MELA RESEARCH

Formative Research on Most at-risk population for HIV/AIDS in Ethiopia

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TABLE OF CONTENTS

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
HIV	Human Immunodeficiency Virus
ART	Antiretroviral Viral Therapy
ARV	Anti-retroviral
BCC	Behavioral change communication
BSS	Behavioral Surveillance Surveys
CBO	Community based organization
CSA	Central Statistical Agency
CSW	Commercial sex workers
DHS	Demographic and Health Survey
EPHA	Ethiopian Pubic Health Association
FGD	Focus Group Discussion
HAPCO	HIV and AIDS Prevention and Control Office
HCT	HIV Counseling and testing
IDI	In-depth Interview
KII	Key Informants Interview
MARPs	Most at risk populations
MOH	Ministry of Health
NGO	Non Governmental Organization
OSY	Out-of-school youth
PLHIV	People living with HIV
PRA	Participatory Rapid Appraisal
PSU	primary sampling unit
SC/US	Save the Children/USA
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
VCT	voluntary counseling and HIV testing

EXECUTIVE SUMMARY

The TransACTION program in Ethiopia, a collaborative effort of the Save the Children Federation, Inc. (SC/US) and its partners, aims to reach out to the most at risk population (MARP) in 120 towns of Ethiopia through HIV/STI prevention, care and support intervention activities. The TransACTION strategic objectives envisages at preventing new HIV infections among at risk population and strengthening linkage to care and support services in towns and commercial hotspots along or linked to with major transportation corridors.

As part of the initial activities of the program, the program conducted a formative research in a sample of its project focus towns. The overall aim of the formative research was to inform the program's behavioral change communication (BCC) strategy development and planning program activities that will target most at risk population in the towns and commercial "hotspots" along or near the transportation corridors. The formative research targeted sex workers, truckers, male and female daily laborers, waitresses, out-of-school youth (OSY) and people living with HIV (PLHIV) in objectively selected 12 program implementation towns. The research employed qualitative methods encompassing Focus Group Discussion (FGD), In-depth interviews (IDI) and Key informants Interview (KII). On the whole, 33 FGDs, 196 IDIs and 95 KIIs were conducted with the different target groups. Field data collection was conducted during the period November - December, 2009.

Based on the key findings, the study provides several programmatic recommendations and entry points for the target groups, as detailed in the main text of this report. Below is a summary of the salient findings by target group.

Sex workers:

Background characteristics and mobility:

- This study interviewed sex workers operating in bars, local drink houses and small red light houses. Most of them were young in the range of 13-29 years. Sex workers in bars/hotels are better educated and well paid per sexual encounter. High numbers of clients per day were reported among those working in red light houses. These sex workers were predominantly of rural origin, less educated and reported to receive less money "to be cheaper" per sexual encounter.
- Sex workers are characterized by high mobility across towns. The main reasons for changing towns include decline in number of clients, disagreement with establishment owners and fellow sex workers, fatigue and seasonal migration to cash crop areas to meet high paying and a larger number of clients in a short span of time.

Types of clients/partners of sex workers:

- Clients/partners of sex workers are broadly categorized into three groups: new paying clients; regular paying clients and non-paying partners/boyfriends.
- Regular paying clients can be exempted from paying for every sexual encounter while they are expected to pay in most instances. Some regular partners reported paying in-kind and giving some gifts to sex workers to cement their relationship, which could eventually lead them to become a non-paying partner.
- Non-paying partners (boyfriends) often spend the daytime and holidays with sex workers. They can also live together and share resources, involving love and care for

each other. Sometimes cohabitation is also reported. In most instances non-paying partners benefited monetarily and materially from such a relationship.

Condom use and barriers:

- Condom use was reported to be high with paying clients although there are situations where sex workers are less strict in their condom behavior. Clients' refusal to use condoms, having sex while drunk, sex workers' negligence and the use of family planning methods other than condoms were reported among the major reasons for the lack of consistent condom use with paying clients.
- Condom use with non-paying partners was reported to be much lower. There is a general consensus that sex workers are less careful and less consistent in their condom use behavior with non-paying partners (boyfriends/lovers). Trust in their loving relationships surfaced as the main reason for not using condoms with boyfriends.

HIV Counseling and Testing (HCT): uptake and barriers

- Seeking HCT by sex workers was reported to be quite low across the towns irrespective of the socio-demographics of sex workers. Fear of HIV positive results and associated stigma prevent sex workers from testing. Most sex workers considered themselves already infected and HIV testing was seen as irrelevant. Other sex workers suggested that they wouldn't want to be tested because they had no plan to abandon sex work.
- When asked their preferences of places to get HCT, most sex workers in this study reported private facilities although the cost for services was reported as a potential barrier. Public health institutions are less preferred for lack of confidentiality, as most sex workers emphasized. Sex workers reported that healthcare providers in public health facilities can easily identify them and spread out the news about their HIV test results to owners and clients.

Sexually Transmitted Infection (STI): awareness, service uptake and barriers

- STI awareness varies in accordance with the type of sex worker. Sex workers in large-sized towns and those working in bars/hotels appeared relatively better informed about STIs including the symptoms, risk perception, and places where services are rendered. On the others hand, sex workers in small towns and those working in local drink /red light houses appeared less informed about STIs and places of service.
- STI diagnosis and treatment seeking behavior by sex workers was reported to be mixed and less clear. Sex workers who are well aware of the symptoms and those operating in bars/hotels reported to be seeking diagnosis and treatment when there was pain, soreness, itching and a foul smell from the vaginal area. For most sex workers in red-light/local houses, the lack of adequate knowledge about STIs prevented them from seeking care. Even when they knew the symptoms, these sex workers often fail to seek care for fear of stigma, shame and harassment by health professionals. Lack of finances to buy the STI drugs was also suggested among the key barriers.

Waitresses:

Background characteristics and mobility:

- The waitresses can be broadly categorized as those working in pastry shops/cafes (non-sex worker setups), in bars/restaurants (sex work setups) and those having double duty i.e. work as waitress in daytime and as sex workers at night.
- Most of the waitresses were in the age group 18-25 years and had at least elementary education; the commonest education level was 6-8th grade.

- Frequent change of town and place of work appeared to be common among these women. Moving from one establishment to another was reported as less common in small towns partly because of the limited number of such establishments. In contrast, women working in big towns reported to change work places/establishments frequently.

Sexual behaviors and vulnerability:

- Waitresses participating across the towns reported that they were exposed to risky sexual behaviors including multiple sexual partnerships and low condom use. The factors that derive their sexual behaviors were numerous and linked to: poverty and the desire to increase one's earnings, peer pressure, family pressure, and customer pressure, among others.
- Although waitresses across the towns reported to be exposed to multiple and concurrent sexual relationships, it was reported that much of this was more common in commercial centers and in towns with high influxes of people.

Transactional and cross-generational sex

- Waitresses form sexual relationships with men across all age brackets but most commonly with older people. Older customers in the establishments were cited as the major groups with whom these women form sexual relationships most frequently.
- The main reason for engaging in cross-generational sex is to get good financial support, which young partners (age-mates) do not easily fulfill. Waitresses reported that that since this is a low wage work; they need extra support from such relationships to cover daily expenses for subsistence, clothes and accessories, house rent and education.

Condom use and barriers:

- Condom use with regular boyfriends or causal partners was reported to be low and inconsistent by waitresses across all the towns.
- These women were reported to be lenient in their condom use with their boyfriends, as this is believed to create some distrust and make a lover furious when condom use is proposed.
- Older and casual partners of waitresses mostly considered low HIV risk from waitresses. Likewise, some waitresses reported that older and married people are at lower risk for HIV and condom use with such people may not be as necessary.
- The lack of negotiation skills and self-efficacy in relation to condom use by waitresses, especially in transactional sex, further deters their condom use behavior.

HIV Counseling and Testing (HCT): uptake and barriers:

- Testing for HIV for these women was reported to be difficult for a number of reasons. Fear of positive results, stigma and being alienated if found HIV positive were repeatedly mentioned as the main concerns for not testing for HIV. For some, HCT is not as necessary due to low HIV risk perception.
- By waitresses' account, due to their low socio-economic class and low wage work, their primary concern was how to get out of the trap of poverty and hopelessness; and that HIV was not seen as their primary concern. This attitude of waitresses was repeatedly implicated among the factors deterring HIV testing.

Sexually Transmitted Infection (STI): awareness, service uptake and barriers

- Awareness of STIs was reported as extremely low and most waitresses were not aware of the common symptoms of STIs and failed to mention some major STDs. As a result, we couldn't assess further these women's knowledge and awareness of places where the STI services were provided and their perceptions on STI testing.

Female daily laborers:

Background characteristics and mobility:

- Most female daily laborers included in this study reported to work in construction sites – for buildings or roads. The range of physical work that they were engaged included, mixing and transporting cement, moving brick, stone and wood in construction sites and cobblestone work for road construction. They were young in the range of 15-28 years. The majority was of rural origin and reported to have low educational status.
- Changing their type of work or work place was reported to be common among these women because of a number of reasons. The short-term nature of most of the daily labor work was among the primary reasons for this. These women also change workplaces in search of better paying jobs, seeking less labor intensive jobs and due to disagreement with employers/bosses. When there was a shortage of construction materials, mostly cement, in the market their work was often interrupted as a result of which they move to other places in search of jobs.

Sexual behaviors and vulnerability:

- Female daily laborers participated in this study reported to be exposed to risky sexual behaviors. Factors putting them at risk included: peer pressure, transactional sex and engaging in sexual relationships in anticipation of love and marriage. The nature of the work environment that involves working closely with fellow male daily laborers and other construction workers in isolated sites/places for long hours was reported among the factors leading to casual and unprotected sex.

Transactional and cross-generational sex

- Cross-generational sex was reported to be less common among the female daily laborers. In most instances, it was reported that partners were around the same age or slightly older. It was emphasized that this type of relationship can be common among female daily laborers who are involved in transactional relationships.
- Transactional sex was reported to be common among female daily laborers. It was said to occur within or outside cross-generational relationships. The main reasons for engaging in transactional sex were to compensate for low wages and fulfill subsistence needs, to buy "expensive" cloths and accessories, to get gifts that were not seen as unusual - men are expected to give gifts as an expression of love. The common types of gifts these women reported to receive from sexual partners included cash, cloths – mostly underwear and bras, accessories and household appliances.

Condom use and barriers

- Condom use by female daily laborers was reported to be low. Women blamed their lack of control over their sexual behavior, persuasion and deceitful acts of men with condoms as major reasons deterring condom use. Their lack of knowledge of condom and embarrassment in buying and carrying condoms and asking the man to use a condom also reported among the barriers to condom use.
- Casual sex in workplaces/sites was mostly performed without condoms partly due to the absence of condom at the work site.
- Female daily laborers recently coming from rural areas were reported to lack the knowledge of condoms and were mostly exposed to unprotected sex.

HIV Counseling and Testing (HCT): uptake and barriers

- The intention to know one's HIV status, especially when having risky sexual behavior and unprotected sex was reported to be difficult for fear of positive results.

Lack of time for testing also emerged among the barriers. Most of all, poverty and the unpredictable nature of their work is their primary concern and seeking HCT is not seen as important.

- Situations encouraging female daily laborers to decide on HIV testing include repeated illness and the free ART access in public health facilities. Anticipation of food and material support for HIV positives and those on ART was reported as a source of optimism to undergo HIV testing for those with repeated illnesses.

Sexually Transmitted Infection (STI): awareness, service uptake and barriers

- This study revealed that knowledge of STIs was extremely low among female daily laborers. Most did not know the major symptoms of STIs although it varied by town. Those in big towns appeared to have relatively better information about STIs although in absolute terms they would be considered as having limited understanding of STIs.
- STI testing and diagnosis reported to be very rare among these women. In the first place, most lack knowledge of the symptoms. Even when they know about it, stigma prevents most from seeking care in health facilities. It was reported that some female daily laborers held the belief that STIs did not exist in their bodies any longer because they were an old disease and they couldn't be infected with an STI.
- For some, self-treatment and getting advice from close friends and using drugs from pharmacies were alternatives to seeking care in health facilities.

Male daily laborers:

Background characteristics and mobility:

- The male daily laborers participating in this study were involved in construction work such as mixing and supplying cement, carving and delivering stones, supplying bricks, wood and metals. Loading and unloading construction materials and other goods and transporting goods (luggage of travelers, food items for households) were also among the major areas of work for these men. They represented varying age brackets, ranging from 16-52 years old although most were under 30 years of age. They reported to have better education than their female daily laborers counterparts.
- The temporary nature of the work was the main reason for high mobility among the male daily laborers. Some left their workplace to get a better paying job and also to learn new and different skills. Relocation by the owners/bosses, and promotion to other job categories were also included among the reasons for high mobility. Disagreement with bosses/employers was also among the reasons for changing workplaces. Some employers were blamed for not paying on time, which often frustrated daily laborers and cause them to leave their workplaces.

Sexual behaviors and vulnerability:

- Different types of sexual partners were reported to be common among the male daily laborers participated in this study. These include marital or steady partners, sex workers (paid sex) and non-sex worker casual partners.
- Paid sex with commercial sex workers was reported to be common by these men. The most common types of sex workers often visited by the male daily laborers are those operating in local drink and in small red light houses. These sex workers are relatively "cheaper" and are there to fulfill the demand for paid sex for people from the low socio-economic class.
- Sexual relationships with casual or steady partners (non sex workers) were also reported to be common among the male daily laborers. The female daily laborers are

included in the main group of women with whom male daily laborers have casual or steady sexual relationships. There are also other groups of women that were reported to be common partners to male daily laborers. By daily laborers' accounts, their common sexual partners included female daily laborers, women selling food and other items in market places (in *Gulet*), housemaids and out-of-school youths.

- According to some male daily laborers, sex workers are preferred to escorting girl friends because girl friends are often very demanding financially and materially.

Condom use and barriers:

- Condom use with sex workers was reported to be high by the male daily laborers. It was also indicated that sex workers often insisted on condom use even when daily laborers showed some negligence about it. On the contrary, condom use with non sex workers (steady or casual partners) was reported to be low and inconsistent.
- The perception that women from rural origins are at low risk for HIV prevents condom use with such women.
- Some reported to make an HIV risk assessment of sexual partners on their own and women who were healthy-looking and chubby were considered to have low or no risk for HIV and condom use with such women was believed to be less important.
- Some male daily laborers blamed their partners for being less observant in their condom behavior. For instance, those women using other contraceptive methods reported to be care less about condoms.
- Absence of condoms at worksites where casual sex was reported to be common was also implicated among the barriers to condom use.

HIV Counseling and Testing (HCT): uptake and barriers:

- Participants indicated that most male daily laborers do not know their HIV status. Fear of positive results and stigma prevents most from testing for HIV. Some avoid testing as they consider themselves already infected with HIV.
- Daily laborers reported to test for HIV especially when they were seriously ill and suspected HIV may be responsible for their condition. The advent of free ART services in public health facilities and the food and material support that is believed to be available for people accessing treatment emerged as the major driver for testing for HIV.

Sexually Transmitted Infection (STI): awareness, service uptake and barriers

- Male daily laborers appeared better informed about STIs than their female counterparts. However, they still have incomplete knowledge about the major symptoms. Knowledge of STIs varies by the age and educational status of daily laborers. Older daily laborers and the better educated appeared better informed about STIs.
- Fear of stigma and judgmental health workers coupled with limited knowledge on the STI symptoms were reported as the key barriers to seeking care for STIs in health facilities. Lack of money to pay for the drugs also emerged among the barriers to seeking care for STIs
- Self-treatment with the drugs available in drug shops and pharmacies without prescriptions was considered the most viable way to treat STIs.

