

**The Practice and Challenges of Commercial Sex Workers in Accessing  
Reproductive Health Needs: the Case of Family Guidance Association of  
Ethiopia Adama Confidential Clinic in Adama Town, East Shoa Zone Oromia  
Region**

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## **DEDICATION**

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## ABSTRACT

Globally and in Ethiopia commercial sex workers (CSWs) are considered a most – at –risk population (MARPS) for RH problems, and their clients play an important role in the spread of HIV STI infections to the general population. Survey of Ethiopia CSWs including biomarker data demonstrated that this population is disproportionately exposed to reproductive health problems. Commercial sex workers face cultural, social, legal and linguistic obstacles to accessing services and information. Equally important, many women in sex work experience violence on the streets, on the job or in their personal lives which increases their vulnerability to HIV and other health concerns.

The purpose of this study was to explore the practices, challenges and the factors which lead sex workers in reproductive health problems and to examine the availability, accessibility and utilization of SRH services in the case of FGAE Adama Confidential Clinic clients. The study participants were sampled using simple random sampling technique were employed. Qualitative research design was employed in order to answer a wide variety of questions related to sex workers responses to actual or potential health and behavioral problems. In this case, a cross-sectional study was also employed to describe the relationship between sex work practice and associated effects.

The result of the study showed those majority age groups were 15 – 24 years 18 respondents which is the major proportion 69.2% were within this age, and most of them were never married, financial drive which comprises the highest proportion 40% of coverage often pushes young ladies into sex work. Most of them agreed that they lack basic knowledge and information about safe sex practices, how to prevent STI, HIV and unwanted pregnancy. This showed that the potential transmission of STI is very high and also this can increase the

possibility of acquiring the HIV/ AIDS. Unwanted pregnancies are also the most frequent and series problems of them. Sometimes they did not know when and from whom they had sex and got pregnant. Different reasons were mentioned by SWs, they usually used condoms as a means of protection from pregnancy and other infectious diseases, but because of condom breakage and slippage they exposed to unplanned pregnancy they also mentioned that these all problems leads to emotional and behavioral problems. Socioeconomic and cultural factors, low health seeking behavior, lack of access and unfriendly health services are the factors that lead them to RH problems.

To conclude, it is important that steps to be taken to improve on the level of awareness on RH among the respondents. The results clearly points out important lessons for health education. This should target the perceptual factors, which tended to provide adequate explanation for the knowledge on modes of transmission, prevention and practices of the respondents towards RH. The high prevalence of STI HIV infection in this target groups in the town and the commercial sex workers demand for SRH services confirm the need to provide these services in the holistic approach. Moreover it is not only accessing and availing the RH services but also making the services friendly is principal importance for commercial sex workers to use the SRH services.

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## LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Anti Retroviral Therapy
BCC	Behavior Change Communication
CWs	Community Workers
CSWs	Commercial Sex Workers
EC	Emergency Contraception
FGAE	Family Guidance Association of Ethiopia
FGDs	Focus Group Discussions
FP	Family Planning
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
GUD	Genital Ulcer Disease
ICPD	International Conference on Population and Development
IDU	Injecting Drug User
MARP	Most at Risk Population
NGOs	Non- Governmental Organizations
OIs	Opportunistic Infections
PAC	Post Abortion Care
PITC	Provider Initiated Testing and Counseling

PLWHA	People Living With HIV/AIDS
RH	Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
STI	Sexually Transmitted Infection
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## CHAPTER1. INTRODUCTION

### 1.1 BACKGROUND

Commercial sex workers have been known in Ethiopia since older times, although there are no data as to when and where commercial sex first appeared in the country. Some sources associate the beginnings of commercial sex with the movement of kings, nobles and warlords, the establishment of cities and the development of trading (Andargachew 1988). Subsequently, towns and government offices became centers for the migration of people, particularly females from rural areas. Initially, the migrant females lived in *tella* or *araki* houses where they helped the owners to prepare local beverages (*tella* or *araki*), worked as waitresses and/or entertained the customers; eventually, many of them became commercial sex workers. Over time, with the growth of Addis Ababa, the number of *tella*, *araki* and tea houses increased. In the 1950s and 1960s, the number of hotels, bars/restaurants, *tella*, *araki*, *tej*, and other eating and drinking establishments, and the number of sex workers increased markedly. The poor socio-economic situation across most of Ethiopia's cities, towns and villages has pushed many women into the sex work and city attract sex workers due to their large mobile client base.

Reproductive health (RH) Services: As early as 1997, the government of Ethiopia began addressing these issues, conducting a national RH needs assessment to guide the country's implementation of the new RH paradigm (WHO, 1999). The assessment called for national and regional exercises to identify RH needs and priorities; craft a consensus on the appropriate scope of RH services; and develop strategies for the implementation of such interventions. Ultimately, it recommended that the MOH "coordinate the development of a national RH strategy and reactivate the National RH Task Force" to assist in drafting that document (WHO 1999). Worldwide, young women and men suffer from a disproportionate share of unplanned pregnancies, abortions, sexually

transmitted diseases (STDs) including HIV/AIDS, female genital mutilation, malnutrition and anemia, infertility, sexual and gender violence, and other serious reproductive health problems (FHI,1997).

Globally and in Ethiopia commercial sex workers (CSWs) are considered a most – at –risk population (MARPS) for RH problems, and their clients play an important role in the spread of HIV STI infections to the general population. Survey of Ethiopia CSWs including biomarker data demonstrated that this population is disproportionately exposed to reproductive health problems. Several factors heighten sex workers' vulnerability to HIV. Many sex workers are migrants and otherwise mobile within nation states and are thus, difficult to reach via standard outreach and health services. They face cultural, social, legal and linguistic obstacles to accessing services and information. Equally important, many women in sex work experience violence on the streets, on the job or in their personal lives, which increases their vulnerability to HIV and other health concerns.

Sex workers are therefore, frequently regarded as easy targets for harassment and violence for several reasons. They are considered immoral and deserving of punishment. Criminalization of sex work contributes to an environment in which, violence against sex workers is tolerated, leaving them less likely to be protected from it. Many sex workers consider violence "normal" or "part of the job" and do not have information about their rights. As a result, they are often reluctant to report incidences of rapes, attempted (or actual) murders, beatings, or sexual assault to the authorities. Majority of incidences of harassment, assault Sex workers are surrounded by a complex web of "gatekeepers" including owners of sex establishments, managers, clients, intimate partners, law enforcement authorities and local power brokers who often have control or power over their daily lives. Some gatekeepers may exert control through subtle means such as holding a debt, emotional manipulation or through overt means such as threat of an actual sexual and physical violence, physical isolation, and threat of handing them over to legal authorities and

forced drug and alcohol use. Sex workers also find it difficult to negotiate safer sex with intimate partners those they call it guard and clients in the context of physical and sexual violence carry out by some of them. They had been sexually coerced by clients who were unwilling to put on a condom.

Sex workers often do not have access to Sexually Transmitted Infection (STI) and HIV/AIDS services. The reasons for this are varied, but violence or fear of violence and discrimination play a role. Health services are often hostile to sex workers, subjecting them to disapproval, refusal to treat their health problems, mandatory HIV testing, exposure of their HIV status and threatening to report them to the authorities. The being treated cruelly in hospitals and clinics, made to wait longer periods to be seen if providers knew that they were sex workers and refused treatment until they agreed to undergo HIV testing. This made many sex workers reluctant to seek health care services.

As many literature show sex workers are marginalized group, and are normally expected to experience poorer health than comparable age groups of the general population. Due to the risk associated with transmittable infectious diseases like sexually transmitted infections and human immune deficiency virus/acquired immune deficiency syndrome, sex workers face more health and psychosocial problems than other women and girls of the same age group. Due to the nature of their work; the community attitudes towards sex worker are not well developed. On the other hand Stigma and discrimination makes them to isolate themselves from the society. This isolation and separation increases their vulnerability to substance abuse, depression and different kinds of violence. The AIDS epidemic has added another layer of stigma and discrimination against sex workers – one in which they are Harassment of those providing outreach services to sex workers by law enforcement authorities may reduce sex workers' access to prevention information and services.

The Family Guidance Association of Ethiopia (FGAE) is the local non-government, not-for-profit organization with over 43 years of dedication in providing quality, broad ranging reproductive health services in Ethiopia complementing governmental efforts. The organization implemented SRH program by focusing on poor and marginalized populations with family planning, safe abortion care, maternal and child health care, prevention and treatment of sexually transmitted diseases (STIs) including HIV and AIDS and associated opportunistic infections. Access is the key to the association's activity, and it works extensively with young people to inform, educate and provide essential SRH services. FGAE also runs special projects targeted at particularly vulnerable individuals and groups: street children, people infected and affected by AIDS, sex workers, and young migrants in 8 of the 11 principal Regions in Ethiopia.

The Adama Confidential Clinic is one of the multipurpose units run under FGAE Central Area office of the association. The Adama Confidential clinic is the only unit in Adama town which provides reproductive health services integrated approach to the specific target groups sex workers and their clients. There have been recent efforts to increase the availability and accessibility of services, in general all preventive and treatment services. In this case gaps in service delivery remain, it is difficult to access those SWs in related to the overall RH needs. In terms of working days and hours, staffs approach, distances from the local site, stigma and discrimination and other barriers. Besides to this the target groups are full of anxiety, depression, loss of self-esteem due to this in some situations giving lower priority to health and HIV prevention over more immediate concerns for safety and survival. Their health seeking behavior low, thus, this study will try to explore the lived RH experience of women engaged in sex work.

## 1.2 STATEMENTS OF THE PROBLEM

Commercial sex has become an increasingly important factor in several countries' epidemics. Limited data suggest that HIV prevalence among sex workers remains relatively low. However, their sexually transmitted infection rates, which generally serve as a precursor for the epidemic's spread, are high. The extent of transmission from sex workers and their clients to other populations is unknown, but sex workers' rising HIV levels can provide an early warning of the epidemic's spread into the general population.

Factors that heighten sex workers' HIV vulnerability include limited access to health, social and legal services; sexual exploitation and trafficking; harmful, or a lack of, protective legislation and policies; gender-related differences and inequalities; limited access to information and prevention means; stigmatization and marginalization; exposure to lifestyle-associated risks such as violence, mobility and substance abuse. Worldwide evidences show that HIV prevalence among commercial sex workers is 12 times higher than the general population. HIV prevalence surveys among sex workers in Ethiopia were carried out regularly in the early years of the epidemic, demonstrating an increasing mean prevalence from 1986 to 1998. By 1998, the prevalence had reached 73% among sex workers attending STD clinics in Addis Ababa.

