Framework

The Biopsychosocial model guided this study. The model's principal assumption is that a behavior/problem should be seen in multiple dimensions that initiate and influence it(Wallace, 1990, p.502) The Biopsychosocial model is a theoretical model that explains behavior from an interdependent systems .It allows to address all major areas of the presenting issue across three spheres: physical, psychological, and socio cultural and it holistically examines the interactive and reciprocal effects of these three aspects on a behavior (Stevens & Smith, 2005, p. 25).

So accordingly, this theoretical model helped to frame the study and consider the biological, psychological and socio cultural aspects in and around individuals to understand both alcohol abuse and sexual behaviors that predispose people to HIV. As "a comprehensive and integrative model, in this research it allowed addressing all major areas of the issue" (Kaplan & Coogan, 2005, p.18).

In this study the Biopsychosocial model is used to explain both alcohol abuse and sexual behavior from the perspective of the three major elements: Biological, Social and Psychological. These behavior and experiences of sexual behavior and alcohol abuse are perceived to be influenced by a complex and ongoing interactions between various biological, psychological and

socio cultural factors surrounding individuals. Behaviors such as these are perceived in terms of the Biopsychosocial environment that predicts which form they take or even whether they take place or not.

In this study this model was applied so that it can help as a lens through which the researcher define the nature of sexuality related susceptibility to HIV and also alcohol abuse from biological, social and psychological perspective. It provided a broad and flexible means for framing the nature of investigation in these three areas.

The conceptual framework of the study is summarized in the following diagram.

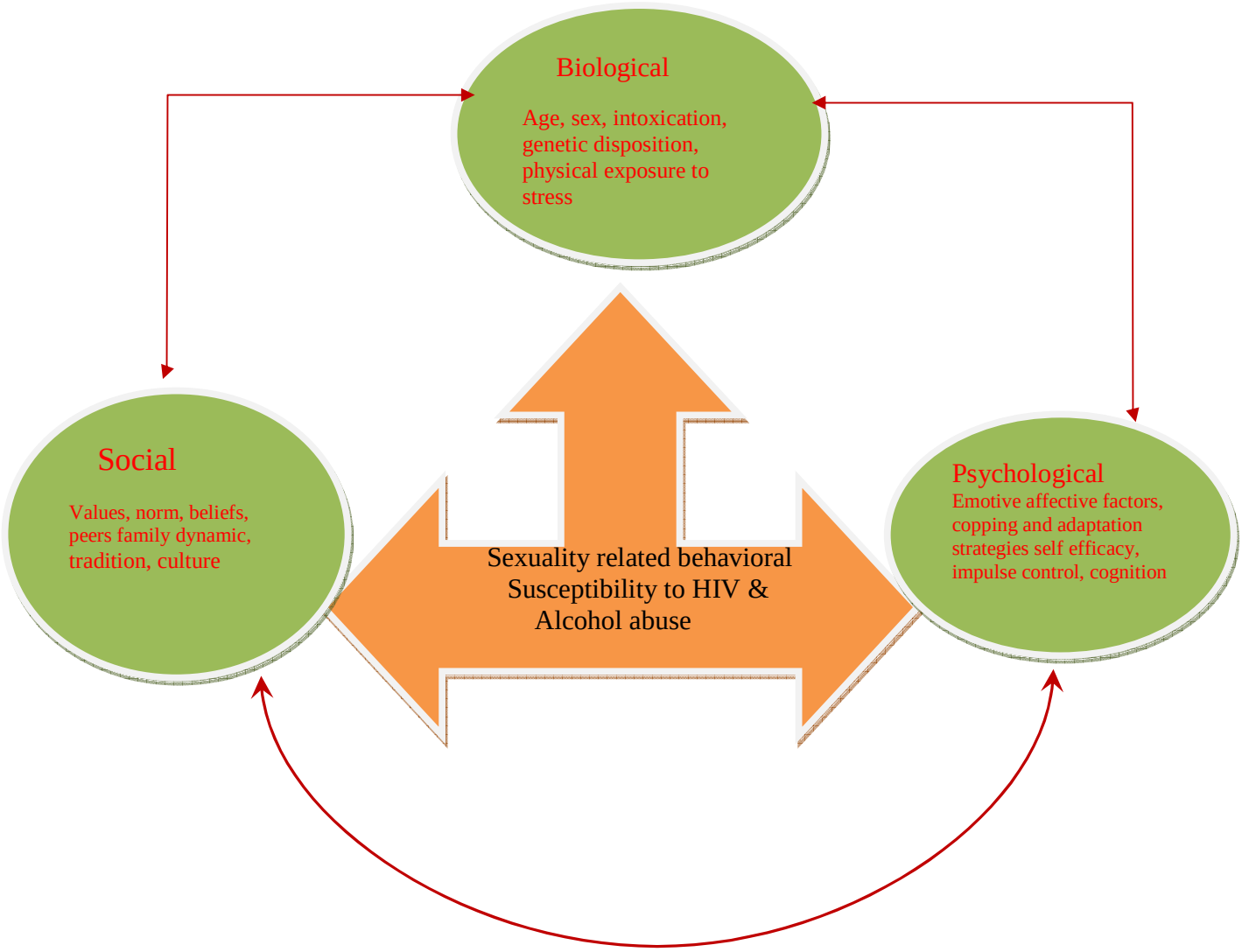

Figure 1: A Biopsychosocial model of sexuality related behavioral susceptibility to HIV

Research Design

The study was developed in terms of qualitative inquiry with a descriptive purpose. This inquiry is best suited for a type of question which is best understood through a detailed account of several individual's common or shared experiences of a phenomenon (Cresswell, 2007, p.80). In addition as Punch (2000,p.8) and Creswell (2007,p. 54) stated qualitative research is important when we need a detailed understanding of the issue and this detail can only be established by

talking directly with people and allowing them to tell the stories unencumbered by what is expected to be found . Thus adopting a qualitative inquiry in this study was based on the justification that the underlying questions of the study are best understood using this approach. The research questions in this study called for an in depth understanding of the issue so that a good detail can be developed to answer them.

Furthermore the research questions in this study basically asked what the situation of this group of people and their environment look like. The general character of the study was concerned with description of facts and characteristics concerning this group and their environment. Hence it was necessitated the use of qualitative approach with a descriptive purpose for this reason (Creswell, 2007, p. 54; Punch, 2000, p.39).

The participants comprised ten individuals. This number of people was found both abundant enough to gather adequate information that was both insightful of major ideas and manageable in terms of time and cost. The interviewees were individuals abusing alcohol (particularly homemade alcohols) selected based on a purposive sampling method. I considered this technique for its credibility taking in to account the availability of many potential participants as the inclusion criteria allowed a relatively sufficient number of people (Creswell, 2007, p.141).

In order to insure the validity of the study substantiating findings with the literature and member checking, through taking the final report back to participants and determining whether the participants feel that the reports are accurate, was undertaken (Creswell,2003.p.221). I tried to ensure consistency of responses through crosschecking questions during interviews. I was the

one to conduct the interview and my role was limited to looking in to the participants experience as it is on the ground without involving personal experiences.

Site Description

Chacha Wereda is a semi urban area located at the skirt of *Debrebirehan* , a town about one hundred and thirty kilometers from *Addis Ababa*. The total number of population is estimated to be more than 2000.The demographic characteristic of *Chacha* community is typical of the general population of the country with high level of young and adult people, low level of old aged population and almost a proportional sex composition. The predominant means of subsistence is agriculture followed by trade.

This site was selected on the criteria that it represents the prototype of an Ethiopian semi urban (small town) community in which homemade alcohol use is customary (Atalay Alem,et al.,1999,p.6). *Chacha* is one typical community in northern *Amhara* region where this tradition is evident. The town qualifies as market places where rural and urban people meet regularly and as a commercial point, there are a number of local drink houses with a high potential of sex workers involvement. Production of alcohol beverages at home, its consumption and retail at small alcohol shops which are the dominant cultural element of most rural and semi urban Ethiopian community are also part of the life style of the *Chacha* community. The cultural context in which alcohol is consumed, social norms and values of sexuality in this community are the reflection of the general culture of the country. This made *Chacha* a place of interest for this research as the focuses of attention was susceptibility of people abusing homemade alcohol to HIV via sexual behavior. This place was found to show the best, most optimal example of the

phenomenon and the setting in which it was most possible to see the situation of the population to be studied (Morse & Richards, 2002).

Inclusion Criteria

The participants of this particular study were selected on the following criteria. Since the study focused on behavioral (sexual) susceptibility to HIV AIDS in the context of people abusing homemade alcohol, male customers of alcohol shops who fulfilled the criteria of alcohol abuse, alcohol abuse as defined in these study, who were sexually active and the residents of *Chacha Woreda* were included. The age specification was from 15 up to 65. This was so considering the fact that people in this age group are those who are most sexually active. The study focused on male population for the reason that it is the culture of the community for men predominantly to use alcohol drinks (Atalay Alem, et al., 1999, p.6).

Data Collection Technique and Procedure

The research used an in depth interview as a primary tool for data collection. In depth interview was believed to best suite the investigation of what individual's experience is, how they experienced it in terms of the conditions, situations, or context, their attitudes and thoughts.

The first two participants were approached through alcohol shop owners and people working in the same shop. At first it was difficult to get volunteers to participate in the study because of the sensitive and personal nature of the subject. After a thorough discussion about the intention and purpose of the interview and issues of confidentiality, the first two participants were willing to go through the interview. Once the two participants decided to get involved, it was easy to find other participants through their network. It was also less difficult to earn their trust because of their friends involvement and clarification about the study.