Truckers

Background characteristics and mobility:

- Most truckers participating in this study were of middle-aged; their age ranging from 23-65 years. They on average have 8 years of schooling (ranging from grade 1 – College diploma).
- Roadside hotels, bars, restaurants, coffee houses, gas stations or tire repair shops, and Khat/Shisha corners are the places where truckers often pass their leisure time when they stop in a town. A few truckers reported to take naps inside their trucks.

Sexual behaviors and vulnerability:

- Paid sex with sex workers and transactional sex with young girls (non-sex workers) reported to be common among truckers.
- By truckers' account, young women (non-sex workers) have recently been more accessible to truckers than ever through Khat/Shish corners and brokers. It is believed that these young girls have "low" HIV risk and are less demanding and less costly than sex workers. Some of these women were reported also avail themselves to truckers by wandering around truck halting points, gas stations and tire repairing sites.
- Young in-school or out-of-school youth, cashiers/waitresses in bars/hotels and female mobile merchants who often ride with truckers were reported among the common sexual partners of truckers.
- The sexual relationships with these young women (non-sex workers) were said to be short-lived because truckers are mobile and their schedules are not always set and as a result partner change was reported to be very common.
- Relationship with these young women (non-sex workers) often involves a transactional component. In a short term relationship, truckers reward partners in cash. Long term relationships involve cash and other material support such as grain, charcoal, firewood, sheep, goats and chickens during holidays.

Condom use and barriers:

- Condom awareness and its efficacy in preventing HIV infection are universal among truckers. Condom use among truckers was high especially with sex workers though not universal. Trucker in particular reported to be less careful in their condom behavior with sex workers in the influence of alcohol. Inconsistency condom use with frequently visited sex workers was also reported.
- In contrast, low and inconsistent condom use with young women (non-sex workers) was reported to be common. The perception of low HIV risk from young women reported to deter condom use. Condom use can be compromised during casual sex inside the truck with female mobile merchants, casual partners who ride with the truckers.

HIV Counseling and Testing (HCT): uptake and barriers

- Testing for HIV was reported to be difficult for truckers because of a number of reasons. Fear of an HIV positive result was reported as the major barrier to testing for HIV. Lack of time to visit public or private facilities for HCT was also mentioned among the impediments. HCT service in public or private health facilities is not preferred mainly due to the truckers' lack of time and long waiting time.

Sexually Transmitted Infection (STI): awareness, service uptake and barriers

- Truckers are well aware of the availability of STI diagnosis and treatment services in public and private health facilities in towns. Truckers unanimously reported that they rarely utilized STI services in public and other facilities due to their lack of time. Even

when they had time to seek care, stigma and fear of confidentiality was reported to deter use.

Male Out-of-school youth (OSY):

Background characteristics:

- The male OSY to participate in this study were recruited from recreation places, roadside corners, DSTV places, Khat/Shisha houses, and parks through snow ball sampling. Their age ranged from 15-24 years. In terms of their educational status, they were comprised of those who completed secondary school (10 or 12 grade), school dropouts, those who have done vocational training but non-working, and very few who have never been to school.

Sexual behaviors

- Sexual practice reported to be common among male OSY in the study towns. The age at sexual debut for these youth was reported to be from 18-20 years. A recent declining trend of age at sexual debut was also reported. These male OSY reported to start sex with females of their own age or younger.
- Expectations of sexual gratification and love, peer pressure, mere interest to experience sex, influence of movies that show erotic behaviors, competition among peers, revealing masculinity and the influence of alcohol were all mentioned as reasons for having sex.

Condom use and barriers:

- Condom use with sex workers was reported to be high. This was reported mainly due to the fact that sex workers insist on condom use. Another reason suggested was that male OSY fear getting HIV from sex workers.
- No parallel HIV risk perception was reported from the male OSYs from non-sex workers and that condom use is less common with non sex workers. In particular, in steady sexual relationships the tendency to avoid condom use as the relationship matures was repeatedly reported.
- Suggested reasons for the lack of condom use with non sex workers include a low HIV risk perception from sex with non sex workers and trusting women they love, feeling that condoms reduce sexual gratification, being embarrassed to buy and carry condoms, inability to use condoms properly, having sex under the influence of alcohol and lack of money to buy condoms.

HIV Counseling and Testing (HCT): uptake and barriers

- Since most OSY reported to engage in risky behaviors, they were very suspicious of themselves therefore testing for HIV is often difficult for the group.
- Across the towns, OSY reported to be aware of places where HCT services are available. Most participants saw HCT services in public facilities as inconvenient. The main reasons for this included long waiting times, the shortage of health workers, and the fear of being seen by other people visiting the facilities.
- Most reported to prefer mobile HCT services as well as HCT services provided solely for youth.

Sexually Transmitted Infection (STI): awareness, service uptake and barriers

- STI awareness among OSY was reported to be very low with most lack the knowledge of the major symptoms and places where service is rendered.

People living with HIV (PLHIV):

Background characteristics and mobility:

- Information was collected from 85 PLHIV. Respondents were recruited through their PLHIV associations and were active members of the associations. Both sexes were included in the study although more females than males were participated. Most were adults aged 30 years or older. About 80% have some education with 17% completing high school.
- Most of them reported to have born in other places and moved to their current residence few years ago. The main reason for leaving their original residence was fear of stigma and discrimination. Other reasons included leaving their original residence in search of better job opportunities, in anticipation of care and support services that are available for PLHIV in big towns, and to use ART in big hospitals without being noticed, among others. In particular, commercial sex workers living with HIV reported to change their place of work quite frequently.

Disclosure of HIV status

- Disclosure of one's HIV status to spouses, close family members, and friends in general was reported to be less common across the towns by the PLHIV participated in this study. Fear of stigma, being blamed, and fear of accusation and violence were identified as the major barriers to disclosing one's HIV status. Disclosure of ART use to spouses/families was also reported to be difficult for most people on treatment. The lack of disclosure of ART use is said to lead to low treatment adherence and discontinuance of ART.
- Disclosure reported to vary by gender, age and type of occupation. There appeared to be a general agreement among participants that males, young people, sex workers, housemaids, men working in restaurants (e.g. cook), and those who sell food items as specific population groups who are less likely than others to disclose their HIV status.

Discordance in HIV status

- PLHIV participated in this study appeared to be well aware of the possibility of discordance in HIV status between couples. Based on their experiences and observations, most participants saw the consequences of discordance as severe. Accusations, verbal and physical abuse, divorce and possible homicides were the consequences of discordance. Participants explained that discordance is a sign of infidelity and that most people couldn't tolerate this.
- There were also reports that a few couples continue with their marriage and family despite their discordant HIV status. Suggested reasons for this were love, strong faith in God, and the intention to raise children together.

Condoms: awareness and use

- PLHIV participating in this study did not dispute over the importance of condom use in any sexual encounter within or outside a marital relationship. Suggested reasons for condom use included the fear of infection by other types of HIV strains, fear of infection with STIs and to prevent unintended pregnancies.
- Despite the noted reasonably high awareness of the benefits of condoms, most PLHIV reported to be inconsistent in their condom behavior. Males and young PLHIV were reported to be more lenient in their condom behaviors. While women were said to be strict because they were concerned about unintended pregnancies and giving birth to an infected child.
- Condom use in marital unions was reported as the most difficult. This is also related to the intention of couples to have children.

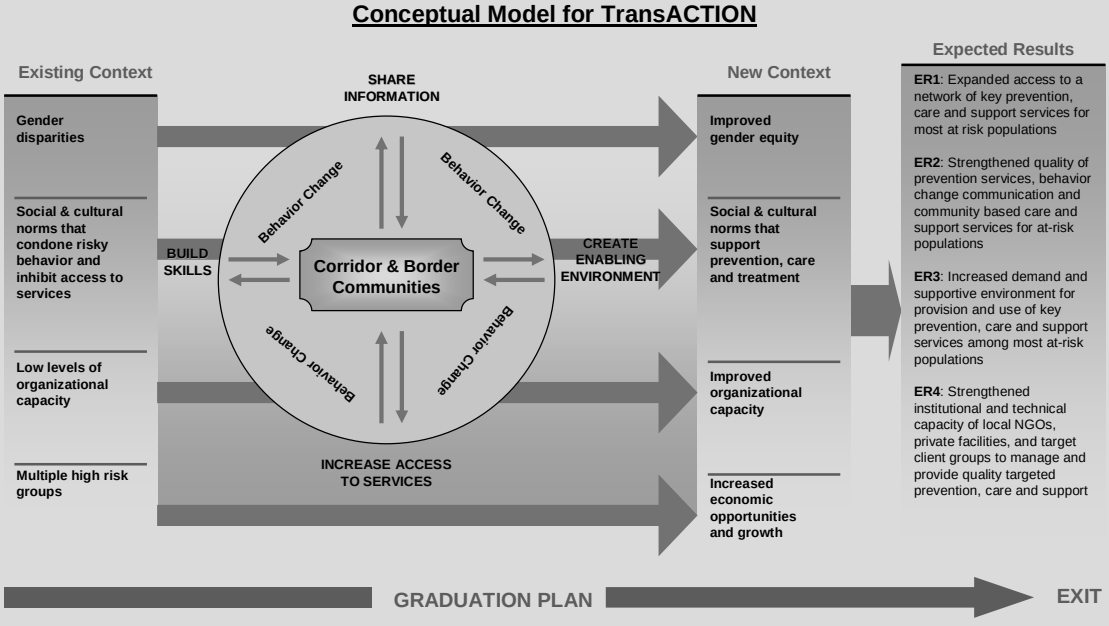
Pregnancy and child birth:

- There is a general intention among PLHIV to have children mostly because they want to see their generation continue. The advent of effective drugs that prevent mother-to-child transmission of HIV and free ART access become the major sources of optimism for PLHIV to have children. There was also a general understanding among PLHIV participating in this study that they had a high chance of giving birth to an HIV negative child with the use of drugs for PMTCT. They also believed that ART can make them healthy and productive enough to raise a child.

I. BACKGROUND AND OBJECTIVES

1.1. The TransACTION program in Ethiopia

The TransACTION program in Ethiopia, a collaborative effort of the Save the Children Federation, Inc. (SC/US) and its partners, aims to reach out to the most at risk population (MARP) in 120 towns of Ethiopia through an HIV/STI prevention, care and support intervention. The TransACTION strategic objectives focus on preventing new HIV infections among at risk population and strengthening linkage to care and support services in towns and commercial hotspots along or linked to major transportation corridors. The program is based on the conceptual model described below.



1.2. Background and study objectives

As part of the initial activities of the program, the TransACTION program conducted formative research in a sample of its project focus towns. The overall aim of the formative research was to inform the program's behavioral change communication (BCC) strategy, development and planning of program activities that will target MARPs and PLWH in the towns and commercial "hotspots" along or near the transportation corridors. This formative research targeted the following groups in 12 TransACTION program implementation

towns, namely: sex workers; truckers; male and female daily laborers; waitresses; out-of-school youth (OSY); and People living with HIV (PLHIV).

The specific objectives of the formative research were:

1. To validate the pre-determined most at risk population by the program and further define specific target groups.
2. To map-out the geographic locations, socio-demographics, risk perceptions, sexual behaviors (including concurrency and casual sex), social networks/gatekeepers, and gender of MARPs in order to create profiles including segmentation of target audiences (e.g. profiles for different subgroups of daily laborers, CSWs etc).
3. To examine individual, community, contextual and structural factors including key social and gender norms influencing risk behaviors among target groups.
4. To examine health seeking behaviors, service needs and preferences of MARPs with reference to VCT, STI, HIV care and support, ART, and other related services.
5. To identify barriers and challenges to women who are most at risk accessing services.
6. To devise and suggest strategy options and entry points for the program to reach out to the various MARPs with particular emphasis on the hard-to-reach, specifically, women, youth and men involved in informal, transactional sexual relationships not identified as 'commercial,' and PLHAs.
7. To provide concrete recommendations for programming.

This report presents findings from formative research that was fielded during the period of November 13 - December 2, 2009.

II. INTRODUCTION

2.1. The status of the HIV/AIDS epidemic in Ethiopia

With a population estimated at nearly 77 million in Mid-2008, Ethiopia is the second most populous country in Africa next to Nigeria. In Ethiopia, the HIV/AIDS epidemic has remained a major public health problem, mainly affecting people in the productive and reproductive age ranges. HIV prevalence in the general population was estimated at 2.1%[1] in 2006. At present, more than one million people are estimated to be living with HIV in Ethiopia. Women account for 59% of the HIV-positive population. Annually, an estimated of 125,147 people are newly infected and 58,290 people die of AIDS[2].

An epidemiological synthesis of the HIV epidemic in Ethiopia concluded that the epidemic is more heterogeneous than previously believed[3]. The study further divulged that the epidemic seems to have stabilized or even declined in most of the major urban areas while increasing in smaller towns. Patterns are less clear in rural areas due to the lack of accumulated epidemiological data. Supporting the argument for focusing on particular hotspots and most at-risk population, the study emphasizes that HIV/AIDS programs should not be based on national-level statistics, but need to be more focused geographically, and directed to areas and populations exhibiting higher prevalence rates.

2.2. Most at risk population for HIV

It is well recognized that vulnerability for HIV is substantially higher in some specific population groups than in the general population and such population groups are identified as most at risk populations (MARPs) for HIV. A MARP is defined as a group within a community with an elevated risk for HIV, often because group members engage in some form of high-risk behaviors; in some cases the behaviors or HIV serostatus of their sex partner may place them at risk.

The national HIV/AIDS policy's IEC strategy[4] gives proper emphasis to vulnerable groups including women, youth, sex workers, mobile groups, street children, and prisoners. Likewise, the strategic framework for the multi-sectoral response for 2004-2008 identified commercial sex workers (CSWs), truckers, migrant laborers, uniformed people, teachers, students and out of school youth (OSY) as the most important vulnerable groups that require special attention. It aims to reduce vulnerability among these special target groups through a number of strategies by: (1) Promoting HIV counseling and testing (HCT) and other behavioral change interventions; (2) Promoting the use of male and female condoms; (3) Providing youth-friendly reproductive health and STI services; (4) Enhancing bargaining

[1] Agreement on a point prevalence of 2.1% was reached in April 2007.
[2] HAPCO. Multi-sectoral HIV/AIDS Response Annual Monitoring & Evaluation Report 2001 Ethiopian Fiscal Year [July 2008- June 2009]. Unpublished.
[3] Berhane Y. Mekonnen Y, Seyoum E, D. Wilson, L. Gelmon. HIV/AIDS In Ethiopia: an epidemiological synthesis. World Bank Global AIDS Program. April 2008
[4] HAPPCO and FMOH. Ethiopian Strategic Plan for the multisectoral HIV/AIDS response, 2004-2008. Addis Ababa. December 2004.

and negotiations skills for safe sex where applicable; (5) Strengthening and expanding school anti-AIDS clubs and mini-Medias; (6) Integrating HIV/AIDS in life skills education and basic curriculum; (7) Developing youth centers and enhancement resorts; (8) Organizing the youth on voluntary basis and providing peer education; (9) Developing youth centers and entertainment resorts; and (10) Providing safe and alternative income generating and employment opportunities where applicable. Despite the policy statements and strategies, appropriate prevention interventions are often lacking among MARPs in the country and this represents important challenges within the groups as well as the general population. This is further complicated by the lack of data on the magnitude and spread of HIV, as well as the circumstances that put them at risk, among MARPs in the country.

The TransACTION program pre-determined some population groups for its program intervention. These groups encompass the globally recognized MARPs including sex workers and truckers as well as locally relevant MARPs including waitresses, male and female daily laborers and out-of-school youth. A brief overview of these groups, concerning the spread of HIV and their vulnerability, based on previously available studies and information is detailed below.