Commercial sex workers are exposed to numerous adverse conditions such as poor living conditions /housing, social stigma and sexually transmitted infections, including HIV. Studies conducted between 1988 and 1991 by the Ministry of Health in 23 Ethiopian towns indicated the seriousness of both HIV and STI among female sex workers (Mehret, 1990; Workineh, 1990). In most urban areas, HIV prevalence among sex workers was over 20% and in some towns prevalence was as high as 50%.



Those literatures on sex workers in Ethiopia mostly has been linked about human immune deficiency virus / acquired immune deficiency syndrome (HIV/AIDS) and STI. Women engaged in sex work have not been properly considered other reproductive health problems and needs as the subjects of research. Regarding to these efforts to address the problem amongst this target population has been also limited. Moreover, the problem has been compounded by Ethiopia's poor socioeconomic conditions. Therefore, this research tries to assess the practices and challenges of those commercial sex workers (CSWs) faces in accessing their sexual and reproductive health needs at the FGAE Adama confidential Clinic.

Therefore, the basic aim of this study attempted to answer the following questions:

- What are the reproductive health practices of commercial sex workers have?
- What reproductive health related challenges commercial sex workers experienced?
- What are the major RH services/ un-meet need to the SWs and how to alleviate the RH problems?

### **1.3 PURPOSE OF THE STUDY**

**The General objective of the study:** to explore the SRH practices and the challenges of the sex workers in FGAE Adama confidential clinic.

**Specific objectives:**

- To examine the practices of sex workers in reproductive health services.
- To investigate the availability, accessibility and utilization of SRH services for and by sex Workers.
- To determine barriers/challenges of reproductive health services among sex workers.

## **1.4 SIGNIFICANCE OF THE STUDY**

This study significantly addresses the RH practices and problems of the sex workers in Adama confidential clinic. The problems of female sex workers are not only economic, psychologically and socially but they are also affected by different reproductive health factors. So this research benefits sex workers to identify major challenges they face and draft out possible solution to remedy such challenges. It also is an opportunity for organizations working directly and indirectly with sex workers and their clients to address the problem of sex workers. Besides, it indicates other institution to provide legal protection and maintain their rights. This study results leads in designing an intervention concerning reproductive health problems/experience of sex workers which is left for other researchers for further studies.

Therefore, briefly, this study is important for the following reasons:

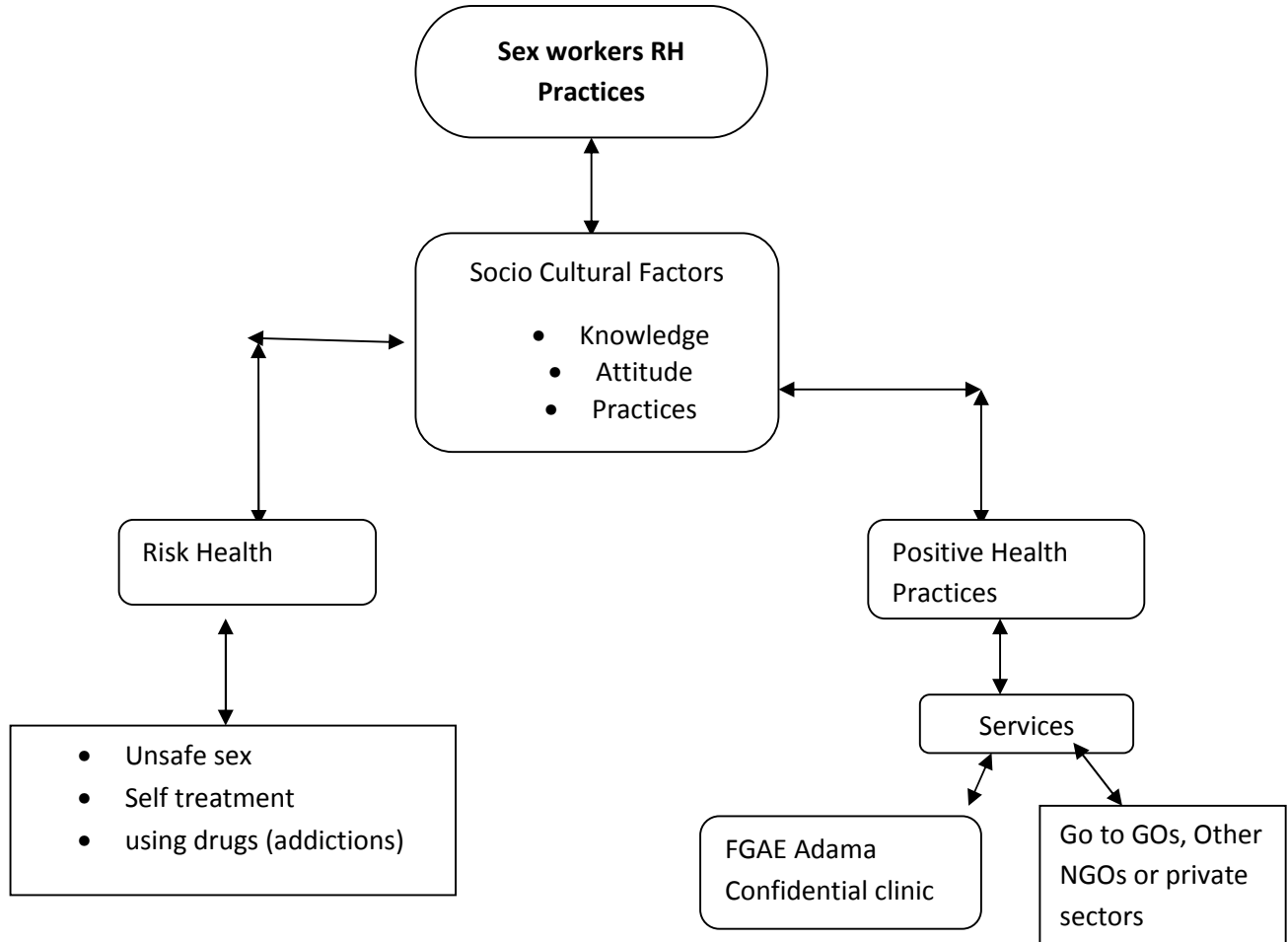
- The study may provide evidence to the concerned body so as to be more aware of and alleviate the SRH problems; it gives an insight to the problem and will help in designing an intervention for the sex workers.
- It can also serve as a point of reference for further study in the area.

## **1.5 CONCEPTUAL FRAME WORK OF THE STUDY**

This framework (figure one below) maps the pathways through which the SWs practices towards RH and their challenges in getting the RH services. Additionally, the framework draws to explore different factors that may influence CSWs in exposing to SRH problems. The Socio demographic and cultural factor such as the variables age, education cultural factors reflect the individual's own influence on use health facilities for reproductive health.

The result leads that to understand and share concerning to the RH experience of the SWs, towards positive health practices or risk perception. It is also to be shared as a baseline experience for other agencies on the intervention of RH related problems and leads to other researchers for further studies.

**Figure One: Conceptual Framework of the Study**



## 1.6 LIMITATION OF THE STUDY

The research was employed qualitative method; in this case it was taking more time with the interviewee, hence some respondents not willing to discuss the detail and to spend the time the checklist required.

## 1.7 TERMS OF DEFINITIONS

**Clients:** are men who pay cash or other resources for sexual services.

**Discrimination:** isolating the disadvantage group

**Home-based sex workers:** Women who sell sex from the building or house where they live.

**Hotel-based sex workers:** Sex workers, sometimes also employed by the hotel to serve food and drinks, who sell sex to the hotel clients.

**Peer education:** is an approach which empowers SWs to work with other SWs,

**Reproductive health (RH):** complete well being in all matters related to the reproductive system

**RH information:** Knowledge/evidence on the topic of reproductive health,

**Sex Workers:** are persons who provide sex for money or goods.

**Sexual relationships:** refers to heterosexual relationships only

**Street-based sex workers:** sex workers who actively solicit clients from the street to sell sex.

**Stigma:** different to the norm of the local social unit

## **CHAPTER 2: REVIEW OF RELATED LITERATURE**

In this chapter the researcher tried to review the contemporary literatures on concepts and meaning of sex work. More over the practices, life experiences, vulnerabilities and challenges of sex workers related to the RH services. The practice of FGAE Adama confidential clinic sex workers RH services implementation also reviewed.

### **2.1 Reproductive Health Definition and Concepts**

Reproductive health is defined as a state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life. Good reproductive health implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. Men and women should be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth. Reproductive Health has a particular interest on the impact changes in reproductive health have globally, and therefore encourages submissions from researchers based in low- and middle-income countries. (Federal Democratic Republic of Ethiopia Ministry of Health, National Reproductive Health Strategy 2006 – 2015)

RH is a comprehensive concept that implies a broad range of health and non-health related interventions. Reflecting this holistic understanding, this section provides an overview of the larger social and institutional contexts that influence the RH status of women and men in the country. The definition of reproductive health (RH) adopted at the 1994 International Conference on Population and Development (ICPD) represented a major step forward in current thinking about

human sexuality and reproduction. Whereas previous views had revolved around demographic goals and programmatic targets, ICPD placed people's needs at centre stage. Not only did it extend the domain of RH beyond the years of reproduction, it situated it within a broader socio-cultural context that included gender roles, respect and protection of human rights. Widely accepted by governments and their development partners, this holistic approach has provided a useful framework for understanding the complexity of RH needs and the multiple factors that give rise to them. But it has also, because of its breadth and inclusiveness, made operationalizing RH concerns all the more difficult. As early as 1997, the government of Ethiopia began addressing these issues, conducting a national RH Needs Assessment to guide the country's implementation of the new RH paradigm (WHO, 1999). The assessment called for national and regional exercises to identify RH needs and priorities; craft a consensus on the appropriate scope of RH services; and develop strategies for the implementation of such interventions. Ultimately, it recommended that the MOH "coordinate the development of a national RH strategy and reactivate the National RH Task Force" to assist in drafting that document (WHO 1999: 64).

## **2.2 Sex Work – Definitions and Concepts**

The term 'sex worker' refers to those engaged in prostitution and is the preferred term used throughout the literature on the subject. The term has been adopted as is it free of complicated, derogatory and sexist connotations which are more commonly associated with the term 'prostitute' (May, Harocopos and Hough, 2000).

Sex work is a term used to describe a wide range of activities relating to the exchange of money (or its equivalent) for the provision of a sexual service. Harcourt and Donovan (2005) compiled a long list of the different types of sexual services practiced by sex workers around the world. From this list, they grouped types of sexual services into two categories; direct and indirect sex work. Direct sex work refers to services, such as indoor and outdoor prostitution as well

as escort services. This type of sex work typically involves the exchange of sex for a fee in which genital contact is common. Indirect sex work refers to services, such as lap dancing, stripping and virtual sex services (over the internet or phone). Genital contact is less common in this type of sex work; however, a fee is still exchanged for the service.