Interviews were carried out soon after the approval of the School of Social Work to proceed and the whole interview took about twenty three days. A date for interview was arranged immediately after I made sure that the potential respondent fulfills the inclusion criteria listed above and the participant decide to go through the interview. One thorough interview per participant was the first intention because of the time and resource constraint. But second interviews were arranged with few participants as needed. Places for interview were selected based on the participant's preference to insure their comfort to speak and confidentiality of the interview. A semi structured questions was used to facilitate the interviews (Appendix, A). Review of findings from previous studies conducted on the issue was also done to substantiate the finding of the study.

Ethical Issues

This research focused on sexual behavior, alcohol abuse and peoples experience in relation to these two. Drinking behavior and sexual experience of people are very personal information. Because of the highly sensitive and personal nature of the subject the need to maintaining confidentiality and anonymity was apparently important.

I took utmost care to ensure privacy, confidentiality and anonymity of participants. Settings for interviews were as private as possible so that participants could feel at liberty to express their thoughts and their information could be kept confidential. Codes that only I can understand were used instead of names to identify participants. The information gained from interviews was kept confidential and it was destroyed after the study was finalized. Nonetheless the findings of the study, which is free of any indication of the personality of the respondents, may be used for any academic or publication purposes.

Another way of addressing ethical issues was by obtaining informed consent from participants. Explanations was given to participants that they have the right to decide to participate or not, and they were informed in detail about the content and purpose of the research before signing a consent forms. By this I made sure that participants took part in the study based on their free will.

Data Analysis Process

In order to analyze the textual data, first the audio taped interviews were transcribed in to *Amharic* then English. Then I studied the data (interview transcription) repeatedly until I achieved an understanding of the main points. I highlighted "significant statements" that provide an understanding of the participants experience. Markers with different colors and a copy of the original interview transcript were used to highlight these statements in order to avoid confusion and keep the original material untouched. This helped maintain the possibility of reference whenever I needed. This process was followed by coding, the purpose of which was "to get from unstructured and messy data to ideas about what is going on in the data" (Morse & Richards, 2002, p.111). It allowed me to simplify and focus on some specific characteristics of the data. The topics about which respondents were talking about served as important base for coding. Out of these codes, thematic areas were developed which refers to labels given to discrete phenomena (Bryman, 2004). These labels were then used to write a description of what the participants experienced (textural description). These labels were also used to write a description of the context or setting that influenced how the participants experienced this phenomenon. First these labels were written in separate sheets. Then every participant's experience of sexuality and alcohol abuse from the transcription paper was copied and categorized under their respective labels that were written in separate sheets. From these descriptions, I wrote a composite

description that presents the “essence” of the lived experience, called the essential, invariant structure through comparison of agreements and similarity within and among categories (Creswell, 2007, p.80).Primarily this passage was focused on the shared experiences of the participants as I tried to derive commonalities in such a way that answer the research questions.

Finding

Socio Demographic Profile

All participants were male and all of them were found to be clustered around the age of mid twenties and early thirties with the exception of one participant in his mid forty. The youngest participant was 24 years whereas the oldest was 46 years old. There were two participants aged 26 and another two aged 27.The rest participants were 30, 31, 32 and 34.Therefore this makes participants to be composed of relatively adult people.

Three participants live with their family, either with their parent(s) or siblings, whereas two are married and live with their family of procreation. Participant 1 lives with his elder brother's family. He used to live with his parents in a nearby countryside area. He came here to access education and work opportunities. Participant 3 and 9 live with their parents and grandmother respectively. Participant 4 and 7 are married and have children of their own. The rest five live alone by themselves. Participant 2 and 6 emigrate from their parent's home in remote rural areas and lived as bachelors in *Chacha* for years. Participant 2 is an Ethio-Eriterean veteran .He left his family to join the army and never get back since then. Participant 6 permanently resides in *Chacha* but happens to visit his family once in a while. Participant 5 grew up there but he lives alone in his dead parent's house (yekebele bet) as he is the only child to his family. Participant 8 has his x-wife and two children at a nearby rural area and he came to *Chacha* seeking for a job. Until recently participant 10 used to live with his girlfriend in cohabitation. However since the last two years he is living alone as his girlfriend went abroad for work.

As to the work type and educational level, most participants dropped out of school after they began secondary school. Participant 1 dropped out of school from grade nine. He had a plan to attend night school while working in his brother's small business. However he couldn't do as planned regarding his education as he left school the first semester he started ninth grade. He is still employed in his brother's shoe repair shop as an assistant.

Participant 2 dropped out of school from grade ten to join the army. He has movie rental shop and he does a small level broker (serategna ena aseri magenagnet , eka mashashat yemesaselut). Participant 3 dropped out of school at grade nine. Until recently he was working on road construction. However currently he is unemployed as the road construction is completed.

Participant 4 attended class only up to grade two. He had a farm land near by the town and farming and trade (of crops) are the main means of subsistence for him and his family which consist his spouse and three children. Participant 5 completed grade twelve but did not continue because he couldn't score the point necessary to join university. He has no permanent job. However he does short term jobs (teberari sira).

Participant 6 dropped out of school at grade eight. Participant 7and participant 9 managed to finish grade eight but couldn't proceed afterwards. Participant 6 is a day laborer. Participant 7 has a horse and a cart he inherited from his father and he earns his income by transporting people and commodities while participant 9 is unemployed.

Participant 10 is a painter (of houses). He has finished school at grade ten and took the national examination for preparatory class to higher education. Currently his main means of subsistence is painting and finishing work for buildings added with the money his girlfriend sends him once in a while from abroad (remittance). Participant 8 went to school up to grade six.

Afterwards he had to support his family by engaging in farming until he sold his oxen and came to *Chacha* in search of better income and employment. For the time being he works in market places as bearer (teshekami).

Almost all participants were found to be followers of orthodox Christianity. All participants except participant1 are members of the Ethiopian Orthodox Tewahido religion. Participant 1 is from Muslim family. Even though some participants explained that they are not strong followers of their religion, all participants still affiliate themselves with their respective religious community.

Experience with Homemade Alcohol Abuse

First Encounter and Current Pattern of Abuse

The most abused type of homemade alcohol beverage among the participants was found to be *Araki* followed by *Tela.* But most participants are not limited to these drinks only. Some participants indicate that these traditional beverages are substitutes for modern alcohol drinks for economical reasons while for most others these drinks are major means of leisure. Also for some participants other substances such as *Chat*, *Shisha* and cigarette accompany these alcohol intake. Most participants indicate that they have started drinking at an early age in the home setting particularly during religious celebrations and holidays. In this respect participant 4 explained:

> I grew up in a family and community where homemade alcohol production and use is the custom. It was the tradition to gather around and drink together with the neighborhoods whenever a drink is made in a household. So I started drinking at a very early age and I lived my life the same (“yenorkubet new”).

Participant 6 also explained:

> As I was in service of God in church, during holidays after mass, me and my friends used to attend festivities of religious holidays at different households in the neighborhood one after another and as boys, to whom drinking alcohol beverages was considered a sign of growing up we used to be invited to drink more and more ("Bemote teta tebiye new yadegkut").

Participant 9 on the other hand was raised with his grandparents whose main means of subsistence was home retail of these alcohols. He explained:

> Growing up my grandmother used to give me a very little amount of alcohol while serving my grandfather and his friends who were also her customers when they gather around at our house for drink (as they usually do most times).

To this contrast, participant 1 indicated that he began drinking late in his teenage. He explained that since he was from a Muslim religion follower family where home fermentation and use of alcohol is not the tradition, he doesn't have an early experience of drinking. Participant 7 also explained that he start drinking late. He said "even though my father was a heavy drinker, he wouldn't allow me and my siblings have more than a glass of *Tella* and that would be only for holidays."

All participants explained that they attend these liquor houses most days of the week unless for reasons of financial difficulty. The most common time is during the evenings after 6 PM. Participant 9 explained that "since I spend the day chewing *Chat* and looking for a daily job or working on one if any is found, it is at the evenings that I go to liquor houses." However, some participants indicate that these alcohols might be taken early in the morning or at the day time. Participant 3 explained "I sometimes drink at mornings before I go to work. Drinking *Araki* before going for work helps me stand the sun burn and gives me strength for the work on the

street (le tsehayu gulbet yihonegnal biye new tewat tewat yemitetaw)." Participant 5 also explained that *Araki* could help the cold weather. Participant 4 on the other hand indicate that at times he and his friends could spend most part of the day time drinking at home. Furthermore for most participants friends and co workers are common reason for regularly attending these liquor houses. These places are where most participants sought for social company, support and leisure. Participant 4 explained:

> Most times one of these drinks will be available at home since my wife brews *Araki* to sell for retailers. But even at times when these beverages are available at home I regularly go out in the evening, to have a drink and chat with friends at the nearby liquor house where we usually attend.

Participant 1 also explained "at the beginning I used to drink just because I was hanging out with friends who were users of *Araki*. But as time goes by I myself become permanent customer (qumai teselaf honkugne)." In much the same way participant 7 explained that he was introduced to these liquor houses for the first time by his co workers who were also his friends. He explained "I used to enjoy having a drink with friends because I was free and I was able to do what independent grown men such as my friends could do." Participant 3 as well explained "after being so exhausted working on the street me and my friends always go to have drink at this liquor houses as these are the places where we get together to enjoy the evening." Furthermore participant 8 explained "living in the city is difficult and living alone makes it even worse. So drinking with friends is what makes me forget about what is going on in my life."

Alcohol Abuse Related Problems

There were physical, psychosocial and economic effects that were brought on participants as a result of their alcohol abuse. Some of the physical effects commonly mentioned by most participants include headache and gastritis. Several participants explained that headache is a common experience every morning. Participant 2 and10 were diagnosed with liver and lung problem respectively due to their long standing heavy *Araki* drinking added with other substances. Participant 2, 5 and 9 have gastritis because of their high dose of alcohol added with *Chat*. Participant 5 explained that currently he can only eat selected food types as a result of his gastritis problem. Other physical conditions most commonly experienced by participants are unfavorable body and mouth odor, nausea and fatigue.