***Sex workers*:** Due to their high HIV prevalence, their increased ability to transmit HIV when co-infected with other STIs, and the broad population groups they reach through their clients, sex workers have often been described as a 'core group', namely, a small group in which the infection is endemic and from whom it spreads to the population at large[5]. The most recent seroprevalence data on sex workers is available from 594 sex workers who tested via mobile HIV counseling and testing in 40 towns in 2008. Of the 594 female sex workers with HIV results available, 25.3% tested positive[6]. Other recent data on sex workers emerged from the 2008 MARPs study of Amhara. Among 349 sex workers, 37% tested positive for HIV. HIV prevalence appeared to increase with age - from 26% among the 14-19 years old to 37.7% and 47.7%, respectively, among the 20-24 and 25 or older age groups. Indeed, the recently documented HIV prevalence rates among sex workers compare well with available HIV prevalence data that date back from the late 1980s and early 1990s. The first HIV prevalence survey among female sex workers in the country was available from 1988, i.e. only four years after the first HIV cases were detected in the country. The survey covered 6234 female sex workers operating in 23 major urban areas on the main trading roads of Ethiopia. HIV prevalence rates ranging between 5.3% and 38.1% with a mean prevalence of 17% was reported. A year later, a survey showed about a quarter (24.7%) of the sex workers in Addis Ababa were already infected[7]. By 1990, HIV prevalence reached 50% among sex workers in four major urban areas of the country[8].

Truckers: Truckers have received significant attention with respect to HIV prevention in Ethiopia. The reason for this attention in relation to HIV is that truckers move between regions and towns with different rates of HIV and have multiple sexual contacts with sex

[5] Aklilu M, Messele T, Tsegaye A, Biru T, Mariam DH, Van Bethem B, et al. Factors associated with HIV-1 infection among sex workers of Addis Ababa, Ethiopia. AIDS 2001, 15:87-96.

[6] Mekonnen, Y. June 2009. Mobile HIV Counseling and Testing: A new lens through which to view the urban HIV epidemic in Ethiopia. Bethesda, MD: Private Sector Partnerships-Ethiopia, Abt Associates Inc.

[7] Mehret M, Khodakevich L, Zewdie D., Ayehunie S, Shanko B, Gizaw G, et al. HIV-1 infection and some related risk factors among female sex workers in Addis Ababa. *Ethiop J Health Dev.*1990c, 4 (2): 171-176.

[8] MOH. AIDS in Ethiopia: 1996. Addis Ababa

workers, local populations and women of varying backgrounds. Their work is often stressful and involves alcohol use, commercial and transactional sexual relationships. Recent sero-epidemiological data on truckers, is in general, lacking in Ethiopia. Of note, the limited data collected on truckers as part of the Amhara MARPs study hinted that trucker are among the most affected by the HIV epidemic. Among 51 truckers tested, 13 were found positive for HIV, giving a prevalence rate of 25.5%[9]. Consistent with the high prevalence rate, a considerable high active Syphilis infection rate was also documented (9.8%) in the group. Self-reported STIs were found to be 6%. In the early years of the HIV epidemic in the country, consistently high HIV prevalence was documented among truckers. HIV prevalence was already 13% in truck drivers in 1988[10]. At that time, the rate was less than 5% in the general population, as indicated by pregnant women attending ANC in Addis Ababa. In 1989, the prevalence among truck drivers increased to 17.3%[11]. Very high prevalence rates were then documented in 1994 (40%) and 1995 (26.7%) among drivers in Gondar, Northwest Ethiopia[12].

Daily laborers: The vast majority of daily laborers in Ethiopia are young people and are characterized by high mobility. The recent expansion of roads, buildings and other construction works in the country result in an unprecedentedly high influx of young people from the rural to urban areas. The association between poverty, mobility and infection with HIV has been documented elsewhere in Africa[13,14]. Only recently has the 2005 Behavioral Surveillance Survey (BSS)[15] of Ethiopia included road construction workers among the identified high-risk groups and found this group exhibiting high risk behaviors. For the first time ever, the Amhara MARPs study gathered serologic data data among daily laborers. The study found an HIV prevalence rate of 15.2% among 349 daily laborers of both sexes[16]. The noted HIV prevalence in this group appeared 7.5 times higher than the national single-point prevalence estimate of 2.1% and nearly 2.8 times higher than the 5.5% HIV prevalence documented for urban Ethiopia in the 2005 DHS, suggesting that these daily laborers are indeed among the most-at risk population. Frequent partner change, compounded by concurrent sexual relationships with casual, commercial and regular partners as well as low and inconsistent condom use in high-risk sex characterize the sexual behaviors of these daily laborers. The study also confirmed the role of frequent partner change, as measured by the lifetime numbers of sexual partners, as the single most important predictor of HIV risk among the laborers after controlling for socio-demographics and STIs.

Waitresses: There is neither sero-prevalence nor behavioral data that signify the risk and vulnerability of waitresses in the country. Nevertheless, anecdotal evidence suggests that

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[9] Survey on MARPs in Amhara region. EPHA 2008

[10] Mehret M, Khodakevich L, Zewdie D. HIV-1 infection among employees of the Ethiopian Freight Transport Corporation. Ethiop J Health Dev. 1990b., 4(2): 177-182.

[11] Mehret M, Khodakevich L, Zewdie D, Shanko B. Progression of Human Immunodeficeiency Virus epidemic in Ethiopia. Ethiop J Health Dev.1990e, 4 (2): 183-187.

[12] Rahlenbeck SI, Yohannes G, Molla K, Reifen R, Assefa A. Infection with HIV, syphilis and hepatitis B in Ethiopia: a survey in blood donors. International Journal of STD & AIDS, 1997, 8:261-264.

[13] Bwayo, J., Plummer, F., Omari, M., Mutere, A., Moses, S., Ndinya-Achola, J., et al. (1994). Human immunodeficiency virus infection in long-distance truck drivers in east Africa. *Archives of Internal Medicine, 154*(12), 1391-1396.

[14] Rakwar, J., Lavreys, L., Thompson, M. L., Jackson, D., Bwayo, J., Hassanali, S., et al. (1999). Cofactors for the acquisition of HIV-1 among heterosexual men: prospective cohort study of trucking company workers in Kenya. *AIDS, 13*(5), 607-614.

[15] HAPCO. 2005 Behavioral Surveillance Survey. 2007

[16] Ibid, 9

waitresses working in cafes/pastry shops/bars/hotels are exposed to the risk of HIV due to the nature of their work that involves frequent interactions with new customers who are often seeking sexual relationships. The high prevalence of transactional and cross-generational sexual relationships among these groups has become a subject of discussion recently. This group has been included recently among MARPs targeted by mass media and radio programs.

Out-of school youth: The 2000 and 2005 BSS[17] and other small scale studies have identified youth age 15-24 among the most at risk population for HIV in the country. The findings from the national epidemiological synthesis suggest that young populations, especially never-married sexually-active females carry the greatest risk of HIV infection in the country, with prevalence rates much higher than the average for both urban and rural areas as well as all women of reproductive age. This is associated with an early age of sexual debut and sexual mixing with high-risk older men, on top of biologic and other gender-related vulnerability.

People living with HIV/AIDS: People living with HIV (PLHIV) in resource limited settings should have access to essential interventions to prevent illness and HIV transmission. Several intervention seen as low cost and of particular importance for people living with HIV were identified including psychosocial counseling and support, disclosure, partner notification and testing and counseling, co-trimoxazole prophylaxis; tuberculosis (TB); preventing fungal infections; sexually transmitted and other reproductive tract infections; preventing malaria; selected vaccine preventable diseases (hepatitis-B, pneumococcal, influenza vaccine, and yellow fever vaccines); nutrition; family planning; preventing mother-to-child transmission of HIV; needle-syringe programs and opioid substitution therapy; and water, sanitation and hygiene[18]. While not all interventions will be needed or equally important in all countries, depending on local and national epidemiology, it is hoped that those most useful will be adopted, adapted as needed and provided to PLHIV. The advent of Anti-retroviral therapy (ART) has improved survival and the quality of life of people living with HIV (PLHIV) in Ethiopia. Since the advent of the ART program in 2003 in the country, over 200,000 people have started on treatment in 481 facilities throughout the country[19]. The impact of the program on survival and quality of life of patients has been documented[20,21]. There is however limited parallel efforts to promote positive prevention such as psychosocial counseling and support, disclosure, partner notification and testing and counseling among PLHIV in the country. These are important areas of intervention to delay HIV/AIDS disease progression, and avoid passing HIV infection on to others or avoid re-infection.

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[17] Ibid, 15

[18] WHO. Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings. ISBN 978 92 4 159670 1

[19] HAPCO. Multi-sectoral HIV/AIDS Response Annual Monitoring & Evaluation Report 2001 Ethiopian Fiscal Year [July 2008- June 2009]. Unpublished.

[20] MOH/HAPCO. Effectiveness of ART program in Ethiopia (unpublished). December 2008

[21] Reniers G et al. Steep decline in population-level AIDS mortality following the introduction of antiretroviral therapy in Addis Ababa, Ethiopia. AIDS, 23:511-518, 2009

III. METHODOLOGY

3.1. Study towns

This formative research was conducted in 12 towns, which were selected objectively from the 120 TransACTION program intervention towns. For the purpose of this study, the towns were broadly categorized as (1) Large-sized towns (Population≥100,000), (2) Medium-sized (population 30,000-100,000), and (3) Small-sized towns (Population 2000-<30,000). Four towns were sampled from each category. The selection of towns involved ranking of towns based on the magnitude and spread of HIV. The ranking of the towns was based primarily upon analysis of available secondary data, which was complemented/supplemented by a participatory research appraisal (PRA).

Secondary data analysis: Town-level HIV prevalence data were not available for most of the TransACTION towns. Available proxy HIV/AIDS data including the number of ART users and ANC based sentinel surveillance HIV data were combined to gauge the spread of HIV/AIDS in the towns. A linear regression model[22] was fitted between town-level HIV prevalence and proportion of "ever started on ART" (for those towns both data were available). The linear regression model was found to be robust in predicting town level HIV prevalence based on the ART data. The number of "ever started on ART" was available from 79 towns and we were able to predict town-level HIV prevalence for all of them.

Participatory Research Appraisal (PRA)*:* The purpose of the PRA was to (1) get expert views on locally relevant most at risk subpopulations in TransACTION program implementation towns (2) and get data from them on distribution and magnitude of these groups in locally relevant terms. The PRA was conducted with selected HIV/AIDS experts from different regions, academic institutions, and other knowledgeable individuals. A PRA guide was developed and employed for the purpose. Based on the findings of the PRA, it was possible to do an independent ranking of the towns by concentration of specific MARPs.

Triangulation and final selection of study towns*:* Information from the quantitative secondary data and the PRA was triangulated to rank towns according to the spread of HIV/AIDS as well as the concentration of MARPs. Separate rankings were presented by domain – i.e. for large-, medium-and small-sized towns. Four towns with high concentration of HIV within a domain were selected, yielding 12 towns in the three domains. The detailed study methodology and the 12 towns for the study were presented to USAID for approval. Three of the towns originally selected for this study were found overlapping with other partner organizations working on MARPs in the Amhara region. This was shortly resolved by substituting three of the towns originally sampled (i.e. *Bahirdar, Dessie and Debremarkos*) with other towns. The final study towns included:*Adama, Asaita, Hawassa, Injibara, Fenote Selam, Yirgalem, Shashemen, Debrebrehan, Mekele, Alamata, Axum,* and *Maichew*.

[22] Predicted town HIV % =[(% ever started on ART + 1.77)/0.46], R=0.75

3.2. Target Population

This formative research targets 6 groups , namely, sex workers, truckers, male and female daily laborers, waitresses, out-of-school youth. It also collects information from people living with HIV/AIDS (PLHIV).

3.3. Methodological scope

The study employed qualitative methods encompassing Focus Group Discussions (FGD), In-depth interviews (IDI) and Key Informant Interviews (KII). On the whole, the study achieved 33 FGDs with MARP sub-groups and PLHIV, 196 IDIs and 95 KIIs. Mapping the specific locations of MARPs (by cluster) was done as part of the formative research to get entry points into the study and recruit study participants.

3.4. Key Informant Interviews (KII)

In each town, data collectors conducted KII to get experts' opinions on the spread of HIV in their towns, opinions about the most-at risk population for HIV, available interventions for MARPs as well as to identify specific locations of the target MARPs in a town. Respondents to the KII included town/woreda HAPCO, the social sector office, the transport office, health workers, religious organizations, Idirs, women's groups, youth groups, NGOs working on HIV/AIDS and with MARPs, construction companies, home-based care workers, Associations of PLHIV, Bar/hotel owners, Associations of sex workers (if there were any), and truckers' associations (if there were any). A KII guide was prepared for data collection (Annex 1). The number of informants per town was determined based on the availability and relevance of potential respondents. On the whole, 95 KIIs were interviewed in the 12 towns.

3.5. Mapping and recruiting MARPs for the study

Depending on the type of MARPs, ethnographic or social mapping[23] was done. The KII was the main information source for the mapping. This study focused on sex workers operating in establishments including bars/hotels, local drink houses and in "red light" houses. Individual sex workers were recruited from the establishments to participate in the FGDs and IDIs. Waitress participants were recruited from cafes/pastries/bars/hotels that were found in the towns after doing a mapping of the locations of the cafes/bars, etc. Male and female daily laborers for the FGDs and IDIs were recruited mostly from construction sites but in some towns they were also recruited from special spots where they flock every morning to seek work. In each town, truck halting points, gas stations, and bars/hotels that are frequented by truckers were mapped and truckers were recruited from these sites. The mapping of Out of school youth (OSY) mainly involved locating special places where unemployed OSY were found in abundance such as recreations sites, parks, Khat[24]/Shisha corners, DSTV houses, and other sites. PLHIV participated in the FGDs and IDIs were

[23] An ethnographic or social mapping procedure was employed to construct the maps for the study. This simply means that in the process of constructing the maps, basic ethnographic techniques such as key informant interviewing, and spending time "walking the community" in the company of key informants, was be employed

[24] the leaves of the shrub Catha edulis which are chewed like tobacco and has the effect of a euphoric stimulant

contacted through their associations or representatives in the towns. Only PLHIV who are members of an association were included.

In the 12 towns, 296 clusters (or Primary sampling units-PSUs) were identified. By type of MARPs, the clusters were comprised of 67 CSWs, 25 truckers, 41 waitresses, 59 female daily laborers, 60 male daily laborers and 44 out-of-school youth.

3.6. Focus group discussion (FGD)

This was the main source of information to address most of the objectives of the formative research. Overall the study included 33 FGDs (i.e. 6 with CSWs, 5 with waitresses, 5 with female daily laborers, 5 with male daily laborers, 5 with out-of-school youth, 2 with truckers, and 5 with PLHIV). Each FGD was conducted with 8-12 participants. The study used the principle of "homogeneous strangers" and snowball sampling to enroll participants in FGDs. An FGD was facilitated by a moderator and a reporter, both of whom were not residents of the study sites. Separate FGD guides were prepared for each study group and translated to Amharic for ease of administration (See Annex 2). All discussions were tape recorded and notes were also taken. The tapes were transcribed verbatim. There was variation in the duration of the FGDs, ranging between 2 and 2.5 hours.