To this perspective, Bethlehem Tekola, in her book *Poverty and the Social Context of Sex Work in Addis Ababa* (2008) explained why she preferred to use the term “sex workers” rather than “prostitute”. She stated, “The term prostitute has come to carry moralistic connotations. It has for long has been employed to separate sex workers from other women, among other things, in terms of their supposed differences on sexual morality”. She further continued by saying by “prostituting” the woman has made a choice to “market her flesh” and services her own lust or the lust of unknown men”. She also explained why she thinks the term “sex work” was relatively suitable by stating that referring as prostitution only to the part played by women without including the part played by purchasers of sex and by the state or its agencies that regulate, tax, proscribe, or indirectly take part in the business (like the tourism industry for instance).

Putting definitions of who do we call or should call sex workers were also of same value for this study even though there appears to be many disagreements involved in it. For the purpose of convenience, in this study sex work was well understood and suitable definitions were selected and are provided here below.

- Sex work is a term that describes the practice of offering sex (or other sex acts) in exchange for money or other material compensation.
- Sex work is defined in terms of selling sex for money as survival mechanism by sex workers persuaded to exchange sex for money. There is no true affection and love in sex work.

But in current situations, sex work may not be necessarily performed for only survival mechanism as the above definitions indicate, but as an additional income generating

activity and also as an entertainment technique. *The Wise – Up Program: Transactional/ Semi Formal Sex Work in Addis Ababa*, Momentum Consultancy 2010.

### **2.3 Commercial Sex Workers in Ethiopia**

Globally and in Ethiopia commercial sex workers (CSWs) are considered Most At-Risk Population (MARPS) for HIV infection, and their clients play an important role in the spread of HIV to the general population, (Marris, Podhisita, Wawer, et.al 1996). Survey of Ethiopia CSWs including biomarker data, demonstrated that this population is disproportionately affected by HIV, The first prevalence study conducted in 23 urban area in 1998, revealed a men HIV prevalence of 17 % with site specific estimates ranging from 5 – 38 % (Mehret, Khodakevich, Zewdie, 1990). Others survey conducted in 1989 and 1990 showed a significant prevalence of HIV among CSWs in Addis Ababa and other major cities, ranging from 25% to 50% (Mehret, Khodakevich, Zewdie, 1990b, FMOH, 1996).

More recent study showed Prevalence of 73% among CSWs attending STI Clinics in Addis Ababa, though this sample is likely to have a higher prevalence than the general population of CSW (Aklilu, Messele, Tsegaye, et.al, 2001). Several risk behavior, including multiple partnerships, alcohol consumption and erratic use of condoms have been associated with STI and HIV among CSWs in Ethiopia (Aleme, Kebede, Mitikie et al., 2006). Woldemariam Girma; Annabel Erulkar Ethiopia (2009): *Commercial Sex Workers in Five Ethiopian Cities: A baseline survey for targeted HIV prevention program for Most at- risk population*”.

### **2.4 Classification of Sex Work**

As Betlehem Tekola discussed the classification of commercial sex workers based on other researcher point of view and hers “there has been what appears to be an endless variety of commercial sex workers” (Betlehem, 2008 P44). However related to the research material the



categories of sex work generally divided into two broad categories as establishment based and street based. Although this type of classification found very practical, those sex work have been practiced or what the overall environment of the non full time or under covered sex workers looked like were ignored or not given enough concern in it. In this case the street based sex work would be much different compared to the establishment based one. In the establishment based type of sex work there have been many places/ location that could be addressed in the category (e.g. hotels, bars, restaurants, brothels, red-light houses, and tella and araki bets). But on the other hand street based sex work can only mean anywhere outside of the establishment or simply somewhere any street.

Street-based sex workers: according to some writer most street base sex workers consisted of university students and other who dropout the institution and considered sex work as an alternative occupation. It stated that “the student that belong to higher level educational institutions, and while studying there, in order to generate additional pocket money or to dress in styles or for other unknown reasons the young girls involve in to sex work. These girls did not always work in the streets, they often could also be found in the hotels and night clubs”.

In addition to the commonly known types of sex work in Addis Ababa, the ones listed below were identified to being widely practiced in different parts of the city:

- Shisha and Beleche Bet sex workers also known as *Kadamies* it is the newly emerging base for sex work and sex works in the city and these business entities often provide customers with private space and rooms for that period of rent that serve both for chewing chat, smoking shisha and as the same time purchasing and conducting sex.
- Massage paroles are also happening to be the place where commercial sex work now a day is reported to have started.

- There is also higher probability that all mentioned above can also work as call Girls for which they communicate with clients with telephone. (The Wise –Up program: *Transactional/ Semi Formal Sex Work in Addis Ababa Momentum* 2010).

## **2.5 The SRH Problems, Underlining Factors and Consequences of the SWs**

Sex workers are at most risk groups and they are exposed to numerous problems such as the health, emotional, social and economic. These all problems are interlinked and lead those unwanted consequences.

### **The SRH problems of SWs**

Sex workers are lacking information regarding to the RH; having trouble negotiating condom use; having low self-esteem; lacking autonomy in sexual and reproductive decision making, being stereotype as “sexually immoral” or “promiscuous”; being assumed to be sex workers; facing challenges around HIV disclosure (to partner, to family, to parents, to children, to co-workers, etc.); contracting STIs/RTIs; having unintended pregnancies; lacking access to HIV/AIDS care, treatment, and support services and also not knowing they are HIV-positive.

### **The causes that contribute SRH problems and consequences**

The cause that leads SWs to RH problem could range from the: personal to the community and societal levels, as well as to the biological level, Some of them are lack of control over sexual life and inability to negotiate condom use, biological vulnerability-not knowing they are at risk, exchanging sex for money or financial support due to poverty, cultural taboos about sex are the major one. The SRH problems can end up with Sevier consequences: SWs are getting sick and became disability and hopeless, SWs are dying without care and treatment services, babies are getting infected, SWs are being blamed for infecting male partners, sometimes leading to violence.

Children are becoming orphaned, communities are losing valuable members, and families are losing sources of support.

### **2.6.1 The health consequences to Sex workers**

Surveys have consistently shown a high and rising HIV prevalence among sex workers, presumed major reservoir of HIV infection in the country (USAID, 2002). A behavioral surveillance survey conducted in 2000 reported that knowledge of HIV prevention methods was low among FSWs; their attitudes towards sexuality and reproductive health issues present a source of concern (FHI, 2002). In several regions, significantly higher rates of sexually transmitted infections (STIs) and HIV infection are found among sex workers and their clients in comparison to other population groups. HIV infection has been found to spread among sex workers before it spreads into the general population. Given the role of STIs as a factor in HIV transmission, high rates of STIs among sex workers are indicators of the potential for rapid spread of HIV among sex workers, their clients, families and extended sexual networks.

High rates of infection among sex workers were to due to a combination of factors that compound this risk. These factors include poverty, low educational level and consequent levels of knowledge about HIV/AIDS and prevention means; limited access to healthcare services and prevention commodities, such as condoms; gender inequalities and limited ability to negotiate condom use; social stigma and low social status; drug or substance abuse and compromised sexual interactions; and lack of protective legislation and policies. In almost all countries where such data are available, prevalence rates among sex workers in general are higher than rates among women

presenting in antenatal clinics. (UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS 2005, *HIV/AIDS, Gender and Sex Work*).

HIV prevalence among sex workers increased dramatically in Addis Abba since 1985. From just under 1 percent, the latest available data show nearly three-fourths of sex workers tested were HIV positive in 1998. HIV prevalence for Sex Workers in Addis Ababa, Ethiopia: 1985-1998. The risk of HIV and other sexually transmitted infections is high among people who engage in sexual activity for income, employment, or non-monetary items, such as food, drugs, and shelter. Seeking care or reducing risk is sometimes difficult for sex workers living with HIV because of other social factors, such as poverty. Sexually transmitted infections (STIs) have shown to enhance the transmission of human immunodeficiency virus (HIV) and to be more common among female commercial sex workers (FSWs). A cross-sectional study was conducted among 625 FSWs in six cities of Argentina in 2000 –2002.

The sex worker is physically harmful STDs (including HIV/AIDS, Chlamydia, gonorrhea, herpes, human papilloma virus, and syphilis) are alarmingly high among women in prostitution. Only 15 % of the women in the Minneapolis/St. Paul study had never contracted one of the STDs, not including AIDS, most injurious to health (Chlamydia, syphilis, gonorrhea, and herpes). General gynecological problems, but in particular chronic pelvic pain and pelvic inflammatory disease (PID), plague women in prostitution. The Minneapolis/St. Paul study reported that 31% of the women interviewed had experienced at least one episode of PID which accounts for most of the serious illness associated with STD infection. Among these women, there was also a high incidence of positive pap smears, several times greater than the Minnesota Department of Health's cervical cancer screening program for low and middle income women. More STD episodes can increase the risk of cervical cancer.

Another physical effect of prostitution is unwanted pregnancy and miscarriage. Over two-thirds of the women in the Minneapolis/St. Paul study had an average of three pregnancies during their time in prostitution, which they attempted to bring to term. Other health effects include irritable bowel syndrome, as well as partial and permanent disability. Ultimately, women in prostitution are also at special risk for self-mutilation, suicide and homicide. 46% of the women in the Minneapolis/St. Paul study had attempted suicide, and 19% had tried to harm themselves physically in other ways.

In developing countries, it has also been estimated that "70 percent of female infertility... is caused by sexually transmitted diseases that can be traced back to their husbands or partners (Jodi L. Jacobson, *The Other Epidemic*, p. 10). Among women in rural Africa, female infertility is widespread from husbands or partners who migrate to urban areas, buy commercial sex, and bring home infection and sexually transmitted diseases. Women in prostitution industries have been blamed for this epidemic of STDs when, in reality, studies confirm that it is men who buy sex in the process of migration who carry the disease from one prostituted woman to another and ultimately back to their wives and girlfriends. In what becomes a vicious cycle, infertility leads to divorce and, in some cases, the ex-wife who is cast aside herself turns to prostitution to survive. "Janice G Raymond *Global Sexual Exploitation of women and Girls speaking out and providing Services health effect of prostitution*"

### **2.6.2 The physical, emotional, social and economic consequences to Sex workers**

The physical health consequences include: injury (bruises, broken bones, black eyes, and concussions). A 1994 study conducted with 68 women in Minneapolis/ St. Paul who had been prostituted for at least six months found that half the women had been physically assaulted by their purchasers, and a third of these experienced purchaser assaults at least several times a year. 23% of

those assaulted were beaten severely enough to have suffered broken bones. Two experienced violence so vicious that they were beaten into a coma. Furthermore, 90% of the women in this study had experienced violence in their personal relationships resulting in miscarriage, stabbing, loss of consciousness, and head injuries. The emotional health consequences of prostitution include severe trauma, stress, depression, anxiety, self-medication through alcohol and drug abuse; and eating disorders are the most common. “*Parriott, Health Experiences of Twin Cities Women Used in Prostitution*”.