Most psychological effects participants indicate were either the result of the alcohol intake itself or due to the socioeconomic problems that participants encountered because of their alcohol abuse. Depression is most frequently mentioned by several participants. Participant 1, 2, 3, 5, 7and 9 explained that if they got drunk at night, they will experience depression (boredom) the next morning. On the other hand participant 1, 5, 6 and 7 explained that they will be depressed unless they took some amount of alcohol every night. Insomnia was mentioned by participants 2 and 10 when they couldn't get alcohol at night.

Embarrassment and humiliation was mentioned by participant 10. He said "I would only go with guys I know in remote neighborhoods from mine and we go at night so that people who know me don't see me going to *Araki* house." Participant 5 and 7 expressed their feeling of inferiority to other people who don't drink. Participant 5 said "It is not a good thing to be called a drunk with local drinks (sekaram yawim ye araki mebal tiru sim ayidelem)." Participants 7

would be annoyed and argumentative towards people especially when he can't access alcohol when he needs it.

Anxiety, depression, guilt and self disappointment were also reflected by participants 3, 4, 7and 9 as a result of argument and quarrel with family members because of their alcohol abuse problem and related misuse of money. Participant 7 explained "sometimes if I got drunk, I wouldn't want to go home because I know what (a fight with his wife) will be waiting for me home." Participant 9 explained that some members of his extended family don't want him around their children and their house. He said they don't trust him with their property and they believe he will be a bad influence to their children because of his drinking behavior.Participant1 explained that his brother's family has threatened to drive him out of their house several times because of the disturbance he created being intoxicated. Participant 3 said his mother doesn't approve of his drinking behavior and nag him to stop with every opportunity she got which makes their relationship uneasy. Participant 9 broke up with his earlier girlfriends because of his problem of alcohol abuse. Participant 7 explained that his relationship with his neighbors is argumentative. He said that his neighbors always complain that they are being disturbed by his behavior when he is drunk and his fight with his wife at night.

All ten participants, however, describe their relationship with their friends, who are also users of these homemade alcohol drinks, as a good one. Unlike the situation with family members, all participants explained that their relationship with their friends goes as far as supporting each other with money for alcohol and other substances. Participant 10 explained that "we understand each other and we will not be embarrassed of anything when we are together because we all are in the same situation." Participant 5 explained unlike with his friends who drink with him, he will feel discomfort when he is with people who don't.

Participants also explained economic problems they have faced as a result of their alcohol abuse problem. Loss of interest and motivation for work, ineffectiveness, and disagreements with their supervisors were mentioned. Participant 3 said he was fired from his previous guarding job in a private market place because he couldn't effectively do his work. He said "I was fired because I couldn't be at my work place for I went to the nearest *Araki* shop with friends and the place was robbed." Participant 5 also quit his previous job because of a related reason. He explained:

> When I drink too much and get home wasted, I will always have hangover the next morning and I feel very tired and loose interest for work in the morning. So I was always late for work because of which I argue with my boss all the time and one day I stopped going.

Participants2, 3, 5 and 7 also explained economical disadvantages of their drinking behavior and consequently the related poor quality of life. Participant 2 and 9 explained that they have borrowed a large sum of money from different people and could not return it on time because they spend what they earn on alcohol and *Chat*.

First Sexual Experience

As explained by participants most of them have an early sexual debut. Participant 3 for instance was involved in a sexual relationship with the opposite sex as early as fourteen years old. In the same way participant 4 explained:

> "Boys were allowed (or tolerated) to have a relationship with the opposite sex in their teenage which implicitly is known and acceptable to involve sexual contact unless it is

> accompanied by out of wed lock pregnancy. So it was when I was very young that I had my first sexual contact with the opposite sex."

Most participants indicate that the major reasons for initiation of sex were curiosity and romance. Consequently for most participants to whom sexual initiation was out of romance, first sexual experience was with a partner they were emotionally involved with while for others to whom sexual initiation was out of curiosity, it was with a partner with whom no prior relationship or emotional attachment was present. Participant 1 explained "I was seventeen years old and it was my age. She was my first girlfriend and we were in love and in a relationship for months before having our first sex." On the other hand participant 9 explained that he had his first sexual experience with a girl he only knew in his school. He explained:

> We were children on the way of turning in to adults and because it was our age we had a desire to experience everything like having a girlfriend. So me and most of my friends did tried many things including sex, *Chat* and alcohol.

In much the same way participant 2 explained that his first sexual experience was with a waitress in the bar whom he happen to know when he went there with his friends to have a drink while he was with the army. He explained that after a week since their acquaintance they have already started having sex.

Even though most participants were aware of the risks for STDs including HIV AIDS, protection use at first sexual intercourse was seldom for reasons such as negative attitude for condom, love and trust, impulsivity, alcohol intake before sex, negligence, fear of stigma, wrong notion about sexual safety and ignorance of risk as a result of young age. Participant 1 explained:

> It was my first time and so was hers. Even though it was the time when AIDS was so famous and scary we didn't use any protection except birth control. At the time condom use was not even the issue as we thought it would ruin our relationship that was built based on trust and love.

Participant 8 also explain "even though we heard about AIDS and the need to use protection, condom use was considered as a taboo ("newer") and we believed that the condom itself is the one bringing the virus so we prefer not using one." Participant 2 as well said that "even though we used condom for the first sexual contacts, we couldn't keep that for long. Since we usually had drinks before sex, we start forgetting about the condom." Participant 6 furthermore explained that he didn't use protection for his first sexual experience because his girlfriends were virgin and because of the fear of social stigma. He explained "I didn't want to ruin my reputation if in case I was found buying a condom." Participant 5, moreover, explained that because of the spontaneous nature of his first sexual experience he didn't use protection.

Participants explained that after their first sexual experience, since for all of them the relationship they had with their first partner didn't last long, they have been sexually involved with several partners including with women they had a stable relationship , with casual sex partners and few, with commercial sex workers.

Recent Sexual Relationship History

As participants said they are all sexually active at the present time. Two of the participants (participant 4 and 7) are married and most others are in a relationship. Other respondents expressed that even though they are not involved in a serious relationship right now

they still have sexual partners and are sexually active. For all participants heterosexuality is found to be the only sexual orientation.

All participants have several life time partners. In explaining their resent sexual history most indicate that they have been involved with multiple partners both over and at a time.

Participant 1 explained that even though he is not in a relationship at the moment during the past eighteen months he has been in three consecutive relationships involving emotional attachment and sexual contact. In addition to this, he indicates that there were/are also women with whom he had sexual relationship for the time being ("legizew abireachew yeneberkuahew"). In much the same way participant 6 explained his current involvement with a women on the same condition. He said "I am not serious about her as I have another girlfriend." Participant 2 on the other hand explained his current relationship:

> "It is a relationship where we both know that we are not committed to each other as she is a married woman. Even though we are sexually involved and didn't talk about it in open, I believe she knows that I am involved with another girl."

He indicates that he is currently sleeping with three women including his married girlfriend. In the same way participants3, 4, 7, 8 and 9 explained their current and recent past sexual involvement with women besides their spouse and girlfriends. Participant 4 explained "I have been with this woman (his mistress) for three years now since the time I start attending her liquor house." Participant 5 also explained about his resent sexual relationship history:

> Before my current girlfriend I have been involved with three girls at a time. Before that too, I had many girlfriends with any of whom I can't say I was exclusive. I wasn't emotionally involved with most of them. Rather I was in love with another girl. It really

> didn't matter for me as long as I got what I wanted from them which basically was sex and sometimes money.

Participant 8 on the other hand said:

> While I was in the rural, at times before I got married, when I used to go to the city with my friends I also used to visit alcohol shops and build relationships with women in the city. But also after I got married too, I continued doing the same.

Sex with casual partner is a common experience for most participants even while being involve in a stable relationship. In reasoning his involvement with casual partners, Participant 9 explained "as my girlfriend was in *Debrebirehan* most days of the week for work, what else can I do about it until she come home?"

Sex with commercial sex worker is still an option for few participants at the present time. Participants 6 and 8 explained that at times they have visited commercial sex worker during the past six months. They also explained that they still visit commercial sex workers. More participants however indicated their involvement with commercial sex workers in the past. Participant 2 explained his previous abundant sexual experience with commercial sex worker while he was in the army. On the other hand participant 9 explained that even though he had sexual experience with commercial sex worker in the past, he is no longer involved with one. He said "the risk is very high."

Protection Use during Recent Sexual Experiences

Protection use during sex explained in terms of male condom use , as all participants indicate this is the only condom type they are familiar with, was not found the most important

and decisive matter for most of the participants. This is particularly of the case if sexual intercourse is with a virgin, with a healthy looking partner (normal body weight and look), and with a stable partner where there is emotional attachment and long term acquaintance. Participant 1 explained:

> During sex with casual partners and with girls I don't know well, there is no guaranty that I don't get the disease since I don't know with how many people she has slept with previously and no one know if she has the disease or not. But In all the serious relationship I had, I trusted them and they trusted me back and since we loved and trust each other and we talked each other's past sexual history, we were confident that there is nothing to worry about and hence to use protection.

Similarly participant 10 explained that in his relationship with his previous girlfriend with whom he used to live in cohabitation, condom was not applicable. He said "we were living in a marriage like arrangement so it was inappropriate to use condom with her." With other stable relationships as well he explained that condom might be used in the beginning but as time goes by it will be left out.