3.7. In-depth Key Informant Interviews (IDI)

In total, we conducted 196 IDIs with the different MARP groups as well as PLHIV. By type of population, the numbers of IDIs conducted were 24 with CSWs, 52 with truckers, 12 with female daily laborers, 12 with male daily laborers, 36 with waitresses, 35 with OSY, and 25 with PLHIV. Participants in the IDI were selected using snowball sampling. The IDIs, in particular, allowed individuals to express their personal feelings and experiences as well as behaviors, which they may find difficult to share in a group setting such as in an FGD. Separate IDI guides were prepared for each study group and translated to Amharic for ease of administration (See Annex 3). All discussions were recorded onto answer sheets and notes were also taken. There was variation in the duration of the FGDs, ranging between 1 and 1.5 hours.

3.8. Training of data collectors and fieldwork

Two-day trainings on the formative research methodology and data collection guides were conducted for 13 data collectors and 3 field supervisors. The training included orientation to the high-risk corridor intervention, key concepts and terms that are relevant to the study as well as expected outcomes. Item by item discussion on each of the data collection guides constituted the major parts of the training. Experts from the TransACTION project participated in the training and also gave orientations to the data collectors.

Four teams of data collectors were formed. Each team was comprised of 3 individuals with the exception of 1 team of 4. Each team was assigned to collect data in 4 towns. Supervisors were also assigned accordingly. The lead consultant and core research team members supervised the process and progress of data collection. Data collection took about 20 days which varied from team to team (From November 13-December 2, 2009). Transcription of

the FGDs was followed after data collection, which took another week to be completed. On the whole, the data collection went smoothly. Nonetheless, data collation was not without challenges. Initially, we anticipated conducting 4 focus group discussions (FGDs) with truckers but after significant attempts by the study teams, only 2 were possible. Due to the nature of their work, pulling truckers for an FGD was very difficult, if not impossible. To compensate for this, we conducted several in-depth interviews with truckers.

3.9. Qualitative analysis

Analysis was guided by the formative research objectives. Content analyses of the FGDs and IDIs were done to generate concepts, key themes and patterns in accordance to the study objectives. Triangulation of information from different sources was done, as deemed necessary.

The content analyses focused on the following thematic areas – mobility, entry into current work, expenditures and savings, gatekeepers, sexual behaviors including transactional and cross-generational sex, condom use, access to HIV/AIDS information and services such as HIV counseling and testing (HCT), sexually transmitted infections (STIs) and Khat and alcohol using behaviors.

The qualitative analyses were supplemented/complemented by, and triangulated with, the KII information, as deemed necessary.

3.10. Study limitations

The study employed qualitative methods, which provided a large body of in-depth and rich information and also allowed interaction among study participants. On the other hand, these techniques (e.g. FGD and IDI) are subject to a number of obvious limitations. Small numbers of respondents, self-selection, unstructured or semi-structured data collection approaches, and subjectivity of responses are among the major limitations.

The study is also limited by its geographic coverage. The TransACTION program intervention focuses on 120 towns. Although the 12 towns for this study were selected objectively as well as to represent different types of towns, they are not meant to represent all the towns where the TransACTION program intervention is being implemented. Thus, findings should generalize with caution.

Three Amhara towns that were originally selected to be part of this study were excluded and replaced by other due to overlap with other partner organizations. The towns excluded have relatively the highest HIV prevalence as well as concentration of most at-risk population. How, if at all, the replacement of these towns may have affected the findings is unknown.

IV. PRESENTATION OF FINDINGS

4.1. Sex workers

4.1.1. Socio-demographics

Most sex worker participants reported to be young, in the range of 13-29 years. Their mean age was 22 years. They reported serving in sex work, on average, for 3 years. The duration in sex work ranged from <1 month to 9 years. On average sex workers participated in the study had 6 years of schooling; 12% could not read or write. Only 3% completed high school. Sex workers from small towns reported to have the lowest education level while those working in big towns were better educated. Also, sex workers working in bars/hotels had relatively better education than those working in local drink houses. About a third of the sex workers were born in rural areas, the remaining were born in small or big urban areas. It was reported that 12% were born in Addis Ababa. In terms of marital status, the majority were never married. About a quarter reported that they were divorced.

4.1.2. Typology of sex workers

This study included sex workers from bars, local drink houses and small red light[25] houses from the 12 towns. Other sex workers such as those working on the street were not included. The sex workers varied by their socio-demographics (education, origin, etc), the number and type of clients they have and the amount of money they receive per sexual encounter. Sex workers in bars/hotels are better educated and well paid per sexual encounter. High numbers of clients per day were reported among those working in red light houses. These sex workers were predominantly of rural origin, less educated and reported to receive less money -"to be cheaper" per sexual encounter. The typology of sex work also varies by size of towns – sex workers in large sized towns are mostly working in bars/hotels and big night clubs. Local drink houses are more common in small towns.

4.1.3. Spending and saving habits

This study did not ask for the income of sex workers while gathering information on their spending and saving habits. Anecdotal evidence indicates that sex work has become a lucrative "business" and the amount of money sex workers receive per sexual encounter was reported to range from a low of 10 Birr to 300 Birr or higher, depending on the type of sex worker.

The major spending categories reported included food, housing costs, clothing and support for families. Another spending category was for makeovers such as hair dressing, expensive outfits, and accessories. Most sex workers also blamed their Khat/alcohol and Shish habits as draining their economic resources. Due to the culture of sharing among sex workers and the fact that most lead a communal lifestyle meant they have to support each other during times of difficulty. Besides, boy friends of sex workers often depend for their subsistence and other incomes on earnings of sex workers.

[25] A red light house is a very small sex work establishments where there is only one sex worker. In red light houses alcohol drinks are not sold. There are clusters of several red light houses in urban slums of some towns.

Saving by sex workers was reported to be difficult. This is perhaps due to their high expenditure pattern as well as the irregularity of their income. A few sex workers participating in this study however reported to have a bank account while others reported to save money through Iquib[26]. Iquib, as a saving scheme, was reported to be less reliable because of the mobility of sex workers. For some sex workers buying expensive jewelry made of gold was considered a means of saving. Jewelry can be sold during times of difficulty.

4.1.4. Mobility of sex workers

Sex workers in general are characterized by high mobility across towns. Based on information from participants of this study, the average duration of stay in the town was reported as 6 months, ranging from less than a month to 36 months. The reasons for changing towns are numerous including decline in number of clients, disagreement with establishment owners and fellow sex workers, seasonal migration to cash crop areas, and fatigue.

The decline in the number of clients emerged among the main reasons for changing towns and place of work. Clients reported to have a high preference for new and "fresh" sex workers and the longer a sex worker stays in a town or an establishment, the number of clients decline and thereby diminish her earnings.

> *"....when you are new you can have many clients. This will not last long. Your popularity will no more there, clients will look for new sex workers. You really need to go to another town where they [clients] see you as new and fresh" Sex worker IDI participant, Axum*

Disagreement with establishment owners/bosses and fellow sex workers reported to be another common reason for leaving a town or an establishment. Competition over clients was reported as common by sex workers. A typical situation is when a regular and high-paying client of a sex worker falls into temptation with a new or different sex worker. This creates serious problems between sex workers, often leading to one leaving town or an establishment.

> *"Some friends are too jealous specially if you attract rich and famous clients. Some [Sex workers] want to destroy you gossiping all things about you. I had such a bad experience in Hawassa that is why I came here" Sex worker, FGD participant, Adama*

Seasonal migration to cash crop areas to meet high paying and a larger number of clients in a short span of time is another reason for their high mobility. Sex workers have their own networks and exchange information and ideas about the business hotspots. The recent widespread access and use of cell phones reported to have facilitated easy communication among sex workers to exchange information and contact trusted friends during times of difficulty.

[26] Iquib is a traditional Rotating Savings and Credit Association

Working in one establishment or town for a long time even with a good number of clients is not often welcomed by sex workers, especially among those working in bars and hotels. Although it is not clear as to why this is, we can speculate that this may well be related to social stigma associated with being identified as a sex worker in a town. It may well be that sex workers want to look fresh and new to a town and establishment so as to meet new clients.

> *".....working in one bar for more than 6 months would make me mad; I have to go... "Sex worker, IDI participant, Maichew*

The lack of safety and feeling of insecurity in some towns, especially due to repeated incidences of verbal and physical abuse and being robbed by gangsters and thieves was reported among the push factors to leave a town. Changing the work place to hide from a husband/boy friend/families/neighbors/friends was also reported by a few sex workers. Brokers also play a key role in persuading sex workers to change from one establishment to another

While changing from one town to another reported to be very common among sex workers, changing establishments within the same town was reported as less common, especially in small-sized towns. In big towns, changing establishments was common. Disagreements with establishment owners as well as being uncomfortable with clients visiting a particular establishment emerged among the main reasons for changing workplace.

4.1.5. Reasons for engagement in commercial sex:

A range of reasons were reported for joining sex work. Nevertheless, for most of the participants the primary rationale for engaging in sex work was economic. Most participants blamed poverty and lack of subsistence as the main push factor.

> *'Following the death of my mother, I came to live with my aunt who owns a small grocery in Sashemene. I worked in her grocery serving customers and entertaining them. I almost started business (sex work) in that grocery but my aunt was controlling of my income. Later on I fled to Adama to begin the business (sex work) with freedom' Sex worker, FGD participant, Adama*

Previous studies also found poverty as the major driver of sex work[27] in Ethiopia. Nevertheless, we argue here that poverty is not the only reason for most women to engage into sex work. Indeed, the vast majority of sex workers come from the poor section of the population but sex work is not the only option for these women. Recently, the vast majority of women from the low socio-economic class are seen actively engaging themselves in various economic activities, including labor intensive jobs such as construction work, petty trading, selling food items, and working as housemaids among others. In terms of their socio-economic background these women are no different from those involved in sex work. This would thus challenge the widely held notion that poverty, under the current reality of urban Ethiopia, is a major driver of sex work. We argue here that the interplay of several push and pull factors are responsible for women engaging in sex work. Indeed, our present study uncovered several drivers of sex work. Poverty, gender norms and expectations, peer

[27] Amhara MARPS survey. 2008 Unpublished

influence, family and social pressures, and individual interest were implicated among the reasons for joining sex work.

Socio-cultural and gender related push factors such as early and arranged marriage were reported by sex workers from rural origins. This has surfaced among the major factors leading to sex work. Sexual abuse and rape was also implicated by some sex workers.

> *'I was forced to marry by my parents at age 9 years and could not go along with the marriage and escaped to town few years after the marriage. I met a girl from our village working as a sex worker in a small town. She helped me to start the work and I eventually ended here' Sex workers, FGD participant, Injibara*

Peer influence emerged among the major drivers of sex work, as reported by most sex workers participating in our study. Sex workers' life style and the amount of money they earn attracted most young girls to sex work. The lucrative nature of sex work and the recently increasing number of sex work establishments with the expansion of towns attract young girls to join in. Sex work is seen as a quick way to make money. The life style of sex workers is superficial and deceptive to most women who are vulnerable to such behavior. These girls are often attracted to the expensive clothing, jewelry and accessories most sex workers have and also by the colorful and vibrant bars in towns.

> *'I was engaged in this work (commercial sex) by looking at the amount of money my fiends earn and the way they live. I am from a very poor family; I have to support my family, brothers and sisters. That is how I became involved in this work' Sex workers, IDI participant, Adama*

> *'I remember there was this woman who was originally from our village and later she left her family and started to live in big town. She used to visit her family in our neighborhood during the holidays. When she came she always had special dresses and also brought several gifts to her family. I grew up with the intention to be like her and joined the business (sex work) when I became young' Sex workers, FGD participant, Adama*

Family intimidation and expectations of support from young girls also emerged among the reasons. Family pressure, indirectly though, is among the factors pushing girls to join sex work. A family expectation of support from offspring means young girls have to shoulder family obligations. Being intimidated by families for being jobless and staying at home without contributing to household income was reported to be a source of frustration, which eventually leads to sex work. In the absence of social skills and access to counseling, these girls will find sex work a viable option to cope with family pressure and obligations.

> *"....my mother used to nag me, telling me how useless I was by comparing with the other girls in our neighborhood who somehow assisted their families. I ran away from home and started working as a cleaner, then a waitress in a big restaurant where there were many sex workers. It didn't take me many months before I ended up in this work (sex work)" Sex worker, IDI participant, Debre Brhan*

4.1.6. Entry routes into sex work:

There were varieties of entry routes into sex work, which vary by place of origin of the women. For urban girls, the dominant route sex workers reported was through peer or friendship networks and brokers. The initial step often taken by urban young girls to start sex work is to leave home, often travel to towns where she has a friend/acquaintance network. Sex work can also be facilitated through peers or brokers who traffic girls from one town to another. Mostly, these girls do not start sex at once. Often times they serve as waitress in sex work establishments to learn about the job. Meeting sex workers in towns and establishments will facilitate her transition into sex work.

There are also other entry routes for urban women. The recent expansion of higher education in most towns of Ethiopia that attracts a large volume of students from different corners of the country is also blamed for increased involvement of young girls and boys in risky sexual behaviors. In the absence of family guidance, supervision and when the support from family is seen as unsatisfactory, young girls start engaging in transactional sex. This eventually leads to abandoning college education and resorting to commercial sex.

For rural girls entry routes are different. The influence of peers is apparent while brokers' role is more vivid. There are different routes by which rural women join sex work. Most rural women left their homes in search for any kind of job, including housemaid, day labor, cleaning and housekeeping, working as waitress in local drink houses, among others. These girls' first contact in towns could be a broker, an urban resident relative, or a friend. The brokers' role is significant, especially in finding and facilitating jobs for these girls. A few were directly hired into local drink houses as waitresses, and big sex work establishments as cleaners and bed makers. Others entered directly into sex work with the help of their peers who were already in the sex work business. The majority, however, started working as housemaids and day labors as soon as they arrived in towns. Night schools, often elementary schools, are important marketplaces where these rural girls meet their peers and sexual partners. Information exchange and networking with peers and brokers helped them understand the urban environment and explore "better" career opportunities. Sex work is seen among the options available for these girls who are frustrated by abusive bosses when working as housemaids and daily laborers.

4.1.7. Gatekeepers

Gatekeepers are not members of a group but have important roles in the day-to-day lives of members of certain groups. Gatekeepers have a reciprocal financial or otherwise relationship with members of a certain group. Sex worker participants reported the different gatekeepers influencing their lives in various ways. These included establishment owners, fellow sex workers, brokers in towns, establishment guards, boyfriends (non-paying partners), gangs/outlaws, and law enforcement bodies.

Establishment owners can have negative or positive roles but on the whole their role is seen quite negative. Sex workers blamed most establishment owners for being too controlling. Sex workers forwarded the following comments concerning establishment owners:

- Owners often instruct a sex worker with whom she should go out with and have sex without considering the interest of a sex worker. Owners sometimes make prior

arrangements with a client and get good commissions for allowing him to have sex with the women of his choice.

- Owners often force sex workers to drink alcohol with a client even beyond their interest and instruct them to ask clients to buy them alcohol. This was because the owners want to sell as much alcohol as they can. A sex worker who doesn't drink is not at all welcomed by most owners.
- Owners demand commissions from a sex worker who has to leave earlier with a client to go to a bedroom
- Disobeying owners one way or the other has severe consequences, including being fired from operating in the establishment

> *"Bar owners do not respect us. They consider us one of their house utensils...." Sex worker, FGD participant, Fenote Selam*
>
> *"...she(the owner) chooses whom I should sleep with and doesn't care about my choices" Sex worker, IDI participant, Injibara*
>
> *"The owner wants us to drink alcohol as much as we can with the client. We are also told to even beg a client to buy us alcohol." Sex worker, IDI participant, Maichew*
>
> *"...we pay commission when we have to go out early in the night with a client" Sex worker, IDI participant, Debre Birhan*

Few sex workers on the other hand saw establishment owners as helpful and protective, which includes giving good advice on how to save money, helping during illness, providing moral support and protection from violent clients and lending money.