The low economic status of FSWs heightens their vulnerability as they engage in unprotected sex. They lack powers to negotiate safe sex and condom. At other times they may be raped or coerced into violent sex; dry sex, with its consequent abrasion and bleeding, increases their risk of contracting HIV (Okeibunor, 1999). They are disadvantaged by a lack of self-esteem and adequate negotiation skills, which compromises their ability to manage the situation and to seek legal action (EUROPAP/TAMPEP, 1998; Metzenrath, 1998; Carrington & Betts, 2001; Lamptey *et al.*, 2002; Onwuliri *et al.*, 2003). In addition, FSWs face constant sexual harassment and abuse from law enforcement agents such as police officers. Worse still the hazy standing of the law in matters status of sex work makes legal protection of sex workers impracticable and HIV interventions for them difficult. The terrifying challenges contribute to the vulnerability, risk, and rising trend of infection among FSWs. Yet targeting interventions to FSWs remains an effective way to reduce the spread of HIV.

## **2.7 Factors Driving Entrance in to Sex Work**

The literature has revealed a wide range of processes which can lead to involvement in sex work. These processes tend to differ depending on local context and the type of sex work.

## **Money, Debt and Low Level Welfare Benefits**

The importance of financial drivers which often push people into sex work, Moffat and Peters, (2004), there are obvious financial rewards for some involved in sex work including brothel owners, managers and sex workers. Brents and Sanders claim that with fewer well-paid jobs available, welfare benefits too low to meet the ever increasing cost of living, in particular, for single mothers and women who are often marginalized from the mainstream employment structure, the financial drive to engage in sex work is very strong. In a separate article, McNaughton and Sanders (2007) state that welfare benefits are not generous enough to prevent poverty or marginal lifestyles. Debt plays a significant role in driving entrance into sex work. Low or insufficient income results in worse outcomes in both long-term health and life-expectancy.

As the Marmot Review (2010) recommends, a minimum income for healthy living would ensure appropriate income for all stages of the life course reducing overall levels of poverty, health inequality and improve living standards. For migrant sex workers, there are a wider range of factors which may result in engagement in sex work. The inability to find work in their home countries is one reason why migrants. Migrants were found to engage in sex work to fund aspirations of social mobility, better living standards, educational aspirations and greater and more rewarding working conditions. (Platt et al.2011).

## **Housing and Addiction**

Homelessness and drug addiction have been identified as the two most significant factors which prompt engagement in on-street sex work and two of the main barriers to stabilizing the lives of sex workers (Spice, 2007; Davis, 2004). In their study into on-street sex workers in reported a high proportion of on-street sex workers who claimed they were either homeless or

living in insecure/temporary accommodation two-thirds and all respondents admitted to problems with drug addiction. This type of engagement in sex work is often described as ‘survival sex’, where people engage in sex work as a last resort, to provide shelter, food, or fund severe addictions in a ‘work-score-use’ cycle (McNaughton and Sanders, 2007).

Additionally, research exploring problematic alcohol use amongst female sex workers across found that alcohol use, before entry into sex work, was used as a coping mechanism to help overcome or deal with experiences of loneliness and abuse during childhood and/or adolescence (Brown, 2013).

### **Violence and Power**

The influence and severity of violence and power, as a driving force of sex work involvement, is important, yet, often overplayed and over emphasized by Government, activist organizations and certain segments of the sex work literature. For example, whilst sex trafficking is an extreme form of violence. The situations in which people fall in to victim to sex trafficking is rarely explored in the literature. However, the claim that victims are often young and debt-bonded, suggests there are socio-economic, financial, power and dependency factors which may drive entrance into sex work through trafficking and control (Jackson, Jeffery and Adamson, 2010).

### **Family Breakdown and ‘Cut of Care’**

The consequences of family breakdown have been documented by studies which consider the links between institutional care services, vulnerability and chronic exclusion, in relation to sex work and wider social exclusion (Berelowitz et al., 2012). The study found that one third of the women they interviewed had been a ‘looked-after’ child and/or young person as a result of family breakdown. Additionally, nearly two-thirds of women reported they had experienced



physical, sexual or emotional abuse during childhood, whilst a third had left school by 14; those in care left earlier. Other research has found that leaving care, prison, hospital, education and mental healthcare systems can lead to or exacerbate social exclusion (Tonybee hall, 2007; Fitzpatrick, Bramley and Johnsen, 2012).

Furthermore, neglect by either the family and/or the care system can lead to, or exacerbate, the vulnerability of some young people (Stein et al., 2009). 'Cut off care', the abrupt reduction or removal of institutional care systems and safety nets, can leave people vulnerable to exploitation from controllers and may result in engagement in sex work through necessity or habit. In many cases, those who have been discharged (cut off) from a particular care system may experience a lack of money, housing, employment, social capital and appropriate networks of support, which can drive people into greater social exclusion and may lead to engagement in sex work as a survival technique and/or as a way out (McNaughton and Sanders, 2007).

### **Mental Health**

Traumatic experiences such as physical or sexual abuse during childhood have negative implications for mental health throughout the life-course. Childhood, past experiences of abuse were said to compound feelings of worthlessness. Furthermore, in a study by Fitzpatrick, Bramley and Johnsen (2012) which looked at pathways into multiple level exclusion and homelessness in UK cities, they found mental health problems to be prominent amongst people who experience chronic social exclusion. Mental ill-health can cause difficulties with employment, social relationships and dealing with day-to-day life, as well as poor physical health, which can lead to social exclusion (Social Exclusion Unit, 2004).

### **Low Education**

The literature suggests that poor education, as well as a lack of training and qualifications, impacts on vulnerability; driving entrance into sex work and reducing the chances of finding alternative forms of employment. In Jeal and Salisbury's (2004) study, they found one-third of interviewees had left education at the age of 14 years or younger. Similarly, Bindel et al. (2012) found 39 per cent of respondents had no training or formal qualifications. Poor education could affect the ability to find mainstream work meaning opportunities to earn an income are limited.

### **Discrimination**

Discrimination can take many forms, such as racism, stigmatization and prejudice. It can prevent social inclusion, driving marginalization and vulnerability. For some migrants, discrimination can exacerbate feelings of isolation and loneliness; common experiences associated with moving to a foreign country where support from family and other social networks may be lacking. Additionally, it can prevent or obstruct access to services and employment which may drive migrants to use other means of survival, such as sex work (UK NSWP, 2008a).

## **2.8 Determinant Factors to the Health of the Sex Workers**

### **Socioeconomic factors**

It indirectly influences HIV/AIDS transmission since they influence the individual's decision to indulge in HIV/AIDS risk behaviors. Poverty was considered a major factor influencing indulgence in heterosexual activities, an established socio cultural and sexual behavior for HIV-risk factor, in these areas. This is supported by 17, who iterated that poverty makes people tend to be less anxious about risk-taking particularly for a long-incubating and slow-killer disease like AIDS. Women in Africa were shown as the principal disseminators of HIV/AIDS in the current epidemic as a result of their lower socio-economic status<sup>13</sup>; and according to<sup>18</sup>, socioeconomic impact of

AIDS hinges on household resources and beyond. Reporting on HIV/AIDS and urban poverty in South Africa, it was concluded that the burden of HIV infection cuts across nations, but lies more heavily on poorer nations and peoples<sup>15</sup>.

**Economic Factors:** are intrinsic to the HIV epidemic. It has been established that a disproportionate burden of the disease exists in less developed countries and among resource-poor communities. For example, sub-Saharan Africa accounts for little more than ten percent of the world population but it is home to sixty-four percent of all people living with HIV.<sup>85</sup> The economic determinants that are described below (poverty, migration, and lack of access to productive resources, education and training) influence HIV vulnerability in several direct and indirect ways.

They stimulate risky behaviors that are responsible for HIV transmission, create obstacles to prevention, and impede efforts to cope with the impact of the epidemic. Socio-cultural norms, such as lack of inheritance rights and access to productive resources, which reinforce women's economic dependence on their male partners, also lead to women's higher vulnerability to HIV. The excessively higher rate of HIV infection among women as compared to men in certain epidemics is also an expression of high gender-based socio-economic inequity.

### **Socio cultural factors**

Socio cultural factors have been identified as responsible for the rapid spread of the disease. These include the following: Gender inequality and male dominance, Violence and sexual violence, Political transition and the legacy of apartheid, Stigma and discrimination, Poverty, Commercialization of sex, Lack of knowledge and misconceptions about HIV/Aids, Cultural beliefs and practices.

## **2.9 The FGAE Adama confidential clinic Practices**

The Adama confidential clinic located at the center of the town Kebele 06 in a densely populated area where most of the night clubs, local drink houses serves daily laborers. Most of the “broker houses” (who transfer bar ladies and housemaids for other town) also located in this area.

**Target Beneficiaries:** are those MARPs (Most at risk populations) particularly commercial sex workers which live in Adama town. The program focus on behavioral and bio - medical services, the service delivery approach is through facility based /clinic and community based. The main aim of the project is the prevention of the new HIV infections: by increasing access high quality HIV/AIDS/STI prevention, care and treatment services for Sex workers.

**Services Components:** Provision of Information and education (awareness raising & demand creation on RH), STI screening and treatment, HIV testing and counseling, condom promotion and distribution, family planning [including emergency contraceptives], management of unintended pregnancy (CAC), laboratory and referral services. The confidential clinic closely works with government, non-government organization and private business sector: town Health Office, local Keble Administration, labour and social affairs, Adama Hospital, Regional Laboratory, Women & Children affairs, Adama Mekdem Ethiopia, Wise up, broker association, bar and local drinking houses and targeted sex workers. Those partners participate in planning, monitoring the implementation of the programs and they provide technical support. (FGAE *Sex Workers Project annual performance report*, 2014).