While a positive attitude and intention is exhibited by most participants regarding the use of condom for sex with unreliable partners, in terms of consistency however, most participants explained their difficulty. Though some participant explained that compared to their past, they have achieved a consistent condom use especially with unreliable partner and at risk people (mostly with commercial sex worker) in their recent sexual life, for most others this is not the case due to several reasons including poor impulse control, negligence and intoxication. In compliance to this is what two participants (participant 2 and 3) explained. Participant 2 said:

> In my early past I remember several incidences where I have slept with commercial sex workers as well as casual partners without using condom. But now even though I have slept with different girls I use condom especially if the situation seem risky for me. I am sure I am going to be fine whether I have sex with one person or ten as long as I am using protection."

In contrast to this however participant 3 explained:

> I intend to use condom with every sexual contact I have with all women except my girlfriend but I usually do not follow that through. Some reason would come up and I would fail to use. Sometimes condom will not be available around at the time of sexual arousal, other times the condom we have in the room will not be enough, and sometimes I would be careless when I get in to that kind of situation and using a condom after that will make no difference, because what has been done is already done.

Also participant 6 explained "even though I believe I have to protect myself as much as I can I was inconsistent in my condom use because of reasons that were out of my control. (Intoxication and impulsivity) " Participant 7 as well explained his difficulty in consistently using condom by saying:

> For a person like me it is difficult to always be alert about condom and use it in every sexual contact with other partners. I couldn't keep a condom in my pocket as that would make my wife suspicious and furious at me if she found out because I have never used condom with my wife.

Similarly participant 9 said:

> It is hard to be always protected unless you keep a condom in your pocket. Casual sex happens without planning and you couldn't always anticipate of having casual sex and be ready to have a protected one. That is what happened most times with me. I will just start feeling uncomfortable about it once it happened.

To the rest of participants exception, participant 4 explained that he has never used condom in his entire life. He explained that in contrast to his sexual experience with several women in his life, he believes he has never been sexually involved with unhealthy women. He explained that now he is indiscriminate in his sexual life than earlier time when he didn't believe in HIV AIDS. As far as his wife and the other woman are concerned He said:

> I know them both for long time and I know they will not go with anybody else. Where else can they bring the disease? So why bother with using condom. Besides in the entire time we have been together, which is a very long time, I haven't been sick and neither were they.

Several participants expressed different ideas based on which they judge their partners risk level and health to determine the use of condom. Among these the prominent includes the following. Participant 2 explained that since his girlfriend is a married woman and she gave birth to a healthy baby recently he believe she is healthy as a result of which he doesn't use protection with her. Also he explained that sex with a virgin partner is safe and he doesn't use protection during sex with such partners. Participant 8 explained that he doesn't use protection with his girlfriend for she came to *Chacha* recently from a remote countryside. He explained "she couldn't have the disease." Participant 5 explained that he is certain that his partner was

healthy because she was his friend's x- girlfriend before he went to abroad a year ago. He said if she had HIV, my friend couldn't make his way to the state as he would have failed the test.

Protections Used Other than Condoms

In explaining what other safe sex ways, if any, they have used, participants explained several ways that they believed and did to protect themselves against HIV and other STDs. One most commonly cited means is the use of different ways of sexual act other than the common vaginal sex. Not so few participants explained that they have tried oral sex, anal sex as well as vaginal outer course. These participants believed that these sex types are safer than that of the common one (vaginal intercourse). Participant 1, 2 and 9 explained that they have used vaginal outer course when they had sex without condom with casual partner. They explained that it could prevent contracting HIV or any other disease as it prevent taking in vaginal flood. Moreover participant 2 explained that while having sex with commercial sex workers he have tried anal and oral sex. He explained:

> Sex with commercial sex worker is paid for and some prostitutes will not resist if you pay them more money than their price and since commercial sex workers are people most at risk, it is worth paying some more money and be safe than take a risk with the regular price.

Also participant 6 has resorted to anal sex few times with commercial sex workers. The explanation he gave is much similar with that of participant 2 that he believed it is safer than the regular one. Participant 5 explained that he had vaginal outer course, oral and anal sex while having sex with some of his girlfriends when it was impossible to use condom or intercourse for various reason. Participants explained that since it is HIV safe to have anal, vaginal outer course

and oral sex, they have never used condom during this times. No participant however explained of being involved in a group sex or forced sex (rape).Furthermore participant 9 and10 explained that they have used coitus interuptus as a way of HIV AIDS prevention especially for sex with casual partners. Participant 9 explained that "if it could prevent pregnancy so can it prevent HIV or any other STD."

Patterns of Sexual Experience

Most participants explain that the usual place where they could have sex is at their house/their partners' house or a friend's house. Some also said, particularly for sex with casual partner and commercial sex worker, they could use an alleyway, hotel room, or in public toilets, *Shisha* house and brothel rooms.

For all participants the usual time when most sexual experiences happen is early at night before getting home. However, not so few participants said they have had sex in the midst of a day. Most times especially at night participants explained that sex is accompanied by alcohol abuse (before or during). In explaining the most common instances where sexual arousal occurs, some participants said that alcohol abuse could cause sexual stimulation while others explained that they are unaffected by it. Participant 2, 5, 8 and 9 explained that drinking alcohol could elevate sexual stimulation. Participant 2, 5 and 9 said that when taken with other substances such as *Shisha*, when watching pornographic movies, and when female partners are around the urge for sex could be stronger than the normal .Participant 5 explained that the level of alcohol he took, the availability of sex partners and prior conversation and temperament will determine sexual stimulation. Participant 8 explained:

> If I am drunk it is most likely that I would want to have sex. It feels like alcohol and sex goes together. If I drink I would want to have more fun and I would go for sex and having alcohol before sex would make it more enjoyable.

An immediate acting out of this sexual stimulation, however, is not a usual experience for these participants. This is partly because sex workers (professional), casual partners or stable partners are not available at these local drink places as it is not the tradition for women to attend these liquor houses and nor commercial sex workers prefer these places for work. Still some participants assert that there are few cases. Participant3 explained that there were cases of instant sex with casual partner after sexual arousal related with alcohol intake. Participant5 explained that he had casual sex with a woman who is the daughter of the owner of the *Araki* house he used to attend. He said "we used to do it in the midst of my stay at their house for drink."

For other participants, nonetheless, it is not the immediate sexual arousal that initiates most sexual contacts. Most sexual experiences according to most participants are anticipated before getting drunk or even having sexual arousal. Participants indicated that rather than alcohol initiating sex, they drink deliberately before sex so that they can enjoy having sex later. Participants believe that having sex while drunk make it more pleasurable and provide relaxation. Participant 1, 4 and 7 explained that even though there were instances where unanticipated casual sex has occurred and alcohol is usually taken in advance, most sexual contacts have been expected in advance to taking any alcohol and having sexual stimulation. They explained that even for those instances of unanticipated sexual experience, they couldn't account alcohol intake as it would have happened without it anyway. In corroborating this, participant 1and 7 mentioned instances of spontaneous sex where there were no alcohol taken

initially. For participant 3, 10 and 6 as well the natural ways (planned sex and physical intimacy) are what often prompt most sexual contacts.

Alcohol Abuse Related Unsafe Sexual Experience

As to how alcohol abuse might affect protection use during sex most participants explained that on instances where they were in advanced state of inebriation, they couldn't precisely remember if they have applied condom properly or even if they have used condom at all. Participant 1 and 6 explained that there are a number of occasions when they couldn't tell whether they have used condom or not because of their inebriation. Participant 7 on the other hand explained that alcohol might have increased his negligence. He explained:

> Even when I am absolutely under the influence of alcohol I am aware if I have to use protection and in most instances when I didn't use one, it was a conscious decision. May be alcohol could increase my carelessness at the time but it didn't blind me of the fact that I have to use.

As to participant 2, 3, 5 and 9, even though they emphasize failure to postpone the urge for sex for most risky sexual contacts they had, they explained that getting drunk added with unavailability of condom around might have encourage sexual risk taking. They explained that in most of instances where they took sexual risks, they could have been drunk. Never the less all participants acknowledge few instances they were sober but had sex without protection for there was no condom around or enough condoms to use the whole time they had sex at that specific time. It is not the alcohol that necessarily that leads to unsafe sex. Yet it could have a definite contribution to it. Participant 3 explained a couple of times when he has been drunk but reminded and also encouraged to use condom just because he happen to have it around. He said

"chances are that I would have continued without it if I couldn't have it at hand and that would have been a mistake I wouldn't have made if I were sober." Just the same way, participant 9 explained:

> Even at times when I was drunk, I could have used a condom if I could grab one from a nearby place. It really could help because I know from my experience that even while I was under the influence of alcohol I looked for condom but failed to have a protected sex because I couldn't have one.

According to participants 8 and 10 the situation is rather the opposite. They explained that at times they were inebriated they are more vigilant of their protection use. Participant 10 said "when I believe I am on the way of being intoxicated I become aware that I might be in trouble so it is usually at these times that I am most careful to use protection (mok yalegne meslo ketesemagne tinikake madreg endalebigne asibalehu)." Also participant 8 explained "it is like when you are weak, you will be on your guards."

Content of Conversation before Sex

Participants indicate that conversations about taking measures of protection, such as demand for blood test or condom use, request about blood status of HIV or previous sexual history almost always occur before having their first sex, if they are ever going to take place. Participant1 explained that in his experience of all the above issues most women he has been with are more interested in knowing about his previous sexual history. He explained:

> I would also like to know my partner's prior sexual history because if I know that she is a virgin there is going to be no fear for anything. But some women could insist on using protection especially if it is their first time. Otherwise condom was not a significant

subject for most of my girlfriends. But if I feel like I need it, it could even be me taking protective measures even when my partner is not asking for it and even when they don't like it they will not be bold enough to challenge you against it."

But neither this participant nor his partners happened to demand to have a blood test as both have never been tested and are unwilling to do so.