> *"....She (the owner) is always advising me to save money so that I can start my own other work" Sex worker, FGD participant, Fenote Selam*

Brokers reported to have notable influence on the lives of sex workers by telling them what to do and where to be employed in the name of advice and good guidance. It was repeatedly reported that some brokers persuade sex workers to change from one establishment to another by making some arrangements with establishment owners. In this process brokers receive commissions from both the sex worker and the establishment owner. They can also facilitate transactional sex between sex workers and truckers, field workers/travelers, foreigners and married business men who prefer to meet sex workers in a secret place. There is a kind of trust between brokers and sex workers because their businesses and economic survival are so entwined, although some sex workers complained about being exploited by brokers. Sexual relationships, often non-paid, with brokersalso surfaced.

Fellow sex workers are the most trusted and give genuine support to their peers.. Facilitation of employment in new establishments, material and moral assistance during financial crises and illnesses, sharing of resources, protecting each other from gangs and possible dangers were repeatedly mentioned. The presence of strong networks among sex workers operating in different towns and establishments reported to ease mobility and provide housing and subsistence support after their arrival.

Hotel/bar guards' role was reported to be conflicting**.** While guards reported protecting sex workers during disputes with clients others can expose sex workers to violence and abuse by making prior arrangements with clients. Guards also receive money from sex workers and sometimes force them to have sex.

Non-paying partners/boy friends: Most non-paying partners/boyfriends were reported as trusted friends to sex workers. In fact, one of the reasons for sex workers engaging in such relationships was to seek protection and assistance in difficult circumstances. In return, it was reported these partners get financial and material support from sex workers. On the negative side, there were reports of abusive and controlling non-paying partners who make the lives of sex workers difficult.

Gangs and outlaws often have a negative impact on the lives of sex workers. They were reported to rob, beat and sexually abuse sex workers. Sex workers are sometimes expected to continually finance gangs to ease this situation. They also reported that outlaw gangs forcefully become boyfriends to sex workers. To escape such difficult circumstances, most sex workers change their workplace and towns in search of better security. Verbal abuse and intimidation by non-working out-of-school youth was also reported.

Law enforcement bodies including policemen and Kebele authorities are not seen as protective to sex workers. Being harassed and verbally abused by these law enforcement bodies was reported by sex workers participating in this study. Non-paid sex by these groups without the consent of sex workers also surfaced. Perhaps one of the reasons for this, as reported by some sex workers, is their being new and non-residents to the towns they were operating in. Most were not registered as residents, which made it difficult for them to confront and report such abuse. The stigma surrounding sex work also hinders sex workers from confronting abusers and seeking justice.

> *"When we have disputes with clients over some strange sex act and those clients who refuse to use condoms, policemen usually take actions against us. They beat us without even trying to know the reasons and force us to either return the money to the clients or do whatever the clients demands" Sex worker, FGD participants, Mekele*

4.1.8. Sexual behaviors and relationships:

Clients/partners of sex workers are broadly categorized into three groups: paying clients; regular paying clients; and non-paying partners/boy friends. There seems to have been some overlap and confusion between regular clients and non-paying partners, as reported by sex workers. Indeed, a transition and graduation from a regular client to non-paying partnership was also reported. Regular partners can be exempted from paying for every sexual encounter while they are expected to pay in most instances. Some regular partners reported paying in-kind and giving some gifts to sex workers to cement their relationship, which could eventually lead them to become a non-paying partner. Relationships with non-paying partners (boyfriends) was apparent. Such partners spend the daytime and holidays with sex workers. They can also live together and share resources, involving love and care for each other. Sometimes cohabitation is also reported. In most instances non-paying partners benefited monetarily and materially from such a relationship.

Profile of paying clients: Men of varying socio-economic and demographics reported to visit sex workers. Nevertheless, the commonest clients reported to include truck drivers, construction workers, mini-bus,intercity bus and Isuzu drivers, civil servants (mostly teachers, filed workers), business men, daily laborers, soldiers, mechanics and farmers.

The type of paying clients of sex workers were reported to vary in accordance with the type of sex worker and size of towns. Sex workers in bars/hotels have clients who have relatively better economic statuses. Since such sex workers are expensive for the vast majority of the poor and those from low socioeconomic class they are often visited by groups that have the economic ability to pay. Common clients for this particular sex work group include truck drivers, construction workers, business men, mini-bus and intercity bus drivers. On the other hand, sex workers operating in local drink and red light houses have their clients whoare mostlydaily laborers, soldiers, mechanics and farmers. They are also there to fulfill the demand for sex for people from different walks of life. Anecdotal evidence suggests that due to the low pay per sexual encounter, these type of sex workers' income is compensated by the high number of clients per day, ranging between 5-8 clients per day.

Profile of non-paying clients: Sex workers across the towns reported having sexual/love relationships with non-paying partners. By sex workers accounts, non-paying partners often represent the youth and varying socio-demographics. Furthermore, the type of non-paying partners reported to vary by type of sex workers. Relationships with non-paying partners mostly formed with the consent of sex workers. For some sex workers the relationship involves serious love affairs and affection. Others saw such relationships as simply to have companionship, comfort and someone to hang out with during their leisure time.

In most instances such relationships involve material and cash support to non-paying partners. There were also reports of the reciprocal nature of the relationship where both benefit from the relationship. Some non-paying partners reported to provide material support to sex workers. It was also repeatedly reported that non-paying partners serve as guardians to sex workers, protect them from gangs and abusive clients. At times of illness and other social problems, boyfriends are there to lend support to sex workers.

On the whole, such relationships were reported to be short-lived mainly because most sex workers are mobile. It was also reported that some non-paying partners become controlling as the relationship matures and tends to be abusive. Infidelity of boyfriends is also among the reasons for breakup.

Sex workers in bars/hotels participating in this study reported mini-bus/Isuzu drivers, male waiters, DJs in sex work establishment, hair dressers, out-of-school youth, and college students, brokers, and a few others among the common non-paying partners. On the other hand, common non-paying partners of sex workers in local drink houses/red light houses reported to include daily laborers, mechanics, Bajaj Taxi drivers, policemen, soldiers and farmers.

4.1.9. Condom use among sex workers

On the whole, by sex workers accounts, condom use was reported to be high and consistent with paying clients although there are situations where sex workers are less strict in their condom behavior.

> *"I don't see any difficulty in condom use by sex workers. I want to live. I also have plans to leave this dirty business (sex worker). I consistently and properly use condom with all my clients" Sex worker, FGD participant, Alamata*

> *"I myself insert condom in a man's penis and also check whether it is inserted properly" Sex worker, IDI participant, Axum*

Sex workers participating in this study did not deny the many challenges surrounding condom use with paying clients. Typical situations where condom is not used consistently or properly with paying clients were repeatedly reported. Clients' refusal to use condoms, having sex while drunk, sex workers' negligence and the use of family planning methods other than condoms were reported among the major reasons for the lack of consistent condom use with paying clients.

Some clients were reported to offer more money; others use force to have sex without a condom. Some clients remove the condom in the middle of sex. Rural paying clients (farmers) were frequently blamed for not wanting to use condoms. On the other hand, sex workers often see rural clients as having low HIV risk and this compromises condom use.

> *"Clients can offer up to 300 birr to have sex without condom and there are some women (sex workers) who couldn't resist the temptations' Sex worker, FGD participant, Injibara*

> *"A gangster once paid me the business in advance and took me to a hotel far away from where I was working. There he insisted to have sex without condom. I cried loud and the watchman came and told him to open the door. He refused and forced to have sex without condom" Sex worker, FGD participant, Hawassa*

> *'Many clients will do anything to have sex without condoms. It seems to me that men are becoming more careless. We, sex workers must be careful' Sex worker, FGD participant, Hawassa*

Alcohol use repeatedly emerged among the barriers to condom use. Sex workers reported that after a lot of alcohol drinks it is often impossible to control ones condom behavior.

> *".....once a client offered me a lot of alcohol and I became drunk. We then went to bed and I also remembered that he had condom. Because I was so drunk I couldn't follow his condom use. I only knew that he had done it without condom in the morning"' Sex worker, FGD participant, Fenote Selam*

There were also reports of a good number of sex workers who considered themselves as already infected with HIV and became sloppy in their condom behavior. Others were totally ignorant about condom use.

"Although I have been hearing about the importance of condoms, I have never used them" Sex worker, FGD participant, Injibara

Some sex workers who use contraceptives (other than condoms) reported to be less consistent in their condom behavior. For such sex workers unwanted pregnancy was their major concern.

Condom use with non-paying partners: This was reported to be most challenging. There is a general consensus that sex workers are less careful and less consistent in their condom use behavior with non-paying partners (boyfriends/lovers). Trust in in their loving relationships surfaced as the main reason for not using condoms with boyfriends.

"I do not use condom with my lover, but I consistently use condom with clients" Sex worker, FGD participant, Injibara

4.1.10. Khat and alcohol use

Khat use by sex workers was reported universally but varied by type of sex worker. Sex workers operating in bars/hotels reported more frequent Khat use than those from local drink houses. Khat is a means of recreation, socializing, and passing leisure time for most sex workers. It was frequently reported that Khat puts sex workers in a better mood since the work is stressful. Some sex workers use Khat to help them interact better with clients and have a good appetite for alcohol. Chewing Khat with non-paying partners/boy friends and with fellow sex workers in groups was reported to be a common practice across the towns. When asked the influence of Khat on consistent and proper condom use, sex workers in general did not see Khat as having a negative effect on their condom behavior.

"I chew Khat to interact and entertain more with clients. I am not a good entertainer when I am not chewing Khat" Sex worker, FGD participant, Hawassa

"A friend of mine does not go to work unless she has chewed Khat" Sex worker, FGD participant, Axum

"The number of sex workers who do not use Khat everyday is very small. Most chew everyday and drink every night" Sex worker, FGD participant, Mekele

Although the intensity and type of alcohol vary by type of sex worker, participants unanimously agreed that the vast majority of sex workers drink alcoholic beverages. While sex workers operating in local drink houses reported to mostly consume local drinks including, *Areke* and *Tella,* those in bars/hotels reported to use Beer and other beverages with high alcoholic contents. Heavy drinking after Khat is commonly reported to break the influence of Khat (locally known as *Chebse*). The fact that condoms are not used or improperly used after alcohol consumption was reiterated by almost all participants across the studied towns. In fact most believe that condom use after heavy drinking is impractical.

"Drinking is a must when you work as a bar lady, because you are not welcomed by the owners if you let the offer of clients down" Sex worker, FGD participant, Adama

"I always drink with clients. I drink to my limits and therefore I have never been drunk" Sex worker, FGD participant, Hawassa

"I must drink after Khat. Even if I do not get a client offering one, I will buy it from my own" Sex worker, FGD participant, Fenote Selam

4.1.11. Access to information and services

On the whole, high HIV risk perception was reported by sex workers participating in this study. Reasons for this include having multiple sexual relationships, inconsistent or incorrect condom use, sharing sharp utensils with fellow sex workers/roommates and extended kissing with a client. Indeed, sex workers singled out infection by HIV among their number one concerns. These being a general consensus among sex workers, there were also those who underestimate their risk of acquiring HIV due to high and consistent condom use. Such participants argued that their risk is not different than the general population.

IEC/BCC: Sex workers across the towns reported public health institutions and mass media as their main sources of information on HIV/AIDS and condoms. In a few of the towns, programs led by non-governmental organizations such as the Wise-up program (By DKT Ethiopia) and peer education activities were reported among the sources of information on HIV/AIDS and condoms.

Sex workers saw available HIV/AIDS intervention efforts in the towns as inadequate because they failed to address the main concerns of sex workers. Lack of interest to participate in such programs is reported among the challenges. In fact, stigma prevents sex workers from attending programs that are even tailor-made for them.

HIV Counseling and Testing (HCT): Across the towns, sex workers appeared well acquainted with places where HCT services are rendered. Public health institutions including health centers and hospitals, private clinics, NGO led programs (e.g. programs by OSSA, FGAE, Mary Joy etc in some towns) and Mobile HCT (in some towns) are commonly known by sex workers.

Seeking HCT by sex workers reported to be quite low across the towns irrespective of the socio-demographics of sex workers. Fear of HIV positive results and associated stigma prevented sex workers from testing. Most sex workers considered themselves already infected and HIV testing was seen as irrelevant. Other sex workers suggested that they wouldn't want to be tested because they have no plan to abandon sex work. These sex workers do not see the value of testing if they stay in the same risky business. However, sex workers reported testing for HIV when they were repeatedly and seriously ill. Nowadays, the free ART service and the associated food/material support services available for patients on ART serve as a motivator for testing among the sick and impoverished sex workers.

When asked their preferences of places to get HCT, most reported private facilities although the cost for services was reported as a potential barrier. Public health institutions are less

preferred for lack of confidentiality, as most sex workers emphasized. Sex workers reported that healthcare providers in public health facilities can easily identify them and spread out the news about their HIV test results to owners and clients. Mobil HCT services, though were reported as better in terms of confidentiality, most sex workers do not see test results as reliable because of its rapidity. Stand alone/dedicated HCT services for sex workers are not at all welcomed by sex workers due to stigma and lack of confidentiality. Outreach HCT services are not preferred for the same reason.

Disclosure of once positive HIV test results to non-paying partners or boyfriends was reported as very difficult if not impossible. Fear of being beaten and even killed by lovers surfaced among the major deterrents. Losing boyfriends was also a reason mentioned among the barriers to disclosure. Stigma and discrimination also prevent sex workers from disclosing test results. HIV positive sex workers often prefer to change towns and continue working as sex worker in other towns.

STI diagnosis and treatment: STI awareness varies in accordance with the type of sex worker. Sex workers in large-sized towns and those working in bars/hotels appeared relatively better informed about STIs including the symptoms, risk perception, and places where services are rendered. On the others hand sex workers in small towns and those working in local drink /red light houses appeared less informed about STIs and places of service.

Among those well aware of STIs, public and private health facilities (e.g. health centers, clinics, hospitals) and pharmacies were repeatedly reported as places where STI services are rendered. NGO facilities including those provided by OSSA, FGAE and Marry Joy were reported by sex workers in some towns.

STI diagnosis and treatment seeking behavior by sex workers was reported to be unclear. Sex workers who are well aware of the symptoms and those operating in bars/hotels reported to be seeking diagnosis and treatment when there was pain, soreness, itching and a foul smell from the vaginal area. For most sex workers in small establishments – local drink houses and those of rural origin the lack of adequate knowledge about STIs and their symptoms prevented them from seeking care. Even when they knew the symptoms, these sex workers often fail to seek care for fear of stigma, shame and harassment by health professionals. Lack of finances to buy the STI drugs was also suggested among the key barriers.

Public health institutions are less preferred for STI diagnosis and testing for fear of stigma and lack of confidentiality. On the other hand, sex workers appeared to have more confidence in private facilities for confidential STI services although high cost for the service was reported as a barrier. Other service provision models such as outreach and standalone STI services were not preferred by sex workers. In terms of gender of healthcare providers, sex workers appear to prefer female healthcare providers for STI diagnosis and care. They tend to have great concern about confidentiality of their STI status if examined by a male health worker. By sex workers accounts, male health workers are less trusted because they can easily spread the news about their STI to establishment owners and clients.

Conflicting responses were forwarded concerning disclosure of STI test results to partners. Some sex workers want to avoid telling the truth to lovers and those partners from whom they gain some financial/material support. As a strategy to hide their STI from lovers these sex workers often shy away from having sex with boyfriends or lovers until they are completely cured. It is unknown, however, whether these sex workers are aware of the possibility of being re-infected from lovers/partners. Other sex workers participating in our study said they would disclose their STI test results regardless of the extent of love or support from partners because they want their partners to also get tested and treated. Such respondents appeared concerned about re-infection if their partner was left untreated.