## **CHAPTER3. RESEARCH METHODOLOGY**

### **3.1. Study Area:**

The study was conducted at Adama town in Oromia National Regional State, from July 2014 to April 2015. According to the central statistics agency statistical report of 2007, Adama woreda total population size of is 155,321 (Male 78997 & Female 76324). The town located around 100 Km distance from Addis Ababa city. The study area was specifically demarcated at four Kebeles in which the study populations are working and living which is called hot spot areas.

### **3.2 Study Population:**

The study populations are all sex workers who are live in Adama town and according to the project baseline assessment conducted in 2012, the total population size of sex workers were estimated around 3999. “*Access Training and Consultancy project baseline assessment: February, 2012*”. The target populations for the study were those actively functioning sex workers who come for different RH services at FGAE confidential clinic on the month of September/2014.

### **3.3 Sampling Frame**

The sampling frame designed and drawn from those commercial sex workers who came to get different health services at the clinic. The study population of this research were female sex workers who are engaged in established base, street and on call who attended the confidential clinic for RH services. In addition confidential clinic staff members of who were directly engaged providing various services on target groups were also included to this study.

### **3.4 Sampling Size**

The actual sample size for the study was 27 respondents one FGD comprised of 9 participants were conducted and 17 participants attended the in-depth interview total of 26

respondents attended in this study. The study participants were sampled using simple random sampling technique were employed to select those volunteer target groups for the study. Commercial sex workers who were present at the clinic on the days of the data collection time were used.

### **3.5 Sampling Method**

The clinic provides different service for an average of 15 sex workers per day. Accordingly the researcher collects data through in-depth interview from those 17 volunteer and interested commercial sex workers 3 clients per day. The FGD were conducted in the clinic comprised of 9 commercial sex workers. Hence, since the study populations are homogenous, a total of 26 samples can represent the total population. To do this, simple random sampling technique were employed. One of the best things about simple random sampling is the ease of assembling the sample. It is also considered as a fair way of selecting a sample from a given population since every member is given equal opportunities of being selected and participated.

Another key feature of simple random sampling is its representativeness of the population. Due to the representativeness of a sample obtained by simple random sampling, it is reasonable to make generalizations from the results of the sample back to the population. An unbiased random selection and a representative sample are also important in drawing conclusions from the results of a study.

### **3.6 Study design**

Qualitative research design was employed in order to answers a wide variety of questions related to sex workers responses to actual or potential health and behavioral problems. The purpose of qualitative research was to describe, explore and explain the health-related

phenomena being studied. The design of qualitative research is the most flexible of the various experimental techniques, encompassing a variety of accepted methods and structures.

In this case, a cross-sectional study was also employed to describe the relationship between sex work practice and associated effects. Focus group discussion (FGD) and interviews were conducted in order to explore the current knowledge, attitude and practices and result of RH among target group. One clinical service provider also involved to the data to show relationship findings from the FGDs and in-depth interviews and highlight pattern of service utilization in the area.

### **3.7. Data collection Tools**

The major instrument for data collection was used an interview guiding questions, which required information on the socio-demographic characteristics, practices and challenges on RH services among the commercial sex workers.

Observation provided the researcher to yield direct information about the nature of the beneficiaries of the service in the SWs friendly clinic. Participant observation helped the researcher to watch and understand the SWs, the agency staff & CWs reaction and the availability of basic reproductive health services.

### **3.8 Methods of Data Analysis and Interpretation**

Analysis of the qualitative data placed emphasis on the interpretation, description and recording/writing of what actually said. All complete interview questionnaires were checked for inconsistencies and missed points. Analysis of data from qualitative source through FGDs was made by summarizing the concepts into different themes. The researcher used to summarize in

English each contact with FGDs and the in depth interview. Contact summaries were prepared for each encounter. The summary contains the main points of each interview according to the themes that were formulated initially.

The process of analysis started with reading and re-reading the transcribed texts and each contact's summaries. Attempts were made to classify the data generated into themes and sub themes to facilitate analysis and interrelate opinions, definitions, concepts and descriptions on similar themes but from different contacts and areas. These categories were formed taking into consideration the objective of the study. During the data analysis, efforts were made to relate the opinions and stories from each encounter with the social standing, religious convictions, educational status, place of residence and economic opportunities. This enabled the investigator to see how each encounter is situated in the broader socio-economic and cultural environments where the informant lives.

Then analysis primarily focused on the textual data in the form of expanded field notes and transcripts of recorded interviews. The respond to certain questions or descriptions as reflection from earlier interviews were systematically interpreted and their meanings put as they said to be incorporated in the analysis.

### **3.9 Validity of the Study**

The result of this study should be understood within the context of the Adama FGAE Confidential clinic in which the study was carried out. Maximum efforts possible were made to select carefully the assistant moderators and recruiters, besides, orientation on the research topics and questions were given. Participants of the FGDs and in depth interview were carefully selected with the assistance of the community workers. Good rapport was established with those sex



workers before engaging directly to the study. Different data sources and methods will be used (triangulation). Thesis was reviewed and criticized by senior experts and professionals.

**Accuracy:-**Accuracy assured by reviewing and checking the instruments which was semi structured interview and FGD questions. All recorded data and notes also taken in order not to miss any valid information.

**Credibility:** - assured by the development of early familiarity with the culture of participants before starting the study. The use of a wide range of different approach according to the SWs interest benefited the study in getting the detail individuals view points and experience.

**Transferability:-** The study result was transferred to concerned body through disseminating research findings. The role of the researcher was presenting the findings and responding to the question raised by the attendants to the concerned body to utilize the finding of this research.

**Resource availability:** The researcher observe the clients of the clinic while serving in the clinic, and the clinic staffs/ professionals and volunteers (CWs) when at their working time to get advice and guidance including the needed materials for reference.

### **3.10 Ethical Considerations**

Letter of permission for the study obtained from St. Merry University College and the FGAE office. Informed consent also obtained verbally for every group or individuals responders during the interviewee and FGD sessions. Study subjects were reassured about the confidentiality of all the information obtained and it will be anonymous /no need of naming/. During the interview, maximum effort made to keep privacy of the respondents and explained to them the purpose of the survey to give us their opinion what they feel.

## **CHAPTER 4: RESEARCH RESULT AND DISCUSSION**

### **4.1 RESULTS**

#### **4.1.1 Response Rate and Demographic Characteristics**

In this study a total of 27 commercial sex workers were designed to participate 18 will be interviewed and one session of FGD consisted of 9 commercial sex workers to be conducted, but 17 (94.2%) participated in the interview study and 9 persons attended the FGD total of 26 sex workers participated in this study. In addition confidential clinic service provider a nurse who was directly engaged providing various services on target groups were also included to this study. The study objective tried to explore the practices, challenges and the factors which lead sex workers in reproductive health services and to examine the availability, accessibility and utilization of SRH services in the case of FGAE Adama Confidential Clinic clients. Both the interview and FGD is conducted at the Adama Confidential clinic in the community workers offices. In order to understand the commercial sex workers general demographic characteristics, factors leading to these activities, the practices on RH, challenges that faced and the contribution factors to challenges, the researcher used different elements consisting interviewing and FGD session. Different issues were raised during FGD and interview sessions which are presented as follows.

The age of respondents were ranged from 14 to 34 years, The majority age group were 15 – 24 years 18 respondents which is the major proportion 69.2% were within this age category while 6 respondents were within in range between 25 -34 years and the rest 2 of them were 14 years old. Among respondents, while the minimum reported age was 14 years, the maximum reported age was 34 years. With regard to their educational level majority of them dropped out-of-school at primary school level nearly 46.2 % of respondents were they only able to

read and write their name in their own language, 7 of them 27% were at elementary level, 3 respondents (11.5%) arrived at high school level, 7(27%) respondents had also never attended education.

With regard to marital status the majority of the respondents (65.4%) were never married, 6 (23%) of them divorced and the rest 11% respondent were separated and divorced involved the sex work business for short period of time to pass the challenges. Working characteristics of sex workers (type of venue) majority 11 (42.3%) respondents were working in the bar, 8 of them (30.8%) are in the small local drinking houses (Tella and Areki bet/houses), the remaining 5 (19.2%) and 2(7.7%) respondents respectively, were working in street-based and Shisha/Bercha bet. Selected characteristics of FSWs based on the duration of sex work. A total of 8 respondents (30.9%) FSWs reported that they were in sex work for less than a year, 5 FSWs who had been in sex work for 3 years; those 10 (38.5%) respondents work more than 5 years.

#### **4.1.2 Factors Leading to Sex Work**

Factors driving entrance in to sex work were a discussed financial drive which comprises the highest proportion 40% of coverage often pushes young ladies into sex work. Family beak down and peer pressure also the second most common reason for their initiation of sex working life which accounts for 32%, Social problems and lack of employment option/ job seeking were mentioned by the respondent as reasons for joining the sex working life. According to the group discussion result, there are various reasons that lead the participant to engage in SW activities. Most of the respondents believed that sex work is a big problem in this town because of the town is business center. Respondents explained that many factors are contribute those women leads to sex work; some are related to quarrel with families, the breakup of family, death of parent and disagreements with their husband, lack of guarantor to work as a

housemaid; some of the women were persuaded by others (such as brokers, bar owners, friends) to become sex workers but many more are related poverty and lack of employment or income generating opportunities for women.

One respondent replayed that,

*“I was live in the rural keble far away 250 km from Adama, My parent didn’t own their private farm land I don’t have a brother three of us were female in the family I was study until grade 6 and my parent asked me to get married when I was 16 years to get some farm land as marriage inheritance. Though I opposed the idea strongly but finally forced to get married. After staying 1 year with my husband I escaped to this town due to facing of different forms of violence”.*

Commercial sex for most women was seen as the only way to generate some income to feed the children and family by the women. The respondents also explained that Women who are raped, deserted by their husbands, or widowed at an early age become commercial sex worker. They further mentioned that young girls enter into commercial sex was mainly due to parental poverty and linked with lack of education. Because of financial problem, some family members encourage their girls to use sex to support the family. This combination was blamed for forcing them to resort to commercial sex. From the discussion the researcher understood that the clients of SWS include long distance truck drivers, construction workers, students, casual /daily laborers, businessmen, field workers, drivers, farmers and others.

### **4.1.3 Major Reproductive Health Practices**

#### **STI & HIV/AIDS Health Related Practices of SWs**

Most participants were well aware of the STD infection is a problem in the study town. They expressed their concern regarding the spread of STD in the community and believed that STD is a serious problem in their community. Most of them stated that SWs and their clients

are the most vulnerable and affected sector of the population. When discussing about contextual risk factors for STD infection in their community, they indicated that most CSWs and CSWs clients are increasingly addicted to drugs such as chat, shisha and also drinking alcohol has become a common practice. Such practices, would often lead to uncontrollable sexual urges and unsafe sexual activities.