Other participants also corroborate that, conversations about previous sexual history are more frequently to take place than either protection use or blood test request. In explaining his experience participants 2 said that though the validity of the information shared is questionable, talks about past sexual experience happened several times than any other subject in this matter. In a much similar way participant 5 explained that with most women he has been involved with, prior sexual experience, pregnancy control and, though not as frequent as these two, condom use talks are among other things what constitute most dialogs before their first sexual experience but not demand for blood test. Most times they are initiated from the women side. Participant 6 explained "why would I ask her if I need to use protection? It will not affect her differently whether I use condom or not."

The essence of most conversation between sexual partners is found to vary based on the type of relationship the couples have. It is implied that in a stable relationship where the couples start having sex without protection, where the partners feel there is sexual responsibility and where there is expectation of trust, it is unlikely for partners to have a conversation that give emphasis to sexual safety. For these participants it includes all matrimonial relationship and serious stable relationships. Even when conversations about sexual safety are to happen, they are often channeled in an implicit ways. It is found that it is much easier to talk in a masked and

indirect ways as it is commonly assumed that questioning on these matters (either directly through questioning blood status or indirectly through demanding to use protection) in a direct way is offensive to the person being asked. A more evident explanation suggesting these points is given by participant 9. He explained:

> In my experience with my girlfriends this kind of conversation came before having our first sex. What I have come to notice from my past is that if we decide to use protection there is a high probability to go without it at some point in time. But once we trust each other and decide and start having sex without condom we are unlikely to discuss about STD protection latter. It will be rude to raise an issue about protection because if she does, it means she is questioning me and is suspicious of my health. This is basically the reason for my breakups with my previous girlfriend. There is` only one reason to ask for condom use after being together and start having sex without it. It means she is questioning if I have the disease and being questioned about HIV makes me angry like everyone else. I guess after hearing a rumor about my history with other girlfriends, some of the women who had been with me tried to blame it on avoiding unwanted pregnancy when they want to use protection. But if I don't trust her I don't need to ask her permission to use a condom and I wouldn't compromise that just because she demanded not to have protection. In fact if a girl insists on no protection use it will make me suspect that she has the virus and she is deliberately trying to transmit the disease for me. Most of them don't argue in these matters anyway because condom or no condom what difference will it have for her? The difference is for me. The only thing she could be disappointed about is that I don't trust her.

Participant 4, in substantiating the above points explained:

> Blood test or condom will do nothing for us because we are husband and wife. There is no need for that kind of talk with my wife. We both know that we are healthy people. It is not considerable because it is inappropriate to bring this kind of thing in our home. It will bring nothing but distance and mistrust between us. With the other woman as well we both didn't see the importance as long as we know each other very well. We have never discussed about it before sex or any other time. We know we both are healthy.

In a more open relationship where there is no sense of obligation for trust and no long term acquaintance participants explained that there is a high possibility for initiating negotiation about protection use from both sides. With most casual partners and in a relationship where both sides know the absence of shared commitment participant explained that it is common and justifiable to ask for protection use than prior sexual experience and demand for blood test . Participant 3 and 5 explained that with their girlfriends with whom they were not seriously involved, it often happened that their relationship is basically for fulfilling their sexual need and both parties could ask for protection use openly. Participant 2 explained:

> In relationships I wasn't serious about, it doesn't matter if she doesn't believe me because I wouldn't believe her too. She needed to protect herself as much as I did. For that I cannot blame her and she cannot blame me. We were just two people having fun for the time being and as long as we had that there is no problem whatever she or I said.

Participant 10 explained:

> With casual partner, it is high probable that you don't know anything about her and she doesn't know anything about you. Even after you talk about each other for a while there is no reason to believe that we both are telling the truth and trust each other. There is no

> time to get to know each other before you happen to sleep with her. There is no time to get tested if we are even to consider it. That is why it is casual sex(dingetegna sex).So it is more likely that the girl demands for condom use if I was going without it for fear of pregnancy as well as HIV AIDS .

On the other hand, on the contrary to what other participants explained, participant 9 explained about sex with casual partner:

> It is almost always impossible to consider talking about this kind of protection matters. On the first place casual sex means accidental sex (dingetegna sex mallet dingetegna new). You wouldn't have the time to talk, or negotiate about condom use or any other thing especially if both of us were in the same emotional state. You will just use it if you happen to have it around but otherwise it is difficult.

Participants also explained that with a commercial sex worker condom use or no use, it depends on the woman. They explained that most times commercial sex workers are not willing to even bring protection use for negotiation. But there are some who would go without it if their payment is raised.

Blood Test Experience

Most participants explained that they have never got tested for HIV. Participant 2, 5, 6 and 7 explained that it is frightening to know if they have the virus. Participant 2 said:

> Having my sexual experience with several people including commercial sex worker without using condom, it is terrifying to know my blood status. I don't want to know if I am going to die soon or latter. I will die when I die.

Participant 1 and 8 said that if people know they went to clinic to get tested, it would be concluded that they have the disease. Participant 8 explained "if people know that I have been to the hospital to have my blood tested, it will be deemed that I have the virus and they will discriminate me." Participant 10 has been in a surgery before four years during the procedure of which he knew that he was HIV negative but never got tested before or after that. Participant 3 and 9 have given their blood to be tested during a blood test campaign but never knew their results as they left the testing center before they could be told. They explained that they were anxious to know. Participant4 never thought of getting tested as he believes that there is no need for that because he thinks there is no possibility he could have got AIDS.

History of Sexually Transmitted Disease

Several participants explained that they have been treated for different sexually transmitted diseases few times before. The common diseases that most participants have been infected with are gonorrhea and syphilis. Participant 2, 4 and 8 have been treated for syphilis. In addition to this participant 2 and 6 were infected with gonorrhea. Participants 1 also explained that he has been treated for sexually transmitted diseases he doesn't know. Participant 8 explained that he had a health complication as a result of a sexually transmitted disease he was infected with. Replying if they have ever been sexually engaged knowing they have been infected with venereal disease, participants 2, 4 and 8 replied positively. Participant1 and 8 on the other hand explained that they have slept with a partner infected with STD knowingly. Participant 2 said he was protected while participant 8 explained that he didn't remember taking any protective measures for that purpose. He explained that he had sex while he was being treated for the illness. Participant 1 explained that he didn't know that he was ill at the time and he didn't use any protection as he and his girlfriend have been having sex without protection.

Participant 4 on the other hand explained that he wasn't protected because he believed it was a curable disease. None however said they have slept with a partner infected with HIV virus knowingly.

Discussion

As the findings indicate participants have several commonalities regarding both their alcohol abuse and sexual behavior. With the exception of one participant, whose religious sects in contrast to the others prohibit the use of alcohol, all participants start drinking early. Most participants start taking alcohol in their early teen age in a family setting as home production, consumption and retail of these alcohol beverages is common particularly for religious celebrations. This finding is similar to that of Atalay Alem, et al (1993, p.6) and Abebaw Fekadu,et al (2007, p.43). It implies that drinking is a way of social life embraced in religious creeds. It is encouraged in family settings and by peers, particularly in the case of males. Alcohol use was normal and expected particularly on occasions of social gathering and celebrations. Also as the finding indicate that children are encouraged to take alcohol in the family setting as it signifies maturity.

Peers are found to be important predictor of alcohol abuse especially during adulthood. As explained by participant, though the home environment is the foundation for alcohol abuse, peers are found to be one of the most sited reasons for attending local liquor shops and using alcohol in a regular base. Mesfin Kassay, Hassen Taha Sherief, Ghimja Fissehaye, Teshome Teklu(1999) also reached the same conclusion. WHO's finding (2005) also indicate that alcohol is considered as a friendship brew in many societies and cultures in Africa (P.34).

Despite several physiological, psychological, social and economical problems they have faced, all participants still attend these local drinks shops and the most commonly abused drinks are *Araki* and *Tela*. These alcohols are usually taken most days of the week and usually at evenings. The liquor houses are seen as a recreational place and a place where social company

and support is sought (WHO, 2005, P.46). For some these local drinks are substitutes for modern drink when it is not available for financial reason. For most others however these drinks constitute a major means of leisure (Mesfin Kassay,et al., 1999). Some also believe that taking alcohol (with friends) helps to put up with difficult life situation and hard physical environment such as severe cold or hot weather as the reason of which they drink. Economic disadvantages such as hard work condition, poor economic status and related underprivileged way of life were also found to be predictor of alcohol abuse among participants. Economic problems such as unemployment and poverty were also significantly associated with substance abuse in general and alcohol abuse in particular among Ethiopian youths (Mesfin Kassay,et al. , 1999). More over a belief that alcohol facilitates or enhance sexual intercourse also contributed towards consumption before sexual intercourse. This has also been the WHO's finding in its cross cultural study among eight countries (WHO, 2005, P.46). It pointed out the same about attitudes regarding substance abuse and sexual activity among youths and adults.

What is particularly significant of these experiences regarding alcohol abuse in terms of vulnerability to STD/HIV infection, is considering its effect on participants protection use. With few exceptions, alcohol intake before sexual intercourse is found to have a negative impact on proper application of condom or its use at all (Cooper, 2002, pp.102; Dereje Kebede et al, 2005,p.2). It is indicated that it weakens an ability to accurately evaluating personal risk , induce negligence and cause one to take sexual risks that otherwise would not be taken. At a very inebriated state, risk taking behavior can go as far as losing consciousness as to what is going on. Alcohol is also found to be a significant contributor of sexual risk taking behavior especially when coupled with a more personal character of poor impulse control and inaccessibility of condom (Leigh & Stall, as sited in Cooper, 2002, p.102). On the other hand, for some others,

alcohol intake has proven to incite vigilance as it triggers the feeling that people are at risk consequently promoting protection use. Regarding this inconsistency about the effect of alcohol on sexual risk taking behavior, Leigh's finding of review of the literature (1990) suggests the same contradiction (p.211).