4.2. Waitresses

4.2.1. Background characteristics

Most of the women working as waitresses reporting were in the age group 18-25 years. Most had at least elementary education and the commonest education level was 6-8th grade. Very few reported completing grade 12. The vast majority were never married. Most were of urban origin. The waitresses can be broadly categorized as those working in pastry shops/cafes (non-sex worker setups), in bars/restaurants (sex work setups) and those having double duty i.e. work as waitress in daytime and as sex workers at night. Based on information from 80 respondents, the median duration of work in current establishments was 18 months, ranging from a low of 2 months to 6 years.

Waitresses reported that this is a low wage work and their salaries can hardly cover basic needs such as food, house rent, cloths, etc. This is further exacerbated as these women are expected to support and shoulder family responsibilities.

4.2.2. Engagement as waitress and entry routes

Most waitresses participating in this study saw this work as a transit to better jobs and career opportunities. As most participants described it, they were involved in this type of work due to poverty and lack of family support. Limited job opportunities were also blamed for this. The following remarks by study participants signify the reasons for engaging into this job.

> *"My parents are very poor and unable to support my education. I was engaged in this business because I want to support myself and continue my education" Waitress, FGD participant, Adama*

> *"I know girls who secured jobs in Aqua-Safe and Honey and Wax companies through customers they met while working as waitresses in the cafes" Waitress, FGD participant, Debre Birhan*

> *"I have a Diploma but couldn't get a job in my field of training. I started this job because it does not require special training" Waitress, FGD participant, Adama*

On the other hand, there are a number of reasons why working as a waitress is preferred over other similar low wage jobs. Participants reported the following reasons for preferring to work as a waitress:

- Convenience of the working environment and its perception as an appealing, neat, and decorated place
- Less workload
- The work does not demand special skills
- More freedom, less harassment
- Better earnings through the tips
- Meeting people (who can help in getting better jobs)

There were variations from town to town about the different routes through which women get the job. Most get this kind of job through their network of peers (friends and relatives) followed by brokers and a few via their own efforts. In particular, in large-sized towns brokers were reported as the main players.

4.2.3. Mobility

In big towns such as Adama, Sashemene and Hawassa most of the waitresses reported to have come from different parts of the country while in small towns these women reported being mostly local residents. Frequent change of town and place of work appeared to be common among these women. Moving from one establishment to another was reported as less common in small towns partly because of the limited number of such establishments. In contrast, women working in big towns reported to change work places/establishments frequently. The following reasons were reported by the participants regarding changing establishments, residence and jobs, in order of importance.

- Disagreement with the owners and fellow workmates
- In search of better salary and/or better tips
- Looking for less labor demanding jobs
- Intimidations by customers following rejection of sexual proposals
- Looking for better job opportunities in bigger towns
- Owners ask waitresses for high compensation fees for a broken or lost item
- Looking for better benefits such as food and shelter
- Brokers facilitate new jobs

4.2.4. Gatekeepers

Across the towns, women working as waitresses reported to have close ties with certain population groups including fellow workers in the establishments, Café/bar owners, drivers and assistants, merchants, tour guides, civil servants, out-of-school youth, brokers and college students. These customers reported to have either positive or negative influences on the day-to-day lives of waitresses in the study towns. Below is a summary of the roles of key gatekeepers.

Hotels/restaurants/cafeterias or coffee house owners: Mixed roles of this group were reported. While some owners were reported as supporting and advising these women, others had negative roles. Waitresses reported that male establishment owners were intimidating and abusive. Expectations of fulfilling the sexual demands of owners also surfaced. In some

cafes these women were expected to wear special clothes and look sexy in order to attract customers.

Brokers - Most brokers were said to be supportive to waitress and find them new jobs. There are also brokers who are not trustworthy, exploiting waitresses financially as well as sexually.

Outlaw/gangsters- youth – The negative influence of this group in the day to day lives of waitresses has been repeatedly reported. Being threatened and mostly forced to engage in unwanted sexual and love affairs was reported.

Fellow co-workers of both sexes- Perhaps waitresses trust their peers more than any other group. It was repeatedly reported that fellow co-workers of both sexes are the most trusted advisors and genuine support is always available from them.

CSWs – Women working as waitresses in commercial sex work settings, such as in big bars/hotels complained about intimidation by sex workers. There were reports that sex workers approached and encouraged waitresses to become one. Sex workers also arrange and facilitate waitresses in meeting male clients.

"Special" Customers – Some customers, especially those working in government offices reported to be good to the women and advise them to go to school, save money and avoid risky behaviors.

4.2.5. Sexual experience and multiple sexual partners

Sexual behavior of waitresses was assessed. Waitresses participating across the towns reported that they were exposed to risky sexual behaviors including multiple sexual partnerships and low condom use. Sexual abstinence was rarely reported among the group. The factors that derive their sexual behaviors were numerous and linked to
: poverty and the desire to increase one's earnings; peer pressure; family pressure; customer pressure; as well as negative attitudes of the community towards these women, among others. Cross-generational and transactional sex often characterizes the nature of their sexual relationships.

> *"Most waitresses have sexual relationships with customers. This is a business for them" Waitress, IDI participant, Injibara*

> *"Since most waitresses receive money from customers for sex, they don't stick to one man. They go out with whoever has the money" Waitress, IDI participant, Mekele*

> *"....when you look at the number of women (waitresses) who use birth controls, you can believe that most are having sex frequently" Waitress, FGD participant, Adama*

The nature of their work that involves interaction with new and regular customers of varying backgrounds is often blamed for making these women vulnerable to risky sexual behaviors. Indeed, waitresses often form sexual relationships with customers. According to the participants in this study, sexual demands most often come from customers visiting their workplaces, and that most customers saw them as "non-professional sex workers" who were easygoing and were there to fulfill the demand for transactional sex. Likewise, these women also fell into sexual temptations with customers in anticipation of financial support, getting better jobs and career opportunities, marriage, and a mere desire for love or sexual need.

Nevertheless, in most instances the decision to engage in a sexual relationship with a customer was primarily based on the expectation of some financial or material gain.

There is a general consensus among participants that it is the customers who initiate such relationships by demonstrating interest in the women serving in cafes. There are some common patterns by which a customer expresses his interest towards a woman. Common ways to do this include leaving a good amount of money as tip, demonstrating good conduct, showing some compassion towards a woman and the quality of advice and guidance given by a customer. Customers who often come alone and sit in one corner of the bar/café for long hours are also considered among those needing sexual relationships with a waitress. Likewise, waitresses can also be attracted to a customer by his personality such as his outfits and possessions, such as cars, that hint at his financial potential.

Although waitresses across the towns reported to be exposed to multiple and concurrent sexual relationships, it was reported that much this was more common in commercial centers and in towns with high influxes of people. In contrast, this was reported relatively less common in small towns and also in some big towns where waitresses have limited access to customers of varying economic status and people on the move.

4.2.6. Cross-generational and transactional sex

This is the most common form of sexual relationships waitresses are engaging in. Although such women form sexual relationships with men across all age brackets, cross-generational sex was reported to be predominant. Older customers in the establishments were cited as the major groups with whom these women form sexual relationships most frequently. The main reason for this is to get good financial support, which young partners (age-mates) do not easily fulfill. Participants reported that since this is a low wage work, they need extra support from such relationships to cover daily expenses for subsistence, clothes and accessories, house rent, and education .

> *"To accept money or gifts from a sexual partner is common. We are aware of this when we start this job" Waitress, IDI participant, Fenote Selam*

> *"There is no woman who does not want to accept money or gift. We all accept money and gifts offered to us by men....." Waitress, IDI participant, Sashemene*

Apart from transactional relationships, anticipation of marriage was reported among the reasons for having relationships with older people. There are also cases whereby some relationships grow into a steady relationship, which can eventually lead to marriage or being a *Kimit* (second wife) to a man. Another reason for engaging in cross-generational sex was the feeling of being protected and also considering oneself as being in the "high social class". Below are selected remarks by waitresses on this topic.

> *"....I know some women (waitresses) who have sex with men as old as their fathers" Waitress, IDI participant, Fenote Selam*

> *"Most waitresses have sexual relationship with older men because they get benefits and that is why they (waitresses) prefer older men to the younger" Waitress, IDI participant, Adama*

'We are engaged in this work because of destitution. We want to establish relationships with those who can financially support us. When a client frequently comes and sits in the corners where we work and leaves relatively higher tips, we establish relationships in anticipation of more financial support' Waitress, FGD participant, Hawassa

"..young people mostly have no money to support us. Old men like drivers and government workers have adequate money to offer for a woman and having sex is common with such people" Waitress, IDI participant, Alamata

Although conflicting responses were forwarded by participants, there is a perception by most waitresses that transactional sex could eventually lead to commercial sex. Women's intention to get more money in a short span of time, feelings of hopelessness and considering oneself "not different from a sex worker", influences from peers, being jealous of the money sex workers earn and customers/brokers pressures were implicated among the major reasons for the transition from transactional sex to commercial sex.

"....one of my friends who used to receive large amount of money after having sexual relationship with a rich man, left the job (waitress job) and started sex business (commercial sex work). She has been consistently nagging me to follow her path by telling me that she gets a large amount of money in one night that is almost equivalent to what I get in a month" Waitress, FGD participant, Hawassa

"We know many girls who are waitresses during the day times and sex workers during the nights" Waitress, FGD participant, Hawassa

In contrast, opponents argued that transactional sex is preferable to formal sex work, as this is a "clever" way of increasing ones income without being labeled as a "sex worker" and losing one's dignity. The many challenges and risks that commercial sex workers have to shoulder were reported to be frustration and that sex work is considered the most dangerous job and the last resort by some of the participants. These participants also argued that most women work as waitresses in anticipation of better and permanent jobs, and that sex work is not among the options.

4.2.7. HIV/AIDS risk perception and prevention

HIV risk perception by women as waitresses appears to be high though not universal. The main reasons for the high HIV risk perception among this group were engagement in multiple sexual relationships and low and inconsistent condom use with boyfriends and causal partners. Few participants saw elevated HIV risk associated with their having sex with older men. Some participants on the other hand saw their HIV risk as low.

HIV risk perception among waitresses appears to vary by town. Waitresses in big towns are more likely than those in smaller ones to perceive their risk of HIV acquisition as high. This seems to be linked with the higher partner change and number of concurrent sexual partnerships among waitresses in big towns than in small towns. In contrast, in some of the small towns studied, such women do not consider themselves as having more different or elevated HIV risk than the general population.

Despite their high perception of HIV risk, most waitresses reported to lack self-efficacy in dealing with their risk and vulnerability to HIV and other sexual and reproductive health problems. Poverty and the desire to increase one's earnings was reported as overshadowing their ability to avert risky sexual behaviors. Their work environment, which involved meeting new people everyday coupled with low wage work often led to transactional sex. One of the main features of transactional sex is that girls have little or no control over their sexual behavior and mostly play a passive role in such relationships. The ability to negotiate for safer sex behavior is nearly impossible in transactional relationships.

For most of these women being honest with a sexual partner is considered the most difficult aspect of their relationship. It was repeatedly reported that once these women were into transactional sex, they would fall into the money trap. Repeated pressure and sex demands from customers was reported to be part of the daily life of a waitress. Most often, they fail to resist or endure such temptations, as a result of which faithfulness to one sexual partner becomes difficult if not impossible. Only a few participants of this study believed that one can be honest to a partner and successfully resist such temptations, especially if one has a goal in life.

Condom use with regular boyfriends or causal partners was reported to be low and inconsistent across all the towns. In the first place, these women do not use condoms with their boyfriends, as this is believed to create some distrust and make a lover furious when condom use is proposed. Secondly, older sexual partners reported avoiding condom use, especially in transactional relationships. Older partners mostly consider low HIV risk from young girls. Likewise, some waitresses reported that older and married people are at lower risk for HIV and condom use with such people may not be as necessary. The lack of negotiation skills and self-efficacy in relation to condom use, especially in transactional sex is among the obstacles to condom use. Sex partner's (regular or casual) were reported to deceive and pretend to use condomsduring sex or remove them. Also tearing of condoms during the sex play was reported. Due to their high partner change and unprotected sex behavior some of these women saw themselves as already infected with HIV and that condom was seen as less important. Other reasons that deterred condom use was the inability of these women to buy and carry condoms without fear and embarrassment. A good portion of the participants also held the belief that it is men's responsibility to use or not to use condoms. Selected remarks on condom behavior of waitresses are detailed below.

> *"…..most waitresses do not have the courage to ask their boy friends to use condom. When men force them to have sex without condom, most waitresses can't even cry laud like sex workers….." Waitress, IDI participant, Yirgalem*

> *"….what worries us (waitresses) most is unwanted pregnancy. We use condom to prevent pregnancy and HIV infection. But those women who use Injectables are less care about condoms" Waitress, IDI participant, Injibara*

> *"….if you receive money from a man, it is the man who decides to use or not to use condom. Most men do not like condoms" Waitress, IDI participant, Adama*

4.2.8. Khat and alcohol use

Opinions were diverse and unclear regarding *Khat* chewing habits of these women but one thing seems clear. These women are not free from the habit but frequency of consumption reported was less intense. There is also some indication that theses women use Khat for recreation during weekends and holidays. The use of Shisha was also reported. Alcohol drinking habits during leisure time and with sexual partners was reported although not as common. Waitresses working in bars and sex work establishments reported to be more prone to these habits than those in pastry shops/cafes.

We couldn't explore the role of Khat in condom behavior of these women due to the relatively lower prevalence of Khat use in the group and that most participants were unable to reflect their views on this. On the other hand, the fact that condoms are not used or improperly used after alcohol consumption was reiterated by most of the participants.

4.2.9. Access to information and services

IEC/BCC: Access to HIV/AIDS and related information including STI and reproductive health (RH) specifically meant to address the needs of waitresses was reported to be quite limited or virtually absent across the towns. Nevertheless, most of these women were able to cite places/sources where HIV/AIDS and RH information and services were available in their towns. Health facilities were reported as the major source. Youth-focused information and services by the Family Guidance Association of Ethiopia (FGAE), Marie-Stopes clinics, and the Ethiopian Red Cross Society (ERCS) were reported in some towns. Mass and print medias were also mentioned among the predominant sources.

HCT: There appears to be high awareness of HIV Counseling and testing (HCT) and the places where the services are rendered. Most of the participants know that HCT services are available in hospitals, health centers, private clinics and NGO facilities. Marie-Stopes clinics, the FGAE, and mobile services were also reported in some towns. Health institutions – public or otherwise – were the most preferred places to get HCT services by most of these women participating in our study. They were of the opinion that stand-alone services for youth were less convenient.

Testing for HIV for these women was reported to be difficult for a number of reasons. Fear of positive results, stigma and being alienated if found HIV positive were repeatedly mentioned as the main concerns for not testing for HIV. For some, HCT is not as necessary due to low HIV risk perception. As most of these women were from the low socio-economic class and involved in low wage work, their primary concern was how to get out of the trap of poverty and hopelessness. HIV was not seen as their primary concern, as repeatedly reported by most study participants.

STI treatment and diagnosis: Awareness of STIs was reported as extremely low and most study participants were not aware of the common symptoms of STIs and failed to mention some major STDs. As a result, we couldn't assess further these women's knowledge and awareness of places where the STI services were provided and their perceptions on STI testing and disclosure of STI test results.