In this survey, respondents were asked whether they ever had STD and they were also asked whether they had suffered from any STD in the previous half year preceding the survey; they are also asked what was done in response to the recent STD infection. Most respondents explained that as they did not notify when they had such health problem (STD) with whom they are having sex. This would imply that there is a high possibility that most CSWs' clients could have been suffering from an STD infection. The low salience of STD also leads people to underestimate the risk of infection and the seriousness of the disease in the community.

Among the participants one respondent explained that,

*“once I had got genital ulcer and told to my friend but she disclose the case to my customers and some of them refuse to have sex with me since then I started to keep as secrete while I face such type of problem and prefer self treatment but after SWFC started to operate in this keble I started to consult for every my problem”.*

To measure the individual perceive self-risk of being infected with AIDS, respondents were asked whether they were concerned that they were at risk of being infected with STI and HIV/AIDS. Most respondent indicated that in spite of high knowledge of AIDS, many people believe that they are invulnerable to HIV/AIDS infection and this feeling encourage many people to ignore the risk of infection and thus take little or no precautions. In order to evaluate

further respondent's knowledge about preventive measures, the researcher asked, if there is anything that can be done to avoid HIV/AIDS. Respondents cited several options, including use of condoms and limiting sex to one person.

One respondent explained that,

*“Previously I engaged in unsafe sex practices when my customers told me us they pay me more money and I used to do this, due to these I was suffered from STD several times, but recently I already stopped any negotiation without condom”.*

Regarding to the issues how STD expose them to HIV/AIDS was discussed, most participants were well aware of the STD infection a problem in the study town. They expressed their concern regarding the spread of STD in the community and believed that STD is a serious problem in their community. Most of them stated that CSWs and CSWs 'clients are the most vulnerable and affected sector of the population. When discussing about contextual risk factors for STD infection in their community, they indicated that most CSWs and CSWs clients are increasingly addicted to drugs such as khat, shisha and also drinking alcohol has become a common practice. Such practices, would often lead to uncontrollable sexual urges and unsafe sexual activities.

Regarding to the methods of STI HIV infection prevention, most of the participants mentioned that the modes of prevention methods include having safe sex by using condom, avoiding using sharp instrument in common and having regular STI check up.

One respondent explained that

*“Since I engaged in this practice for the past 3 yrs I didn't usually getting STI check up from nearby clinics due to lack of awareness on the benefit of check up and usually seek medical care*

*when I get sick. But once my friend of mine who is a PE informed that “having regular STI check up is one of the way in which someone prevent himself from getting STI”, since then I usually do this practices and prevent myself and others”.*

They also described the types of STI which they know like gonorrhia, syphilis, HIV, chancroid and genital warts are mentioned by most respondents. Based on the practice of service utilization, most respondents replied that since the start up of the Adama Confidential clinic it reduce the time spent in searching RH services which is far away from the local site. Besides, to the knowledge in knowing the availability of different types STI and the modes of transmission and prevention also increased.

Regarding on this one respondent explained that,

*“I had been traveled to far distance to get SRH services, but in between I missed the appointment given me to go back for another check up due to the distances”.*

Due to the availability of confidential clinic, the practices of utilizing the RH services are increased. Most of the respondents replayed as they tested for HIV and screened for STI on regular bases. The clinical service provider also indicated that now days most of the SW is regularly screened on STI and HIV.

### **Family Planning Practices:**

The respondents mentioned that to prevent unplanned and unwanted pregnancy there are using many options. Such as oral contraceptive pill, condom, inject able and the other long terms which is inserted under the skin. The method choice is left for the clients to choose the method in which they are interested from the available contraceptive methods. They usually get the service from the Adama confidential clinic, private clinic and also from the pharmacy.

One respondent explained that,

*“I used to use oral contraceptive pill from the pharmacy for about one years, while I face some side effects, it was difficult to get proper counseling and after the last 3 months I started to use the method from Adama cC with method counseling now I am comfortable with the method”.*

Based on method choice, the service Provider described that most of the 2SWs are using condom as the dual method of protection and some of them preferred to use long term FP methods because of their mobility from place to place.

### **Condom Usage and Negotiation Skill**

The respondents suggested there now a day there are different agencies that provide different types RH services. So they got full information on the benefit and usages of condom correctly and consistently. The respondents also indicated that some of the business owners have rule and regulation to enforce every commercial sex workers to use condom when they are engaged in business. They added that the communities have full information and protection for the commercial sex worker while they got conflict with some of their clients who ask to have sex without condom.

One participant explained that

*“Once I had mate with the new client and he invited me to drink an alcohol. In the mid night, he asked me to have sex without condom and I Saied no, he promised to pay me more money but I refused. Finally when he tried to forced me I cried shout and the nearby people arrived the place and warns him and while he opened the door I escaped”*

A 17 year young female SW stated the following in relation to condom usage.

*“Now a days we have protect ourselves and other though correct and consistent usage of condom, we loss some of those paying clients, but we provided value for our health”*



Based on results from this discussion session the researcher understood that most of the SWs are agreed and practices on the correct and consistent usage of condom.

#### **4.1.4 Major Reproductive Health Challenges among Commercial Sex Workers**

##### **Lack of basic information and awareness on RH:**

According to discussion made among commercial sex workers most of them agreed that they lack basic knowledge and information about safe sex practices, how to prevent STI, HIV and unwanted pregnancy. The FGD reveals that the IEC are provided only in the limited areas by different agencies.

At the community level the continuity and the quality of RH IEC on sex work is very limited, some of the respondents had never heard the concept of peer education. As per the service provider response, even though the Peer educators provide IEC services at outreach level but due to different reasons like lack of interest to attend the IEC sessions was found as one of the problems which leads the SWs to have misconception on RH issues .

##### **Sexual Transmitted Infection and HIV/AIDS:**

As per their responses, some of the SWs didn't know the mode of prevention and the SS of STI. Based on the exposure to STI for the last 3 months, some respondents explained that they have got infection and they treated at private clinic and confidential clinic. This showed that the potential transmission of STI is very high and also this can increase the possibility of acquiring the HIV/ AIDS. The Adama confidential Clinic 2013 annual report also indicated that, the positivity rate of STI among commercial sex work was 15 % which showed that the SWs are highly exposed to the risk of STI including its complication.

Regarding to the HIV/AIDS, most of them lacks practices of periodic HIV testing while others did not want to be tested, because of fear of stigma and discrimination by their peers/ friends and the community if their result is positive for HIV. The other reason of refusing HIV testing was found that if they became HIV positive, they may lose their business.

One participant in the FGD session support this idea by saying,

*“I feared HIV positivity, because the community may stigmatize and discriminate me and also the business owners didn’t accept me”.*

The service provider also indicate that in the Confidential clinic the first 2014 half year performance report showed that the positivity is around 4.2% of new infection rate which is very high when comparing with the national prevalence rate.

### **Unwanted Pregnancy and child birth**

Most of the participants mentioned that, unwanted pregnancies are the most frequent and series problems of them. Sometimes they did not know when and from whom they had sex and got pregnant. The reason they mentioned were, they usually used condoms as a means of protection from pregnancy and other infectious diseases, but because of condom breakage and slippage they exposed to unplanned pregnancy. When such cases is happened they didn’t even report to the health facility to get post coital contraceptive methods in steady they simply used vaginal wash after sexual contact for prevention of pregnancy and STD. The group discussion revealed that some of the SWs miss their appointment date for resupplying of contraceptives because of their mobility from one town to other which made them to discontinue the method.

Among those respondents in this study a young lady who’s her age was 18 year old explained that,

*“I was lived with my aunt after the death of my mother, at the age of 16 yrs old, my aunt was given me the responsibility of the selling local alcohol Due to the nature of my work, I started to exposed to sexual intercourse with the different persons. I didn’t have any information about STI & HIV, and pregnancy. When my abdomen size was increase, I was worried for the incidence and one of my friends told me that I was pregnant. Following this, my aunt fired me home because of the pregnancy and left for nearby town on my foot. While I was searching for the place for shelter, the labor was started. In this case those who watched these incidences immediately took me to Kuyera Hospital and gave birth assisted with instrument. After staying for about one day, I discharged and I got 10 day stay in one of volunteer family who was willing to support me. After staying 10 days I sated to travel to Adama town to seek for a job. , during my journey my infant was passed away, in order to sustain my daily life, I continued my previous SW Job. Currently because of SWFC I have got adequate information and knowledge on STI/ HIV and family planning and started tu use inject able contraceptive method.”*

### **The Emotional Health:**

Others also mentioned that the emotional problem they experience include trauma and violence. Physically they injured bruises, broken bones, black eyes, and concussions The client of commercial sex workers usually abuses them with different types of sexual practices and different forms of physical abuse. They provide services to those drunker which is intoxicated with alcohol and uses different substances. In this case some of them attack by their customers and developed both physical and emotional trauma that leads to physical disability, stress, depression and anxiety.

### **Stigma and Discrimination:**

Most respondents indicated that they are stigmatized and discriminated by the society, due to these reason the commercial sex workers often exclude themselves from social interaction, benefited from utilization of resources and accessing the service. The discrimination and violence faced by many sex workers is often a challenge than HIV and sexual health. Stigma and discrimination: it is immoral and which influence the human personality.

One respondent explained that,

*“Nobody sees us as the part of the community member, rather they see us as illegal and immoral people”*

### **Psychological and social barriers:**

The respondents mentioned that, sex is a means of survival for them who are poor and lacks other means of income to survive. They are assured; vulnerability is high to sexual violence, coercion and abuse. On the other hand the community didn't understand the problem of the SWs faced, mostly they categorize the commercial sex workers as they are addicted, infected and carrier of the HIV.

### **Unsafe sex and violence among Sex Workers:**

During the discussion session the respondent explained that, paying clients are forced to acct sexual intercourse without condom. Some of the clients also break the tip of the condom to have body contact. Those none paying boyfriends (the so called body guard) doesn't

want to use condom but they have more than one girl friends.’’ We accepted that we still engage in risky behavior, such as having sex without a condom’.

In this discussion the researcher understood that even though the national prevalence rate indicate decreased, but the actual experience among sex worker in not using condom properly and consistently may increase the risk of HIV infection.