Alcohol intake especially when coupled with other substances, pornographic movies and female company, was also associated with sexual stimulation (WHO, 2005, P.8). Even though immediate acting out of sexual stimulation in relation to alcohol intake is not a common experience, it counts for quite few cases. This is particularly of a significant interest when it is seen together with another environmental predictor of unsafe sexual behavior. Even though condoms are accessible in stores and bars, this is not the case for traditional liquor houses where the participants attend more often. Neither the most common places where participants happened to have sex accommodate condoms. Considering the association of alcohol intake and unsafe sexual behavior particularly in the case of these participants, this makes the situation even more difficult to uphold a safer sexual behavior. Perhaps looking it the other way accessibility of condom at these places might have a help in efforts to take up a safer sexual behavior ((Chen & Hearst, 2004, p.40).

Most participants have an early sexual debut (Fekadu Mazengia & Alemayehu Worku, 2009, p.154). The most common reason for sexual initiation was curiosity and romance. Protection use was not considered for reasons much similar with what has been mentioned for present failure to use one. While heterosexuality is the only sexual orientation, all participants have a several life time partners. Premarital, extra marital and casual sex happened to be the general sexual behavior pattern among participants. HAPCO &GAMET's review of related literatures (2008) also note a similar behavior pattern as the most predisposing factor to HIV in

the country (P.34). According to most participants experience it is common to have sex before marriage starting from an early age. It is also found common to have more than one partner at a time or sexual involvement with several casual partners. At the same time extramarital relations were accepted as long as they were not disclosed. These perhaps suggest the existing social tolerance and acceptance for premarital, extra marital and casual sex in contrast to existing social values about virginity and marital faithfulness (Fekadu Mazengia & Alemayehu Worku, 2009,p.154;WHO, 2005, P.40). To a considerable extent people witnessed a reservation about sexual involvement with partners such as commercial sex workers whom they believe are at greater risk. Yet sexual relationship with a commercial sex worker, even though not frequent and not for most participants, it is still a practice. Sexual relationship for monetary gain was also mentioned by one participant.

Conversations about sexual safety between partners, if ever going to happen, usually take place before having first sexual contact and conversation about prior sexual experience happen more often than any other subject on this matter. Discussions about condom use also happen frequently compared to blood test requests which are the very least to be raised.

The findings, however, indicate that the pattern of these kind of conversations as well as their practicability is determined by the type of relationship the couples have. In a stable relationship where the couples know each other for longer time, where they start having sex without protection and where there is expectation of trust, it is unlikely for partners to have a conversation that give emphasis to sexual safety. This takes account of matrimonial and stable relationships. In these relationships, even at times these kinds of issues are raised, they are usually channeled through an indirect and masked way because it is believed to be offensive to the person being asked.

Also gender based sexuality roles are found to be another impediment for initiation of communication and negotiation that is focused on sexual safety in these type of relationships. (Matshalaga, 1999, p.88; HAPCO & GAMET, 2008, P.22). Women are perceived as passive when it comes to their sexuality. They are barred from any decision concerning protection use, especially in this kind of relationships, which place most decision making power at the hand of the male partners. This will deny any chance for communication and negotiation concerning condom use and ultimately allowing no room for change in current sexual practice among participants.

With the exception of one participant who claims that conversation about sexual safety is difficult with a casual partner because of its spontaneous nature, in a more open relationship where there is no sense of obligation for trust and no long term acquaintance participants explained that there is a high possibility for initiating negotiation about protection use from both sides. This usually works for casual partners, and commercial sex workers (Chen & Hearst, 2004, p.40).

Male condom is the only condom participants are familiar with and if ever used it is the only type. Regarding the pattern of condom use, just like that of conversations about sexual safety, condoms use are less likely to happen in relationships where sex partners are virgin, where sex has already been started without condom, where there is long term acquaintance and emotional attachment than otherwise, implying that between married couples and in a stable relationship (where mutual trust is expected or present) condom use is insignificant (Chen & Hearst, 2004,p.41; Matshalaga, 1999,p.92;Kelly, 1995, p.346). This also explains why condom is used at the beginning of most relationships but left out latter on as partners develop trust and affection for each other. It is considered as irrelevant for people in these kinds of relationships as

it is believed to bring distance and mistrust between partners. More specifically condom in this kind of relationship is believed to reduce sexual sensitivity. Never the less a strong conviction about the importance of condom during sex with commercial sex worker and casual partners has been noticed among most participants. Condom is also most used for sexual contacts with casual partners and more regularly with commercial sex workers (Chen & Hearst, 2004, p.40).

Perhaps the frequent failure to maintain safer sex behavior in relationships where partners know and trust one another than otherwise, could also suggests attitude concerning condom which focuses on disease prevention and suspicion than those that emphasize safer sex as a way for people to show their concern, love, affection, and care for one another(Kelly, 1995,p.346). The other way round, this attitude about condom might have prevented protection use among regular partners and married couples

Yet even in those sexual contacts participants intend to use protection, for most of them consistency is a major difficulty because of several reasons (Chen & Hearst, 2004, p.42). A poor impulse control at times of sexual arousal when there is no condom at hand is an important predictor of inconsistent condom use at the individual level (Kelly, 1995, p.346). Once this happened, sexual risk taking behavior with the same partner will continue further reinforced by a belief that protection use afterwards will make no difference. In addition to this though to a significant degree among most participants condom use appears to be an increasingly acceptable alternative in the face of the risk for HIV infection, a tendency to deny sexual risk resulting in rejection of condom use appear to be the case for one participant (WHO, 2005, P.40).

Again at the micro level factors that predict risky sexual behaviors can be seen in terms of cognitive factors (WHO, 2005, p.39). Certain beliefs and understandings held by participants are found significant in affecting their decision regarding protection use. These cognitive aspects

involve poor understanding of the transmission of STI/HIV and inaccurate estimation of personal risk. More specifically a belief that particular ways of performing sexual act without condom such as anal sex, oral sex, and coitus interruptus could prevent HIV infection, judgment about people's sero status based on irrelevant criteria such as appearance, virginity, marital status place of residence, age, third person's sero status and a healthy child are found eminent. Equally important is perceived self efficacy of enacting positive behavior change which promotes indulgence in unprotected sexual behaviors through self preached incapability (Kelly, 1995, p.346). Distorted self image, misunderstanding about sexual safety and estimation of risk based on wrong measures such as these placed participants in a precarious situation by promoting unprotected sexual engagement based on a false assumption.

Another important aspect of risky sexual behavior at the individual level is seen through participant's exposure to STDs other than HIV and sexual behaviors during these times. It is indicated that quite a few participants had been infected with some of the common STDs. Some were diseased repeatedly. This by itself could somehow foretell the sexual risk these people are in. Sex while being infected by an STD or with a partner who has an STD without the use of protection on the other hand boosts this risk (HAPCO & GAMET, 2008, p.37) and this had been the case for most participants. With the exception of one participant, STD infection is not found a determining factor for protection use. Most explained their negligence and ignorance about it. Perhaps they are unaware as to how it might elevate their risk of contracting HIV.

Except for one participant who was required to get tested once for other reason, blood test for HIV AIDS is not an experience for participants. HAPCO & GAMET (2008) also indicate a low level of voluntary counseling and testing service utilization nationwide (P.45). Participants explained that getting tested is frightening. This is partially because HIV is still associated with

death and hence fears of dying and social stigma prohibiting one from getting a blood test. Participants also explained that people equate positive HIV blood status with the mere idea of getting tested. They believe it entail discrimination from their social groups. One participant also believe that he doesn't need getting his blood tested because he judged himself as a healthy person despite his risky sexual experience with several women in his past.

Conclusion and Social Work Implication

Conclusion

This study on behavioral susceptibility to HIV AIDS with a descriptive purpose has generated rich amount of information through in depth interview with people abusing homemade alcohol. The study has based its inquiry mainly on the experience of the participants. Existing literatures on issues relevant to the subject of inquiry have been reviewed to ground the study and substantiate basic findings. Even though abundant studies that have been devoted to the inquiry of HIV related issues have been found, specific studies on the experience of homemade alcohol abusers in the context of a semi urban community, is barely done. Hence in this study it has been tried to assess this group's susceptibility to HIV and circumstances that predispose them. It has been tried to gather as in depth information as possible on the experiences of this group of people through interviews.

The study has found out that risky sexual orientation such as premarital sex, extra marital sex, sex with several partners both over and at a time, sex with a casual partner and commercial sex worker are what constitute most people's past and recent sexual experience. Consistency in condom use in these sexual relationships is further compromised because of several reasons related to cognitive, affective, behavioral, socio cultural and situational factors. The implication is that sexual risk taking behavior is still a major problem and people are at greater risk for HIV AIDS/STDs. In agreement with this, speaks people's experience with several other sexually transmitted illnesses.

This study found out that on one hand, in relationships where trust is the basic issue it is implausible for people to maintain sexual safety. In these kind of relationships there is a

tendency to equate trust with unquestioning partners sero status hence allowing sex without protection. People also tend to attach meanings to condom that would prevent them from using one in such relationship. Estimation of personal risk based on irrelevant criteria, therefore making it inaccurate one and leading to unsafe sexual involvement, is also found to be key factor in this regard. On the other hand, with undependable partners, casual partners and commercial sex workers, people actually have a better attitude and experience of using protection. However despite most participants' acceptance and intention of using condom particularly with these sex partners, failure to use protection is a recurrent happening. At the micro level poor impulse control, distorted self efficacy of enacting positive behavioral change, negligence of risk or misguided notions about safe sex and ways of HIV transmission counts for the great deal of unsafe sexual experiences. Though not as much significant as what are mentioned above, denial of risk leading to rejection of condom use was also noted.