4.3. Female daily laborers

4.3.1. Background characteristics

Female daily laborers participating in this study were young – their average age was 19 years old; within the age range of 15-28 years. The majority (67%) were born in rural areas. Three-quarters were never married, the remainder comprised of married or divorced women. Their work duration, as daily laborers, ranged from 1 month to 8 years. About 10% of the participants were illiterate and 30% completed high school. 40% had elementary education and about 20% had 7-8 years of schooling. Daily laborers in small towns had relatively lower educational status.

Most female daily laborers reported to work in construction sites – for roads or buildings. The range of physical work that they were engaged inincluded cobblestone work for road construction, mixing and transporting cement, and moving brick, stone and wood in construction sites. Transporting goods (physically carrying on their backs), washing clothes and preparing cereals and vegetables were among the activities they were often involved in.

4.3.2. Mobility

Changing their type of work or work place was reported to be common among female daily laborers because of a number of reasons. The short-term nature of most of the day labor work was among the primary reasons for this. These women also change workplaces in search of better paying jobs, seeking less labor intensive jobs and due to disagreement with employers/bosses. When there was a shortage of construction materials, mostly cement, in the market their work was often interrupted as a result of which they move to other places in search of jobs. There were also reports that some female daily laborers totally abandoned day labor work to start up small businesses such as local drink selling stalls - *tella, arakie* and selling *Injera*, and small petty trading (*Gulet*).

4.3.3. Engagement in daily labor work and entry route

Female daily laborers saw their job as the only viable option available since most did not have skills and a high level of education to get better jobs. There were also reasons for preferring to work as a daily laborer over other similar low wage work such as house maiden and petty trading. Relatively better work freedom and less harassment was reported to characterize day labor work although it is physically demanding. Better earnings than working as a housemaid was also reported. Some of the participants also saw this work as a transition to better career opportunities and a way to develop skills. The social network amongst peers and people from the same of origin made the day labor work more appealing than other low wage work.

There are different entry routes into day labor work, as reported by participants. Female daily laborers mostly get the job through their network of people from similar ethnic backgrounds and areas of origin. There are also reports of female daily laborers searching for jobs on their own.A typical situation is when daily laborers flock to roadsides every morning where they are picked up, hired on the spot and transported to workplaces.

4.3.4. Income, expenditure and saving

Daily laborers participating in this study reported that their daily rate has increased in recent years because of the tough economic climate. Most still complain that their earnings are not adequate to cover their basic needs. Reports from different towns indicate that female daily laborers get 12-17 Birr per day. Of note, male daily laborers get better rates (~20 birr/day). This is because males are always assigned to more physically demanding activities that females often can't endure. According to the participants in this study, their income is mostly spent on basic needs such as food/clothing, house rent, school fees (some attend night schools), health costs, monthly payments for *Idir* (Burial association) and support to families and children.

Saving money was reported to be very difficult if not impossible mainly because of low wages and the soaring price of living. A few reported small savings through *Ikub,* however.

4.3.5. Gatekeepers

By the female daily laborers' accounts, the following people have positive or negative influences in their daily lives.

Employers/bosses: Employers are seen as having a making or breaking role. Since the day labor work does not involve special skills, it was reported that employers/bosses often do not see daily laborers as useful. There is also this notion that a daily laborer can be replaced easily. As a result the acceptance of bosses is critical for daily laborers to get the job as well as to maintain the job. Fulfilling sexual demand of immediate bosses was also reported. While this is a common pattern, female daily laborers did not deny the fact that some owners are supportive and good mannered.
Female co-workers: Daily laborers depend on their peer network to get jobs and also to get support during times of difficulty and illness. Sharing houses and living in the same quarters was reported to be common among female daily laborers.
Male co-workers: Male daily laborers reported to have mostly positive influence while some were reported to be abusive. Male daily laborers facilitate new jobs, and also help females during the times of difficulty. Some male co-workers were said to assist their female co-workers even during work by lending a hand and helping the females avoid dangerous and physically demanding activities. On the negative side, there were reports of intimidation, sexual harassment and even rape by male daily laborers.
Brokers: Brokers are important to female daily laborers. Finding new jobs and switching to other jobs can be facilitated by brokers. It is said that the relationship between brokers and female daily laborers is often reciprocal, as daily laborers have to pay commissions for the brokers. Sexual relationships with brokers were also reported.
Government offices: There are reports from some towns that the Women's Affairs office is actively helping daily laborers to get jobs and increase awareness of their rights and obligations. IGA support through government offices was also reported.

4.3.6. Sexual behaviors and relationships

On the whole, participants believed that daily laborers were exposed to risky sexual behaviors. Their young age compounded by high mobility and living on their own or in

groups with fellow friends was reported among the major drivers of risky sexual behavior. The nature of the work environment that involves working closely with fellow male daily laborers and other construction workers in isolated sites/places for long hours was reported among the factors leading to casual and unprotected sex. Other factors putting them at risk included: peer pressure; transactional sex; and engaging in sexual relationships in anticipation of love and marriage.

We asked participants to mention their common sexual partners. Male daily laborers, skilled workers at the construction site including carpenters, plumber, painters, cobblestone workers, construction site managers, and supervisors were the major sexual partners reported. Others partners of the female daily laborers included mechanics, petty traders, kiosk owners, brokers and out-of-school youth (non-working).

There are different ways by which the female daily laborers meet their sexual partners. Most reported to form sexual partnerships with fellow male daily laborers in workplaces. Night schools (elementary schools) were reported among places where female daily laborers meet different people including brokers and other low wage workers. Meeting partners through peers and dating in groups was also repeatedly reported. Kiosk owners and male petty traders working in the neighborhood where the female daily laborers reside were also reported to form sexual relationships with these women. Female daily laborers meet these people when buying food and other items. Gangs (non-working) stalk young female daily laborers and most of these relationships are formed without the consent of the women.

Expectations out of relationships may vary from gaining material and financial support from a partner (transactional sex) to true love and marriage. A man's economic potential is often seen as an important factor to be considered a good candidate either for marriage or for transactional relationship.

In general most female daily laborers across the towns can be characterized by risky sexual behaviors and multiple relationships yet there are certain segments of the daily laborers who shy away from such behaviors. This was particularly true for those daily laborers who are non-migrants and work within their community. For these women, if married, dedication to their marriage and family was their number one concern. Some avoid such behavior because it is against their religious beliefs. Others were happy with the money they earned from their work and they did't see any reason to engage in transactional sex. Fear of being infected with HIV/AIDS and STIs was reported among the reasons for not engaging oneself in risky sexual behaviors for some. There are also those female daily laborers who saw themselves as "unattractive" to most men due to the nature of their work.

4.3.7. Cross-generational sex and transactional sex

Cross-generational sex was reported to be less common among the female daily laborers. It was emphasized that this type of relationship can be common among female daily laborers who are involved in transactional relationships. In most instances, it was reported that partners were around the same age or slightly older. Nevertheless, it was also reported that construction supervisors, older skilled workers, and other sex partners of female daily laborers were mostly 40 years or older.

By the female daily laborers accounts, cross-generational sex is not considered as a "strange" or "out-of-the-norm" kind of relationship. Prevailing societal and cultural norms seem to endorse cross-generational relationship, especially if it leads to marriage. For female daily laborers cross-generational sex is a concern only when the man's age is too old, 50-60 years or older. His physical looks also matter. The main reason for having sexual relationships with older partners was to gain cash and material benefits from the relationship. Expectations of marriage and love in such relationships were rarely reported. Intimidation by older employers/bosses and fear of losing her job if she refused sexual demands were among the reasons for engaging in cross-generational sex.

Transactional sex was reported to be common among female daily laborers. It was said to occur within or outside cross-generational relationships. The main reasons for engaging in transactional sex were to compensate for low wages and fulfill subsistence needs, to buy "expensive" cloths and accessories, to get gifts that were not seen as unusual - men are expected to give gifts as an expression of love. Female daily laborers reported that they needed the money to start up new businesses (e.g. local drink selling stalls, *Injera*, and petty trade). The common types of gifts female daily laborers reported to receive from sexual partners included cash, cloths – mostly underwear and bras, accessories and household appliances.

> *"I would like my lover to enable me complete my education and provide good support and happy life" Female Daily laborer, FGD participant, Yirgalem*

Another form of transactional sex included having sex in exchange for job security – i.e. to secure a job/get protection in the work environment (with bosses). Sex in exchange for promises of a new job or promotion was also reported. There were reports of daily laborers engaging in transactional sex with more than one partner. Participants reported that receiving money from sexual partners was "addictive" for some daily laborers and that these women would fall into a money trap.

There was no clear evidence whether transactional sex led to commercial sex among female daily laborers, and suggestions are also conflicting. Some suggested that the high desire for money would eventually lead to commercial sex, while others saw this differently. Since sex work is stigmatizing, such women prefer to have transactional sex without engaging directly in commercial sex. There were also opinions by some that a woman would stop engaging in transactional sex if she found someone to marry.

4.3.8. HIV/AIDS risk perception and risk prevention

HIV risk perception is high but not universal. Most daily laborers saw themselves as having increased risk for HIV while a few did not see their risk as high or different from the general population. Having multiple sexual partnerships, low and inconsistent condom use, "forced" sex or "rape" in the workplace/on-site and having sex under the influence of alcohol(mostly local drinks such as *tella, areke* with a partner) were implicated among the factors that put female daily laborers at risk for HIV. While having sex on-site was reported to be common by both the female and male daily laborers participating in this study, the male daily laborers reported that in most instances the females were willing participants. Both the female and

male participants agreed that most casual sex that happened on-site/at the workplace did not involve condom use.

Although female daily laborers saw their HIV risk as high, it was not their primary concern. There appears a common opinion by daily laborers that their primary concern is poverty and finding good and permanent jobs and that HIV/AIDS is not their main worry.

> *"…..what concerns us most is our daily bread not HIV/AIDS" Female Daily laborer, FGD participant, Axum*

On the whole, condom use by female daily laborers was reported to be low. It was repeatedly reported by participants regarding negligence in condoms use by daily laborers, especially in steady sexual relationships. Inconsistent condom use in transactional sexual relationships has surfaced since it is often the primary decision of the man to use or not use condoms and that women have little control over or lack negotiation power for condom use. Women blamed their lack of control over their sexual behavior, persuasion and deceitful acts of men with condoms as major reasons deterring condom use. Lack of knowledge and embarrassment in buying and carrying condoms and asking the man to use a condom as a female daily laborer were also among the barriers to condom use.

> *"We are easy going and do whatever a man asks us to do especially when he has money…..there is no doubt that most women (female daily laborers) go out without condom" Female Daily laborer, FGD participant, Hawassa*

It was also repeatedly emphasized that daily laborers recently coming from rural areas lacked the knowledge of condoms and were mostly exposed to unprotected sex. Male daily laborers also reported that casual sex in workplaces/sites was mostly performed without condoms due to the absence of condom at the work site.

Female daily laborers participating in this study reported places where condoms could be found including: kiosks, health facilities, pharmacies, etc.. Lack of access to condoms in the workplace was repeatedly reported.

4.3.9. Khat and alcohol use

The prevalence of Khat use among female daily laborers depended on their place of origin and the regularity of Khat behavior in a town. Daily laborers in the north reported to be relatively less used to Khat behavior. Since most female daily laborers came from rural areas where Khat is not known at all or rarely practiced, they are less prone to this behavior. In some towns in the South including Hawassa and Sashemene there were reports of some mild Khat use behavior among the female daily laborers. High Khat consumption was reported among daily laborers in Asayita.

Alcohol use during leisure time and on holidays was reported to be common among female daily laborers. Local drinks such as *Tella and Areke* were used but *Tella* was reported by far as the most common across the study towns. Drinking *Tella* in groups with sexual partners was reported to be common on weekends and during holidays.

"I always drink Tella because it gives me comfort and good mood" Female Daily laborer, FGD participant, Injbara

4.3.10. Access to HIV/AIDS/STI information and services

IEC/BCC: Overall, female daily laborers across towns reported having access to information on HIV/AIDS. Sources included health institutions, radio, print media, and friends. In a few of the towns, workplace HIV/AIDS programs were reported. Access to information reported to varied by town. For instance, daily laborers from Asayita reported to have little or no access to information on HIV/AIDS. In big towns, such as Hawassa, better access to workplace IEC/BCC activities was reported.

Most female laborer participants wanted to see HIV/AIDS and related activities being delivered in their workplaces. They indicated that workplace programs could be delivered during lunch time, outside working hours and leisure time. Most female daily laborers were of the opinion that they preferred to see programs that are designed to fully engage daily laborers as active participants. A high willingness to participate in such types of programs was also reported.

When asked whether the bosses/owners of the companies would permit the participation of female daily laborers in any IEC/BCC activities, most reported affirmatively to the question. However, it was underlined that this is possible only if the activities are to be organized during leisure time, lunch time or outside working hours.

HCT: Most female daily laborers appeared to be aware of the presence of HIV Counseling and Testing (HCT) services mostly in health institutions. In some towns, they reported NGO facilities including Marry Joy and FGAE clients. Mobile HCT services were also reported. HCT services in hospitals and health centers were reported to be the most preferred by female daily laborers because most believed that these facilities provided superior quality services.

The intention to know one's HIV status, especially when having risky sexual behavior and unprotected sex was reported to be difficult for fear of a positive result. Lack of time for testing emerged among the barriers. However, there were situations that encouraged p participants to decide to get tested. Repeated illness and free ART access were reported among the main reasons for people to have HIV testing. Anticipation of food and material support for HIV positives and those on ART were reported to serve as a magnet for HIV testing among those with repeated illnesses.

Responses related to disclosing one's HIV positive test results to a partner were reported as a difficult thing to do. In most instances, these women prefer not to disclose due to fear of stigma, accusation, being beaten or even murdered by partners, fear of losing a partner and the intention to continue sexual activities with their partners. Disclosure was reported to be much more difficult especially when the women were the ones bringing the virus to the family or partner. A few respondents saw the benefits of disclosure especially to prevent further infection and also to have partners benefit from the free ART that was available in public health facilities.

STI diagnosis and treatment: On the whole, this study revealed that knowledge of STIs was extremely low among female daily laborers. Most female daily laborers participating in our study did not know the major symptoms of STIs although it varied by town. Daily laborers in big towns appeared to have relatively better information about STIs although in absolute terms they would be considered as having limited understanding of STIs. These respondents reported health institutions as places where diagnosis and treatment for STIs are available.

STI testing and diagnosis reported to be very rare among daily laborers. In the first place, most lack knowledge of the symptoms. Even when they know about it, stigma prevents most from seeking care in health facilities. It was reported that some female daily laborers held the belief that STIs did not exist in their bodies any longer because they were an old disease and they couldn't still be infected with an STI. Self treatment and getting advice from close friends and using drugs from pharmacies were alternatives to seeking care in health facilities.

With regards to disclosure of STI status to sexual partners, it was reported that this is always difficult for any woman and female daily laborers are not different. Possible reasons included fear of accusation, physical abuse by partners, fear of losing partners, and also stigma.

4.4. Male daily laborers Preliminary Findings

4.4.1. Background characteristics

The male daily laborers participating in this study were 26 years of age on average, ranging from 16-52 years. The majority of the participants (65%) were born in rural areas. Fifty-four percent were married; the remainder were never married or divorced/widowed. The mean duration of work as a daily laborer was reported at 5 years, ranging from 1 month to 15 years. About 35% had primary education (1-6 Graders) and a fifth had completed high school. About a third had 7-9 years of schooling. About 10% reported to be college students.

Construction work such as mixing and supplying cement, carving and delivering stones, supplying bricks, wood and metals were the predominant types of work these daily laborers engaged in. Loading and unloading construction materials and other goods and transporting goods (luggage of travelers, food items for households) were also among the major areas of work for these men. Preparing mud/clay for reinforcing wooden houses and cementing the clay and digging ditches for water pipes and telecommunication cables, digging pit latrines for families and harvesting crops were also reported among labor activities.