#### **4.1.5 Factors that Lead to Sustain the RH problem**

##### **Socioeconomic and cultural factors**

The respondents described as poverty was a major factor influencing to engage in SW activities and accept the risks, such as multi partner sexual activities. Some of them described they face poverty, and lack of access not only to health care services but also to other social services. This sometimes becomes barrier in receiving RH services. The economic constraints such as lack of other job opportunity forced them to remain in these risks. The stigma and discrimination which they face by their families and communities also another issue which affects the health of the SWs. Lack of knowledge and misunderstandings regarding to the positive health practices mostly influenced by the nearby communities traditional and cultural beliefs. Most of the SWs are directly or indirectly affects in utilization of RH services. The SWs usually lacks an access to education and other skill training that became the cause for remaining in this activities. Many women in rural area also lack economic power due to the male dominance, and some of them expose to unwanted marriage. In this case, they obligated to migrate to urban to support themselves financially.

##### **Low Health Seeking Behavior:**

Regarding to health seeking behavior, respondents mentioned that, while they are getting sick, they preferred self treatment rather than going to health facility. The reasons are due to lack of awareness in effect of self treatment, poor self image and high cost of treatment. But currently they had understood that these all expose themselves to the development of drug resistances and complications and also this mal practices have an impact on the control of STI HIV infections. Besides to this, they explained about the FGAE Adama confidential clinic which is the only clinic available in their working area which doesn't need transportation cost and made them to feels at home. The clinic provides different RH service for SW in integrated approach. This approaches in friendly manner able the SWs to get the services free of charge. Since the startup of the clinic service, the health seeking behavior of SWs was changed positively towards RH.

#### **Lack of Access to Health Services:**

During the FGD session the issue related to the factor which challenged the commercial sex workers on RH services utilization problems was discussed, in this regard the commercial sex workers blaming the existing sexual and reproductive health services. The reason behind is the limitedness of clinic which is targeting the commercial sex workers by government and nongovernment organization. When they got sick they may forced to attend private clinic which costs the amount of money that may not affordable by itself. Besides, those health centers which are responsible to provide health care for the whole community are not as such accessible for the sex workers. Some of Health worker not accept SWs as the other community part they approach in negative attitudes towards commercial sex workers. The level and capacity of service providers also differed some of them didn't accept in friendly approach. Some of participant explained that the confidential clinic working hour also not convenient for them, since it does not consider the convenient time for commercial sex workers to utilize the service at lunch time.

## **Alcohol and Other Substance Addiction**

The respondents mentioned that, spending time in the afternoon and to be alert at working hour and at night time, they usually using “chat”, some of them also smoke cigarette when they are “chewing chat”. There is also another tobacco named “shisha”. During the night time when they are working in the bar, they have supposed to drink an alcohol when they invited by the customers.

Self-treatment to forget all their stress through consuming alcohol, chat chewing and substance using and eating disorders are the challenge the SWs faced mostly. Almost all the respondents in the study exposed themselves to substance-addiction to work their business actively and to forget their trauma they experienced. These brought a challenge in sex workers life by impairing judgment and difficulties in negotiating safer sex practice with their customers due to the influence of drugs and alcohol.

## 4.2 DISCUSSION

The commercial sex workers who participated in this study were recruited through community workers at the Adama confidential clinic. The present study was an attempt to explore the commercial sex workers RH practices, challenges and those predisposing factor for RH problems among the respondents, the researcher used different elements by selecting the most common RH problems different issues on STI HIV/AIDS, condom usage, awareness and family planning issues.

The survey revealed varying demographic backgrounds of the SWs, regarding the age group, majority of the respondents were 15 -24 years old which shows those adolescents are involved in SW more than any age group. Even if their number is small, other teen age groups were also involved in the SW business. Majority are working in the established base bar and hotels and they were migrated from rural and urban settlements. Regarding the educational level, most of them drop out their schooling at the elementary level; some of them educated and few respondents continued their education at night school.

Regarding to the factors which leads to be a SW, most of them have common feature in their economic and social vulnerability. They are mostly single and driven by financial problem to engage in sex work business. The literature review indicated below also support the finding obtained through FGD. “The consequences of family breakdown have been documented by studies



which consider the links between institutionalized care services, vulnerability and chronic exclusion, in relation to sex work and wider social exclusion (Berelowitz et al., 2012)".

In other study finding show the importance of financial drivers which often push people into sex work, (Moffat and Peters, 2004), there are obvious financial rewards for some involved in sex work including brothel owners, managers and sex workers. These are typically young girls who are in sex work because of the tradition that the elder girl of the family is required to economically support the household through sex work. It may also be that they are drawn into sex work to seek more money because of the need to support a larger size of their family. The study demonstrated that adolescent's age groups are often driven into sexual practices at their earlier age.

Regarding to the RH practices, some of the respondents demonstrated good awareness and positive health practices. They expressed their concern regarding the spread of STD in the community and believed that STD is a serious problem in their community. Most of them stated that SWs and their clients are the most vulnerable and affected sector of the population. On the other hand most respondent indicated that in spite of high knowledge of AIDS, many people believe that they are invulnerable to HIV/AIDS infection and this feeling encourage many people to ignore the risk of infection and thus take little or no precautions. As per the result of the study some of them demonstrated that they completely ignore the diseases modes of transmission, preventions and other reproductive health issues. A good number reported the use of condom; the others who fail to use and cant able to negotiate with their boyfriends it remain the transmission of HIV in the community will continue. The respondents suggested the creation of awareness on RH and its prevention not only among the commercial sex workers but also needs to involve male partners.

Commercial sex workers are exposed to different RH problems like lacking information; contracting and exposing to sexual Transmitted Infection and HIV/AIDS having trouble on condom usage, unwanted Pregnancy and child birth; lacking access to HIV/AIDS care, treatment, and support services, Stigma and discrimination.

Other study also described about the high rate of infection among commercial sex workers. A behavioral surveillance survey conducted in 2000 reported that knowledge of HIV prevention methods was low among commercial sex workers; their attitudes towards sexuality and reproductive health issues present a source of concern (FHI, 2002).

Other than RH, the commercial sex workers exposed to emotional health consequences of which include severe trauma. Psychological and social barriers: they mentioned they are highly vulnerable in to sexual violence, coercion and abuse. Sexual abuse and exploitation is also one of the rising social problems affecting the physical, social and emotional wellbeing of sex workers. The cause could range from the: personal to the societal levels, as well as to the biological level such as lack of access to health services, alcohol and other substance use Addiction, low Health Seeking Behavior and Socioeconomic and cultural factors are the main factors mentioned by the respondents.

The finding in other research the Adama confidential clinic baseline research results also indicates that sexual and reproductive health of commercial sex workers is intricately connected to other aspects in their lives such as alcohol and other drug use, self esteem, and perception of judgment from peers.

Regarding to RH problems, in this study the researcher revealed different factors that lead to sustain the RH problem such as lack of access to health Services, low health seeking

behavior, socioeconomic and cultural factors and alcohol or other substance addiction are the major problems which lead to those women in to risk and complicated RH problems.

In other study finding also indicated similar results, high rates of infection among commercial sex workers may not be due to the fact that they have multiple partners but rather due to a combination of factors that compound this risk. These factors include poverty, low educational level and consequent levels of knowledge about HIV/AIDS and prevention means; limited access to healthcare services and prevention commodities, such as condoms; gender inequalities and limited ability to negotiate condom use; social stigma and low social status; drug or substance abuse and compromised sexual interactions; and lack of protective legislation and policies. UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS 2005, *HIV/AIDS, Gender and Sex Work*.

These all have its own consequences and complication. Thus to address the commercial sex workers RH problems with innovative approach those government NGO, private business sectors including the overall community needs to have urgent attention and action at Adama town.

## **CHAPTER 5: CONCLUSSION AND RECOMENDATION**

### **5.1 CONCLUSION**

These data highlight that the need of RH services to those MARPS groups especially commercial sex workers. Women struggling against adverse conditions such as illiteracy, lower status in society, and less economic opportunities are especially vulnerable to being infected by HIV, as sex work may be one of the few economic options available for these women.

The study has discovered the commercial sex workers RH practices that have come to the Adama confidential clinic, their SRH knowledge which was well pronounced in their HIV related misconceptions, their knowledge on STI and on their fertility awareness. Whereas the commercial sex workers shows positive attitude towards accessing of SRH services signify the need to avail such services. Moreover, the high prevalence of STI HIV infection in this target groups in the town and the commercial sex workers demand for SRH services confirm the need to provide these services in the holistic approach. Moreover it is not only accessing and availing the RH services but also making the services friendly is principal importance for commercial sex workers to use the SRH services.

Following the findings of this study, it is important that steps to be taken to improve on the level of awareness on RH among the respondents. The results clearly points out important lessons for health education. This should target the perceptual factors, which tended to provide adequate explanation for the knowledge on modes of transmission, prevention and practices of the respondents towards RH.

## **5.2 RECOMMENDATION**

In the background of this study the researcher seen the increasing numbers of women infected with STI HIV infection, there is a need to address the specific factors that contribute to women's vulnerability and risk. This increased risk of HIV in women is also a reflection of gender inequalities. Recommendations for action are made within the context of RH services program based on the findings of the study. To address the RH problems in those sex workers they identified themselves they are unique, and has different needs for health information and service based on the range of factors that include their age, knowledge, practice, culture, social situation, and physical or emotional problems. Based on the findings of the study respondents describe and suggest to fulfill the following health needs:

### **1, Information and Counseling Services on RH**

Through proper information, education and communication (IEC) the SWs enables to develop knowledge and makes to protect themselves against HIV/STIs and unintended pregnancies. Information helps them to have good negotiation skill of safe sex practice and it avoids the misconceptions about RH. The counseling process supports the SWs to have full information regarding to their RH and able them to choose and decide the safest and better RH practices. It

encourage them to change risky behavior, counseling motivate the SWs on how to seek health service, protection from violence, forced sex or sexual coercion.

## **2, Reproductive Health Services**

Increasing the availability and accessibility of comprehensive RH services specifically targeting commercial sex workers, in general all preventive and treatment services need to be expanded and made available. To protect and improve their current health, to understand their sexuality and reproductive health needs, learn to take active responsibility for their reproductive health, prevent STIs, HIV and unintended pregnancies, prevention serious health problem.

To address those basic RH needs they also mentioned to fulfill the following standards:-

- Addressing the RH right to full broad range of reproductive health service options to those commercial sex workers.
- Protect gender inequalities and differences that character the social cultural and economic lives of the commercial sex workers which influence their RH.
- The health need of commercial sex workers are the best addressed by a holistic and integrated approach that takes complete of their physical, mental and social wellbeing through prevention, treatment, care and support services.
- Community support and participation are critical to the effectiveness target specific /SWs/ health services and programs.
- The commercial sex workers needs to be part of the RH program and to participate voluntarily in the planning development, implementation as peer educators and evaluation

of service and programs ensures the proper addressing of services. Those volunteer peer educators could be trained on basic RH to have adequate knowledge and then enables them to provide correct information/ education on the reproductive health practices.