At a macro level alcohol is found to be associated with failure to have a safe sexual behavior by reducing vigilance and inducing negligence. Also, as it is accounted for sexual stimulations, when coupled with inaccessibility of condoms at liquor houses, a common situational impediment of sexual safety, it can have a potential to creates a difficult condition to uphold a safe sexual behavior. Alcohol abuse is found to be structured on a more socio cultural base. Its intake is reinforced by traditions, beliefs and values that pertain to the general community. Furthermore peer influence, tough physical environment, harsh work condition, economic stress and difficult life situation are found to be a determinant factor to abusing alcohol on a regular base. While it is found to be one of the key predictors of failure to use protection, on the contrary, alcohol was also found to be a cue for precautions against sexual risk taking behaviors. Other important social impediments to safe sex and positive life style are found to be

prevailing negative attitudes about getting blood test for HIV AIDS and gender disparities on decision making about sexuality. Looked at the other way round, these two are believed to have a potential effect on the sexual life style people choose.

Social Work Implication

At the base of social work profession is the empowerment and liberation of people to enhance their well being. Social work is a profession with a particular interest in people who are at risk and socially segregate. People who abuse homemade alcohol are found to be a group of people at risk when it comes to sexual behavior related susceptibility to HIV.

This study noted that risky sexual orientations such as sex with several partners and risky partners without the use of protection are major part of sexual behavior in this community. Several predictors have been identified in the psychological, behavioral, economical, situational and social cultural environments that make it a concern beyond the medical profession. There are a lot to be done in these regard and social work, with its abundant and relevant skills and values to the matter, can play a great role in it.

Even though people seem to be well conscious of the risks of acquiring HIV through sexual contacts, there still remains to be a gap in awareness. People happen to know less about matters that are profound about accurate risk evaluation, HIV transmission and safe sex. This awareness gap regarding what protections are effective in terms of protecting oneself against STDs and dependable ways of determining sexual risk needs to be addressed if change is to come. There is also a need for change in the meanings people associate with trust and condom use in stable relationships. It is noted that condom use is not a feasible option in this relationships for it is believed to imply mistrust, pose distance and sexual insensitivity. There is a need for

attitude change about condom use from the one that is focused on disease prevention and lack of trust to the one that emphasize safer sex embracing concern and care. Social workers can play a great role as educators in this regard in the general community as well as this particular group.

The research conducted herein has also showed that behavioral and situational factors such as poor impulse control, inaccessibility of condom and weak self efficacy about achieving positive life styles are significant in terms of promoting risky sexual behavior. These call for the attention of the social work profession. Social workers can influence this situation by identifying the gap and accessing services such as condom in places where they are mostly to be utilized. Also by building on several learning and behavioral modification knowledge base, skills and techniques social workers can help people in this setting challenged their problem and achieving behavioral competences and positive life styles.

Personal level risk reduction strategies alone will not be sufficient to effectively prevent and control HIV because an individual's personal strategies are conditioned by the socio cultural, economical and political (policy) contexts.

As suggested in the findings of the current study, economic stress and harsh work conditions /unemployment are found to be one predictor of alcohol abuse. Also it is indicated that social influence, culture and traditions are important factors behind most participants alcohol abuse problem. Also as indicated in this study, for most participants there is a tendency to consider alcohol shops as leisure place. This culturally structured, socially and economically reinforced alcohol abuse behavior has a strong association with sexual risk taking disposition.

Furthermore this study reveal that there is a tendency to perceive women as passive agent in terms of their sexuality, therefore biasing decision making power in matters such as condom

use to one side, to the man. This gender disparity regarding decision making on sexual matters is found to be an obstruction for adopting safe sexual behavior through impeding the possibility of safety negotiation. Hence the underlying social dynamics such as these should be incorporated into an effective HIV prevention strategy for a better outcome. At a macro level, social workers can identify both challenges and entry points such as these in the environment that the service system need to intervene at and act as a change agents.

As indicated in this study, in contrast to the traditional social value of virginity, abstinence till marriage and marital faithfulness, there is a growing tendency in social tolerance for sexual promiscuity. Social workers can influence this situation by promoting these traditional social values, which are very relevant for sexual risk reduction, working in partnership with other social change agents in the community such as the church and mosques.

Though national policies on the issue of HIV AIDS prevention, control and treatment has been enacted and put in to implementations , apparently the findings of this study indicates the fact that poor outcomes have continued, suggesting greater efforts and commitments are still required to effectively implementing the policies and bring about significant improvement in the same regard. This study also elucidates some of the contextual predictors of risky sexual behavior such as alcohol abuse, thus highlighting where the focus of social policies must be. Social workers can play a role as lobbyist and enhance the focus of responsible bodies on social policy making regarding the issue of licit substance abuse, related problems and the need for control system.

Furthermore, having in mind the fact that vulnerability to HIV in relation with sexual behavior is one of the most researched areas in Ethiopia, social workers with their skills of social work research can still carry out further relevant studies in relation to licit as well as illicit

substance abuse that would inform and ameliorate the service delivery system and prevention, control and treatment efforts.

In conclusion, through applying the findings of the study , social workers can be important part of the prevention and control efforts of substance abuse related risky sexual behavior in particular and HIV AIDS in general at the personal, family and general public levels.

Reference

Abebaw Fekadu, Atalay Alem & Hanlon, C. (2007). Alcohol and drug abuse in Ethiopia: Past, present and future. *African Journal of Drug and Alcohol Studies*. *6(1)*, 39-53. Retrieved from http://www.crisanet.org/abstracts_6.1.htm?page=Fekadu

Acuda, S.(1988, Auguest 7-9). Alcohol in developing countries. *possibilities and limitation, Paper presented at the Alcohol research in developing countries*:, Oslo, Norway

Addictions Foundation of Manitoba (AFM). (2000). *A biopsychosocial model of addiction*. Retrieved from: http://www.afm.mb.ca/pdf/BPS-FINAL.pdf

American Psychiatric Association. (1994).*Diagnostic and statistical manual of mental disorder*. Washington, DC: American Psychiatric Association.

Atalay Alem, Dereje Kebede & Kullgren, G. (1999). The prevalence and socioeconomic correlates of khat chewing in Butajira, Ethiopia. *Acta Psychiatrica Scandinavica 397*, 84-91.retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1600-0447.1999.tb10699.x/abstract

Atalay Alem, Derege Kebede, Getnet Mitike, Fikre Enqusellase, Frehiwot Berhane, Yigeremu Abebe.et al., (2003). (Risky sexual behaviour, alcohol use, problem drinking and Khat chewing in Ethiopia). Unpublished row data

Bryman, A. (2004). *Social research methods*. New York: Oxford University Press

Canning,D. (2006).The economics of HIV/AIDS in low income countries: The case for prevention. *Journal of Economic Perspectives, 20(3)*, 121-142, retrieved from http://www.jstor.org/stable/30033669

Chippindale,S.& French,L.(2001). ABC of Aids: HIV Counseling and the Psychosocial Management of Patients with HIV or Aids. BMJ: British Medical Journal, 322(7301), pp. 1533-1535. Retrieved from, http://www.jstor.org/stable/25467179

Cohen,S. (2003). Beyond slogans: lessons from Uganda's experience with ABC and HIV/AIDS. *Reproductive Health Matters, 12 (23),* 132-135.retrieved from http://www.jstor.org/stable/3775982

Cooper, M.L.(1992) Alcohol and increased behavioral risk for AIDS. *Alcohol Hlth Res. World 16***:** 64-72.

Cooper, L.M. (2002). Alcohol use and risky sexual behavior among college students and youth: evaluating the evidence. *Journal of studies on alcohol, 14.*111-117 Retrieved from,http://www.collegedrinkingprevention.gov/media/Journal/101-Cooper.pdf

Creswell,J.W.(2003). *Research design: qualitative, quantitative, and mixed method approaches*. Thousand Oaks, London, New Delhi: Sage publication

Creswell,J.W.(2007).*Qualitative inquiry and research design: Choosing among five approaches*. Thousank Oaks, London, New Delhi : Sage publication

Denning,P.,Little,J., & Glickman,A.(2004).*Over the influence: The harm reduction guide for managing drug and alcohol.* New York / London: The Guilford Press

Derege Kebede, Atalay Alem, Getnet Mitike, Fikre Enquselassie, Frehiwot Berhane, Yigeremu Abebe et al. , (2005). Khat , alcohol use and risky sex behavior among in school and out of school youth in Ethiopia. *BMC Public Health. 5:109.* doi:10.1186/1471-2458-5-109

Federal Democratic Republic of Ethiopia.(1998). Policy on HIV/AIDS. Retrieved from:http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_125382.pdf

Fekadu Mazengia & Alemayehu Worku., (2009). Age at sexual initiation and factors associated with it among youths in North East Ethiopia. *Ethiop. J. Health Dev.*23(2): 154-162

Gerald,S.(2010). *The AIDS update*. New York: McGraw-Hill

Hearst , N. & Chen,S.,(2004). Condom promotion for AIDS prevention in the developing world: Is It working?. *Studies in Family Planning*. 35(1): 39-47 retrieved from http://www.jstor.org/page/info/about/policies/terms.jsp

HAPCO and GAMET (2008).HIV/AIDS in Ethiopia; an epidemiological synthesis. *World Bank Global HIV/AIDS Program*. Retrieved from http://www.worldbank.org/AIDS

Kaplan, D.M. & Coogan, S.L. (2005). The next advancement in counseling*:* The biopsychosocial model. *American Counseling Association.3*, 17-25 Retrieved from: http://www.counseling.org/Resources /Library/VISTAS/vistas05/Vistas05.art03.pdf

Kelly,J.A.,(1995). Advances in HIV/AIDS education and prevention. *Family Relations*. 44(4): 345-352. Retrieved from http://www.jstor.org/page/info/about/policies/terms.jsp

Kim.C,R.,& Free,C.(2008). Recent evaluations of the peer led approach in adolescent sexual health education: A systematic review, *International Family Planning Perspectives, 34(2),* 89-96 Retrieved from http://www.jstor.org/stable/30039271

Leigh, B.C., (1990).The relationship of substance use during sex to high-risk sexual behavior *The Journal of Sex Research.* 27(2): 199-213 retrieved from http://www.jstor.org/page/info/about/policies/terms.jsp.