- To involve in other job activities, the sex workers should be provided with income generating skill training that improve their financial capability and develop their confidences,.

## REFERENCES

- Aklilu M, Messele T, Tsegaye A, (2001), *Factors associated with HIV-1 infection among sex workers of Addis Ababa, Ethiopia* 15:87-96.
- Barry, K., (1995) *the Prostitution of Sexuality: The Global Exploitation of Women*, New York: University Press.
- Bethlehem Tekola (2008), *Poverty and the Social Context of Sex Work in Addis Ababa: 23- 44*
- Central and Eastern European Harm Reduction Network July 2005 *Sex Work, HIV/AIDS, and Human Rights*
- Family Health International (FHI) – Ethiopia in collaboration with the Addis Ababa City Administration Health Bureau (AACAHB) August (2002), *Mapping and Census of Female Sex Workers in Addisa Ababa*
- Federal Ministry of Health, Federal HIV/AIDS Prevention and Control Office, September 2011 *HIV Prevention Package MARPS and Vulnerable Groups, Addis Ababa Ethiopia*
- Federal Democratic Republic of Ethiopia Ministry of Health, National Reproductive Health

Strategy (2006 – 2015)

Federal HIV/AIDS Prevention and Control Office September 2011, Addis Ababa, Ethiopia P 13.

FGAE *Sex Workers Project Baseline Assessment* February, 2012

FGAE *Sex Workers Project annual performance report*, 2014

Gegu Degu Alene (1999), *Knowledge and practice of condom in preventing HIV/AIDS infection*

*among commercial sex workers in three small towns of northwestern Ethiopia*, P 5.

Jessica Jitta1 Martin Okello No. 004/2010 *Prevention of HIV/AIDS Infection Among Female*

*Commercial Sex Workers in Kampala, Uganda*

Mehret M, Khodakevich L, Shanko B, Belete F. 1990d, *Sexual behaviors and some social*

*features of female sex workers in the city of Addis Ababa* 4 (2): 133-137.

Momentum Consultancy (2010), *Transactional/ Semi Formal Sex Work in Addis Ababa*, P 13

MOH/HAPCO: Ethiopia. *HIV/AIDS Behavioral Surveillance Survey (BSS) – Ethiopia 2006:*

Round Two. 2007.

MOH AIDS in Ethiopia: Addis Ababa 1998. *Sex workers Prevalence:* 171-176.

Report of a WHO technical consultation on RH, Geneva, November 2010: 4–5

Reuben Balfour with Jessica Allen April 2014, *Sex Workers and Social Exclusion by the UCL*

*Institute of Health Equity*

*Sexual and Reproductive health needs of Sex workers/Tanzania* Rodrigo | November 29, 2012

Talent Youth Association TaYA (2015), *the Importance of Sex Work Interventions*

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS 2005, *HIV/AIDS, Gender and Sex*

*Work*

United Nations Population Information Network (POPIN) UN Population Division, Department



of Economic and Social Affairs, *Guidelines on Reproductive Health: 3 & 5*

WHO 2011 November *Preventing HIV among sex workers in sub-Saharan Africa: A literature Review*

Woldemariam Girma and Annabel Erulkar September 2009, *Commercial Sex Workers in Five Ethiopian Cities, A baseline survey for Targeted HIV Prevention Program for Most At-Risk Population.*

## Work plan

**Table 1: Summary of the Work Plan**

S.N	Activities	Implementation Time Line						Responsible Person
		Jun	July	August	Sept.	March	April	
1	Developing the research activity plan		X					I
2	Discussion with advisors on the research action plan		X					I
3	Submit the research proposal to advisor and get appropriate comments		X					I
4	Preparation of the Data collection instruments			X				I

5	Organizing a meeting with the agencies who provide service for the SWs how to conduct the research			X				I
6	Selecting data collectors and training them		X					I
7	Data collection		X	X				I + DC
8	Data entry and cleaning				X			I + DEC
9	Data analysis				X			I
10	Write up of the draft report					X		I
11	Submission of the draft report to advisors					X		I
12	Get the necessary feedback and rewrite and provide final draft to the advisor					X	X	I

I= Investigator    DC= Data collectors    DEC= Data Entry Clerk

## Budget Breakdown

**Table2: Budget Breakdown**

S.No	Item	Unit measure (birr)	unit price in Ethiopian birr	Total Amount in Birr
<b>1</b>	<b>Personnel</b>			
	<b>Principal investigator</b>			
	Supervisor(s)	Individual	100 birr x 7 days x 3person	2100.00
	Data collector	Individual	75 birr x 10 person x 10days	7500.00
	Data clerk/Data entry	Individual	100birr x 3days x1	300.00
	Secretary	Individual	150 birr x 5days x1	750.00
	<b>Sub Total</b>			<b>10,650.00</b>
<b>2</b>	Supplies/Stationeries			

	Photocopy and printing paper	Pk	80birr x8pks	640.00
	Questionnaire Duplications		Birr0.50 x3000 pages	1500.00
	Stationeries ( pencils, erasers, writing pad, flat file, sharpener, stapler, stapler wire,)			1250.00
	Printing and Binding of documents			500.00
	<b>Sub Total</b>			<b>3890.00</b>
<b>3</b>	<b>Training of data collectors</b>			
	Refreshment	10	Birr 10X15x2days	300.00
	Lunch Allowance	50	Birr 50x10x2	1000.00
	<b>Sub Total</b>			<b>1300.00</b>
4	Refreshment for FGD participants	10	Birr15X30 participants	450.00
	Sub Total			450.00
	<b>Sub Total</b>			<b>900</b>

	<b>Total</b>			<b>16740.00</b>
6	Contingency (10%)			<b>1674.00</b>
	<b>Grand Total</b>			<b>18, 414.00</b>

### **St. Mary University /IGNOU Master Degree in Social Work (MSW)**

#### **In-depth Interview Questions / Check list Designed for Target groups**

Date: \_\_\_\_\_

Venue: \_\_\_\_\_

Time started: \_\_\_\_\_ Time ended: \_\_\_\_\_

Interviewer name: \_\_\_\_\_ Sig. \_\_\_\_\_

#### **Introduction:-**

You are all welcome. First of all I am happy that you could make time to me. We are here to collect information about the practices and challenge the commercial sex workers on RH.

#### **Consent format:-**

You have been randomly selected to participate in this study hence you are expected to provide us vital information and experience to share with us on this subject. There is no right or wrong answer. All comments, both positive and negative are welcome. So feel free to

express your opinion honestly and openly. Your name as well as address is not recorded in this interview to protect your confidentiality.

You are also free to decide on whether or not to participate in this study. I am also encouraging respondents to feel free to say anything concerning the topic of discussion, because your information is very important to this study. Again, I would like to confirm to you that all your comments are confidential and used for research purpose only.

Thank you very much again.

1. Background: your age in year, your educational level, marital status, current work place, period you start as sex work
2. What makes/ leads you to involve in sex work activities?
3. What are the major RH problems mention at least three?
4. Have you got any RH services components (STI, HCT, FP, CAC services and condom promotion and distribution) in this town? From whom/ where you got the services?
5. What are the services components available in the FGAE Adama confidential clinic?
6. Is the service affordable, available and accessible in the FGAE Adama confidential clinic?
7. Have you got outreach services at your local site by the CWs sent from FGAE Adama confidential clinic?
8. What are the challenges faced to get the SRH services for SWs?
9. What do you suggest/ recommend improving the services at the community and facility level?

Thank you!

**St. Mary University /IGNOU Master Degree in Social Work (MSW)**

**Topic Guide designed for FGD beneficiaries/ target groups**

Date of FGD: \_\_\_\_\_

Venue: \_\_\_\_\_

Time started: \_\_\_\_\_ Time ended: \_\_\_\_\_

Facilitator/moderator name: \_\_\_\_\_ Sig. \_\_\_\_\_

**Introduction:-**

You are all welcome. First of all we are happy that you could make time to us. We are here to collect information about the practices and challenge the commercial sex workers on RH.

**Consent format for focus group discussions.**

You have been randomly selected to participate in this discussion hence you are expected to provide us vital information and experience to share with us on this subject. There is no

right or wrong answer. All comments, both positive and negative are welcome. We would like to have many points of view and to be open discussion, so feel free to express your opinion honestly and openly. Your name as well as address is not recorded in this interview to protect your confidentiality.

Individuals are free to decide on whether or not to participate in the discussion. We also encourage members to feel free to say anything concerning the topic of discussion, because your information is very important to evaluate and improve the program. Again, we would like to confirm to you that all your comments are confidential and used for research purpose only.

Thank you very much again. (The facilitator asks participants to introduce themselves at this stage and then introduce you.)

1. Background: your age in year, your educational level, marital status, current work place, period you start as sex work
2. Is the confidential clinic and the outreach service affordable, available and accessible to your need?
3. Would you mention the main RH problems to SWs in your area?
4. Have you heard/ aware about the types, sign and symptoms of HIV, STDs? Would you mention it?
5. Would you mention about the mode of transmissions and prevention of HIV, STDs?
6. Have you known your HIV ser status (Have you conduct HIV test with in this three months)?
7. What do you recommend to alleviate these RH problems?

Thank you for your cooperation



## **St. Mary University IGNOU Master Degree in Social Work (MSW)**

### **In-depth interview questions for the Service providers (FGAE Confidential Clinic)**

#### **Introduction:-**

You are all welcome. First of all I am happy that you could make time to me. We are here to collect information about the practices and challenge the commercial sex workers on RH.

#### **Consent format:-**

You have been randomly selected to participate in this study hence you are expected to provide us vital information and experience to share with us on this subject. There is no right or wrong answer. All comments, both positive and negative are welcome. So feel free to express your opinion honestly and openly. Your name as well as address is not recorded in this interview to protect your confidentiality.

You are also free to decide on whether or not to participate in this study. I am also encouraging you to feel free to say anything concerning the topic of discussion, because your information is very important to this study. Again, I would like to confirm to you that all your comments are confidential and used for research purpose only.

Thank you very much again.

1. Would you mention the target groups and main SRH program area in your facility?
2. What are the types of services components you are providing in the facility (Clinic) and community level (outreach)?
3. For what services are most SWs came to the clinic?
4. What are the components of STI HIV services?
5. What types of FP available? Which method of FP is more commonly preferred?
6. What are the attitude and practices of condom usage in SWs?
7. What are the knowledge, practices and attitude of SWs towards SRH services?
8. Would you mention the main SRH problems of SWs in your target area?
9. What are the major challenges faced during service provision and what are the causes for it?
10. What measure you recommend to tackle the challenges?

Thank you for your cooperation