Leigh, B.C. and Stall, R.(1993) Substance use and risky sexual behavior for exposure to HIV: Issues in methodology. *Amer. Psychol. 48***:** 1035-1045.

Malhotra,S.(2008).Impact of sexual revolution: Consequences of risky sexual behavior. *Journal of American Physicians and Surgeons, 14,* 101-117 retrieved from http://www.jpands.org/vol13no3/malhotra.pdf

Matshalaga,N.(1999). Gender issues in STIs/HIV/AIDS prevention and control: The case of four private sector organizations in Zimbabwe. *African Journal of Reproductive Health,* 3, (2): 87-96 retrieved from http://www.jstor.org/page/info/about/policies/terms.jsp.

Mesfin Kassay, Hassen Taha Sherief, Ghimja Fissehaye, Teshome Teklu.,(1999). Knowledge of drug use and associated factors as perceived by health professionals, farmers, the youth and law enforcement agencies in Ethiopia. ..*Ethiop. J. Health Dev.* 13(2)141-149

Morse, J.M. & Richards, L. (2002). *Read me first: A user's guide to qualitative methods.* London: Sage Publications.

Obot,S.I.(2006). Alcohol use and related problems in sub Saharan Africa. *African journal of drug and alcohol studies.5 (1)* 17-26 Retrieved from http://indexmedicus.afro.who.int/iah/fulltext/Pages%20from%202006vol5.pdf

Odejide, A.O. (2006).Alcohol policies in Africa: *African Journal of Drug & Alcohol Studies,5 (1)* 27-40 retrieved from http://www.crisanet.org/abstracts_5_1.htm?page=Odejide

Odejide, A.O. (2006). Status of drug use/abuse in Africa: A review.*International Journal of Mental Health and Addiction*. *4*, 87–102 retrieved from http://www.springerlink.com/content/qh04553j70t9k12j/

Punch,K.F.(2000), *Developing effective research proposal: essential resource for social resource*. London, Sage Publication

Sinding,S.W. (2005). Does 'CNN' (condoms, needles and negotiation) work better than 'ABC (abstinence, being faithful and condom use) in attacking the AIDS epidemic? *International Family Planning Perspectives, 31(1),* 38-40. Retrieved from http://www.jstor.org/stable/3649501

Singh,S., Darroch,J.E.,& Bankole,A.(2004). A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline. Reproductive Health Matters, 12(23), pp. 129-13. Retrieved from http://www.jstor.org/stable/3775981

Smith,A.M.(2004) HIV prevention :Perspective of a faith based agency. *The Furrow, 55, (11).* 616-630. Retrieved from: http://www.jstor.org/stable/27665044

Steinitz,L.Y.(2007). African stars: Lessons learned from social services in Africa. *Journal of HIV/AIDS & Social Services, 6(4),* 7 – 22. DOI: 10.1300/J187v06n04_02

Stevens, P., & Smith, R. L. (2005). *Substance abuse counseling: Theory and practice* Upper Saddle River, NJ: Pearson/Merrill Prentice Hall

Sussman, S. & Ames, S.L. (2008). *Drug abuse: Concepts, prevention and cessation*: USA: Cambridge University Press, retrieved from www.cambridge.org/9780521716154

Wallace,J. (1990). The new disease model of alcoholism: *Western Journal of Medicine*.152, 502-505.

World Health Organization (WHO). (2004). *Global status report on alcohol*.

World Health Organization (WHO). (2005).Alcohol use and sexual risk behavior:

A cross cultural study in eight countries. *World health organization*. retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2393527/pdf/bullwho00039-0129.pdf

Appendix A

Interview Guide Questions

1) Can you tell me about your recent personal history with regard to sexual intercourse?

The following points are expected to be addressed

- Pattern of sexual intercourse including when, how often where and with whom
- Type of Protection used if any
- Type of sexual practices
- Perception about What safe sex and risky sexual behavior is
- Content of conversation and communication with sexual partner before sexual intercourse
- Experience related with voluntary counseling and testing

2) Can you tell me about your previous history with regard to sexual intercourse?

The following points are expected to be addressed

- Pattern of sexual intercourse including when, how often where and with whom
- Type of Protection used if any
- Type of sexual practices
- Perception about What safe sex and risky sexual behavior is
- Content of conversation and communication with sexual partner before sexual intercourse

3) What are important motivators for unsafe/safe sexual practices?

4) What are important motivations for alcohol use?

5) What factors in your personal, social, environmental, cultural life do you think influence your sexual and alcohol use behavior

APPENDIX B

Informed Consent Form

My name is Tizita Abebe and I am a student at Addis Ababa University (school). I have contacted you today in order to carry out a personal interview for a study that aims to assess how Behavioral Change Communication for the prevention of STDs affects sexual behavior. I am doing this study for the requirement of the education that I am attending in Addis Ababa. This study will not be possible without the participation and partnership of you. Therefore, I kindly request your participation by providing genuine information, which is very imperative for the success of the study.

The study is focused on assessing how BCC programs are affecting sexual behavior and in what a context is it being implemented. The understanding of this could be helpful in several ways by guiding intervention programs plans and policies regarding sexually transmitted diseases including HIVAIDS.

One of the issues that you must bear in mind is that your participation in the interview to follow is totally voluntary. I will take all the necessary measures to maintain confidentiality, so that your identity will not be identified with what you will say. If, after reading this note, you decide that you do not wish to go through the interview, you can indicate this to me and that will be the end of the matter. You also have the right to withdraw from the interview at any time without the need to explain why and the information you gave may not be used. If you do however decide to go ahead, you should be aware of the following points. The use of tape recorders will be essential to correctly capture the conversations for later use, and the recordings will be locked in a safe place and will not be exposed to another party. The notes that I will take

and tapes will be destroyed after the study is completed and approved by the school. The final results of the study (including the information you have given but not any information that could identify you) will be submitted to my school and may be used for further academic and publication purposes. Your participation in this research will not affect your relationships with your family and community since all the information you are going to give will be kept confidential between you and the researcher. The interview will take a maximum of 180 minutes . Some questions may make you feel uncomfortable, since the topics to be discussed are sensitive. If any question makes you feel uncomfortable, please indicate it and you do not have to answer any unpleasant questions if you do not wish to. If something is unclear, or if you have any doubts whatsoever, please tell me. I would like you to sign below if you agree to participate in the study. I thank you in advance for your participation.

I agree to participate in the study

Participant's code_____

Date: _____

I certify that in my presence the participant has been informed about the possible benefits and risks of participation in the research and has been given the opportunity to ask any questions.

Tizita Abebe, Researcher:

Date: _____

Contact number: _____

Appendix C

Resource Allocation

S.N	ACTIVITY	ITEMS	UNIT OF MEASUREMENT	PRICE PER UNIT	AMT (No.)	TOTAL PRICE (Birr)	REMARK
1	Transportation and Use of facilities	Bus ticket Taxi hotel	Frequency of use of transportation and days of stay at the research site	70	25	1750	
2	Secretarial service	Printing, binding, copying	No. of expected subsections in the thesis report	50	30	1500	Also includes consent forms and other items for print
		Purchase of recordable compact discs for backup and print	Piece	4	30	120	
3	Purchase of	Plain paper	Packet	80	2	160	

	stationery and recording materials for data collection	Writing pads (Small)	Piece	4.5	5	22.5	
		Highlighters	Packet	25	3	75	
		Tape recorder	Piece	500	1	500	
		Ear phones	Piece	200	1	200	
		Cassettes	Piece	5	20	100	
		Batteries (Energizer)	Pair	15	20	300	
	Allowance	Per dime for participants	Hours spent during interview	30birr per hour	26hour	680	
4	Refreshment for respondents during data collection	Soft drinks for interviewees	Piece	4	20	80	The total number of participants is thirteen,
		Bottled water for participants (Optional)	Piece	5	30	150	
Contingency cost = 500					GRAND TOTAL	6137.5	

Appendix D

Time Table

S.N	ACTIVITY	MAJOR AIM/S	TIME ALLOCATED	CONCERNED PERSON/S	REMARK
1	Secondary data collection/ Literature search	To support the research with pre-existing, relevant literature	Ongoing until the end of thesis report writing	Student	
2	respondent selection	To determine respondents	15th to 20 th of March	student	
3	Preparation for data collection	- To prepare all needed materials for data collection - To make appointments with participants	21st to 25th of March	Student	- Needed materials include tape recorders, cassettes, microphones, batteries, stationery, etc.
4	Primary Data collection:- depth interviews	To gather qualitative data	26th of March to 20 th of April	Student and participants	More than two interviews will not be done per day. All days of the week

					including Weekends will be used to the collected data.
5	- Transcription of interviews , Synthesis , Coding, developing concepts and categories	To prepare the data for analysis	21st of April to 5th of May 2010	Student	Although this takes too much time, the researcher will do her best to do it within this time range. .
6	Data analysis	To interpret the data	6th of May to 15th of May	Student	Data analysis requires enough time for it to be done rigorously.
7	Finalizing thesis report writing	To compile the different chapters of the thesis	On or before 14th of May , 2010	Student	Report writing will be an ongoing process as the researcher will engage in the write up at each stage/chapter

Declaration

I, the undersigned Tizita Abebe, hereby confirm that this study in the title "Sexuality Related Behavioral Risk to HIV AIDS; Examining the Experience of People Abusing Home Made Alcohol Beverages " is carried out by me, and any material used in this study is properly acknowledged.

Name Tizita Abebe Signature_____ Date: July 2011