4.4.2. Mobility

Amongst the male daily laborers shifting from one type of day labor work to another and also changing the workplace were reported to be common. The temporary nature of the work was the main reason for high mobility. Since the work is physically demanding and very intense it creates fatigue and some daily laborers fail to endure the stressful work environment leading to changing to another type of less physical demanding day labor work. Disagreement with bosses was also among the reasons for changing workplaces. Some left

their workplace to get a better paying job and also to learn new and different skills. Relocation by the owners/bosses, and promotion to other job categories were also included among the reasons for high mobility. Some employers were blamed for not paying daily laborers on time, which often frustrated daily laborers and cause them to leave their workplaces.

4.4.3. Income, expenditure and saving

The male daily laborers participating across the towns unanimously reported this job as the only available option to them, as it requires little or no skill as far as one is physically fit for the job. On top of this, the job is seen as a transition to better jobs where one can learn skills such as carpentry, cobblestone work, and building and road construction skills.

Male daily laborers complained about low wages for a very labor demanding job. Though it varies from one workplace to another, on average their day rate was reported at 20 Birr. According to participants, this low day rate is spent mostly on subsistence such as food, clothing and house rent. Some used the money to also pay their school fees and support their families. The money is also used for recreational purposes such as alcohol (mostly local drinks), Khat and cigarettes including paying for sex. Most reported they couldn't save money because of the low wage work and in fact most complained they were often short of money.

4.4.4. Spending leisure time

Male daily laborers across the towns reported to spend their leisure time in different places. This also varied by town as well as availability of recreation sites. Nevertheless, across the towns included in this study, local drink houses (*Tella/Arakie* houses) repeatedly emerged as the places most preferred by daily laborers to spend their free time. The presence of sex workers in most local drink houses made them more attractive to daily laborers. In fact, daily laborers are among the main clients of sex workers operating in local drink and red light houses, as reported by sex workers participating in this study as well as the male day labor participants. Having Khat in groups in their living quarters was also reported.

Some daily laborers reported avoiding alcohol or Khat during their leisure time and preferred spending their free time in a decent and productive manner. Such daily laborers reported to mostly watch movies and football games (in DSTV houses). Others, few though, said to spend their leisure time washing clothes, bathing and doing other household chores. There were also those busy studying and doing school assignments during their free time. Attending churches ceremonies and visiting relatives/friends were also reported by several participants.

4.4.5. Gatekeepers

Unlike what has been documented for the female daily laborers, the male daily laborers participating in this study saw the influence of other people in their daily lives as less important. Even when they encountered abusive bosses/employers mostly said that they had the willpower to resist and refuse working for such people. It was also reported that male daily laborers had no problem finding jobs in towns as far as they were healthy and

physically strong and that they didn't see any reason to tolerate any outrageous behavior from bosses. They indicated that they always preferred to work for bosses that were considerate and paid salaries on time. In fact, daily laborers relied on their co-workers/peers to find new jobs and to help them in times of difficulty. Sharing living quarters with fellow daily laborers and even living in groups was reported to be common.

4.4.6. Sexual behaviors and relationships

Unequivocally, the vast majority of male daily laborers reported to be sexually active and exposed to risky sexual behavior. Different types of sexual partners included marital or steady partners, sex workers, and non-sex workers. The nature of their work, which often involves high mobility; meeting new women and working closely with fellow female daily laborers were among the reasons for such behavior. There are also opinions by male daily laborers that a lack of trust often shadows permanent and long term relationships with most women. Most female daily laborers were said to be fussy and wanted to form long term relationships or marriages with someone with a better income and status and that male daily laborers couldn't fulfill this demand. Frequently spending leisure time in bars (local drink houses) where sex workers were present in abundance was reported among the main factors for being unfaithful to a partner and engaging in multiple relationships.

> *"There are daily laborers who keep on changing women like their socks" Male Daily laborer, FGD participant, Maichew*
> *"…..even those married daily laborers have sex with different women. What they give (money) to these women is unusually more than what they give to their wives" Male Daily laborer, FGD participant, Maichew*

Paying clients of sex workers: Paid sex with commercial sex workers was reported to be common among male daily laborers. There were also reports that this practice is more common among the unmarried and young daily laborers who visit local drink houses frequently. As discussed above, the most common types of sex workers often visited by male daily laborers are those operating in local drink and in small red light houses. These sex workers are relatively "cheaper" and are there to fulfill the demand for paid sex for people from the low socio-economic class. It was reported that these sex workers charged on average 10 Birr per sexual encounter or sometimes even less. This type of sexual relationship was preferred to escorting girl friends that are very demanding. Sex workers reported to give them pleasure, which helped them get some relief from stressful work. The fact that sex workers are in attendance at the local drink houses makes it easier for daily laborers to enjoy alcohol and sex at the same time in the same place.

> *"Tella and arakie houses are our best places to entertain. You can find sex workers with low process, 10 or 15 birr. You can't fully enjoy your holiday without having sex and drink" Male Daily laborer, IDI participant, Adama*

> *"Most of us (male daily laborers) have sex and Tela or Areke when we receive our weekly payment" Male Daily laborer, IDI participant, Maichew*

Sexual relationship with Non-sex workers (other women): Sexual relationships with casual or steady partners (non sex workers) were also reported to be common among male

daily laborers. Female daily laborers are included in the main group of women with whom male daily laborers have casual or steady sexual relationships. There are also other groups of women that were reported to be common partners to male daily laborers. By daily laborers' accounts, their common sexual partners included female daily laborers, women selling food and other items in market places (in *Gulet*), housemaids, out-of-school youth, and women (married or unmarried) who hire laborers to transport things or work temporarily in their houses.

> *"I myself have sexual relationship with a woman daily laborer. We work together and I love her. I give her some gifts when I get extra money" Male Daily laborer, IDI participant, Mekelle*

> *"We have relationships with jo bless girls and students because these girls usually look for some sort of support" Male Daily laborer, IDI participant, Maichew*

4.4.7. Transactional sex

Sexual relationships of most male daily laborers were reported to involve some form of transaction. Most male daily laborers complained about the change in attitude of their female daily laborer counterparts and other female sexual partners who were becoming more materialistic and expecting cash or gifts from relationships.

> *"You can't have long relationship with women daily laborers because they have sex with different people and always expect gifts" Male Daily laborer, IDI participant, Adama*

There appears to be some common pattern in the type of gifts male daily laborers present to their sexual partners. Underwear emerged as the common gift across the study towns. Buying cosmetics and cloths were also reported. During festivals they buy beef and chicken as holiday presents for their sexual partners. A few reported buying some household appliances and giving direct cash support. This was corroborated by reports from the female daily laborers.

Relationships that involve some transactional component were reported to be short lived. This is mainly because daily laborers cannot afford to sustain such a relationship for very long. Some participants reported that they often provided some kind of support at the start of the relationship, but later the support dwindled. Some women will breakup relationships when the support discontinues. Others will carry on until they find someone who can fulfill their material demands. Others will continue having sexual relationship with a male daily laborer for the sake of love and sexual gratification even if they are no longer gaining anything financially. Sometimes it is the male daily laborer who leaves the woman due to frustration and fear of competing with other men over a demanding woman. The abundance of sex workers that can easily fulfill the sexual demands of male daily laborers and who are relatively "cheaper" means that male daily laborers shouldn't bother themselves with caring for a demanding girlfriend.

4.4.8. HIV/AIDS risk perception and prevention

It should be emphasized that although most male daily laborers participating in this study perceived high HIV risk, infection with HIV was not among their primary concerns. Rather,

daily laborers appeared to be more worried about their poor economic conditions and how to get by day to day. In fact, this attitude was reported to deter them from taking the necessary action to avert their HIV risk.

> *"I have been moving from town to town in search of job and slept with different women in the different towns. I was not very strict in my condom use and it is possible that I am exposed to the disease (HIV)" Male Daily laborer, FGD participant, Adama*

On the whole, condom use with sex workers was reported to be high. It was also indicated that sex workers often insisted on condom use even when daily laborers showed some negligence about it.

> *"Sex workers will not let us to have sex without condom. Some even teach us on how to use condom properly" Male Daily laborer, IDI participant, Adama*

On the contrary, condom use by male daily laborers with non sex workers (steady or casual partners) was reported to be low and inconsistent. Different reasons were suggested for this. The perception that women from rural origins are at low risk for HIV prevents them from using condoms. Some reported to make an HIV risk assessment of sexual partners on their own and women who were healthy-looking and chubby were considered to have low or no risk for HIV and condom use with such women was believed to be less important. Besides, a lack of awareness of HIV in general and condoms in particular emerged among the barriers to condom use among daily laborers of rural origin who recently migrated. Absence of condoms at worksites where casual sex was common and having sex under the influence of alcohol was also reported. There were also reports that some women, especially those using other contraceptive methods, care less about condoms because these women are more concerned about pregnancy than infection with HIV. Fear of carrying or buying condoms was also reported among the barriers to condom use.

> *"A friend of mine told me that a lady with whom he dated did not want to use condom. I warned him not to have sex without condoms. Later we learned that she was HIV positive" Male Daily laborer, FGD participant, Debre Birhan*

4.4.9. Khat and alcohol use

Khat behavior of male daily laborers is dependent on its abundance in the town. In large-sized towns most daily laborers use Khat during lunch time as well as weekends and holidays. In small towns such as Asayita, Khat chewing was reported as almost universal. In most small towns such as Amhara and Tigray, this behavior was reported to be less common, while the use of alcohol by male daily laborers, especially local drinks such as *Tella, Areke,* and *Tej,* was reported to be quite common across the study towns. It was repeatedly reported that alcohol use often leads to high sexual desire and, as a result of which most daily laborers will have sex with sex workers or other partners under the influence of alcohol. When both the man and his partner, a sex worker or otherwise, are drunk, condom use was reported to be difficult and, even when it was used, it was used incorrectly.

4.4.10. Access to information and services

IEC/BCC: Health institutions, radio, print media, and awareness creation activities by some NGOs in the workplaces were reported among the sources of information on HIV/AIDS/STI for daily laborers. Access to such information, however, was reported to vary by town. For instance, daily laborers in Hawassa and Adama complained about the lack of access to information on HIV/AIDS/STIs while those in small towns such as Fenote Selam and Maichew reported better access. In some towns it is not clear if programs are adequate to address the sexual reproductive and related concerns of daily laborers. Taken together, this study revealed that workplace IEC/BCC activities concerning HIV/AIDS and sexual health are limited across the study towns. Daily laborers have the opinion that such programs should be made available and accessible in workplaces. Ensuring the involvement of company owners/bosses and Kebele administrations was also suggested for the success of such programs. In all the towns, male daily laborers expressed their willingness to participate actively in such activities.

HCT: Most participants mentioned hospitals, health centers, private facilities and NGO facilities (in some towns) as places where HCT services are available. There are also reports of mobile HCT services in some towns. When asked their preference of places where HCT services should be provided, hospital and health centers were rated at the top. This was because daily laborers believed that HCT services in these facilities are of high quality and test results are dependable. Test results of mobile HCT services were reported to be less reliable by most daily laborers participating in our study. In fact, this kind of attitude has surfaced in the other population groups included in this study. This perception seems to emerge from the rapid nature of the tests results, which is new to most of the population groups.

Participants indicated that most male daily laborers do not know their HIV status. As discussed elsewhere in this report, fear of positive results and stigma prevents most daily laborers from testing for HIV. Some daily laborers avoid testing as they consider themselves already infected with HIV. Nevertheless, daily laborers reported to test for HIV especially when they were seriously ill and suspected HIV may be responsible for their condition. Peer influence was also reported for leading to testing. The advent of free ART services in public health facilities and the food and material support that is often available for people on ART emerged as the major driver for testing for HIV.

Disclosure of HIV test results to sexual partners was reported to be the most difficult thing to do by most male daily laborers. For most, fear of stigma, accusation, blame and also fear of losing a sexual partner often limited people from sharing their positive test results.

STI diagnosis and treatment: Male daily laborers appeared better informed about STIs than their female counterparts. However, they still have incomplete knowledge about the major symptoms. Knowledge of STIs varies by the age and educational status of daily laborers. Older daily laborers and the better educated appeared better informed about STIs. By daily laborers' accounts, STIs are uncommon among male daily laborers. This should be interpreted with caution because the same daily laborers reported that they wouldn't disclose their STIs to anyone, if infected.

For those who are aware of STIs, health institutions including hospitals and health centers were reported as places where diagnosis and treatment services were available. Traditional medicine for the treatment of STIs was also mentioned.

Lack of adequate knowledge about STIs and their symptoms coupled with fear of stigma and judgmental health workers were reported as the key barriers to seeking care for STIs in health facilities. Self treatment with the drugs available in drug shops and pharmacies without prescriptions was considered the most viable way to treat STIs. Lack of money to pay for the drugs also emerged among the barriers to seeking care for STIs.

4.5. Truckers

4.5.1. Background characteristics

The mean age of truckers was 38 years (range: 23-65) suggesting that most are middle-aged adults. These truckers on average have 8 years of schooling (ranging from grade 1 – College diploma). About a third had completed high school. On the other hand, 27% had only elementary education (1-6 grades). The majority of the participants (78%) reported to be married, followed by never married. Very few (2 individuals) reported to be divorced/widowed. Most truckers (95%) reported their main residence to be in Addis Ababa. On average these truckers served in this job for 12 years (range: 1-40 years). About 11% worked for 4 years or less.

4.5.2. Towns and transportation routes

Truckers who participated in this study reported to prefer towns that had good hotels, bars and restaurants, coffee houses and bedrooms. Other characteristics that make a town appealing to truckers included good weather conditions, good security and peace and where standard spare parts shops are available. Some truckers also reported that they preferred to spend their leisure time in a town where there is Khat and Shisha corners and young women in abundance. The Eastern-Ethio-Djibouti route was reported to be the most preferred because of better salaries there, allowances and access to some contraband business for the truckers. By truckers' accounts, the following towns, by transportation routes, are the most preferred.

- ***North-west route:*** Dejen, Debre Markos, Fnote Selam, Dangla and Bahr Dar, Gonder, and Woreta
- ***Eastern - Ethiopoi-Djibouti route***: Nazareth, Welenchiti, Awash Arba, Metehara, Adayitu, Indafo, Milie, Logiya, Wuha Lmat, and Chifra,
- ***Northern route:*** Shewa Robit, Woldiya, Alamata, Mehoni, Hewani, Mekele, Axum, Shirie, and Humera,
- ***Southern route*** : Dukem, Mojo, Ziway, and Sheshemene

Road side hotels, bars, restaurants, coffee houses, gas stations or tire repair shops, and Khat/Shisha corners are the places where truckers often pass their leisure time when they stop in a town. A few truckers reported to take naps inside their trucks. There are different people that truckers have acquaintances with in a town. Bar/hotel owners are among the

people who have close acquaintances with truckers. Sex workers and waitresses are reported among the people truckers mostly hung out with. In some towns, such as Sashemene, truckers spend their leisure time with owners of Khat/Shisha houses. Tire repairers and mechanics are also among the type of people who have close relationships with truckers.

4.5.3. Sexual experiences and relationships

Multiple sexual partnerships and concurrency was reported to be common among truckers. Participants reported that truckers have sexual relationships with almost all types of women, including sex workers, non-sex workers (casual partners), their girlfriends and wives.

> *".....one of the truck drivers I know never passes a night without sex. The sad thing is this person is married" Trucker, IDI participant, Adama*

Sexual relationships with Sex workers: Visiting sex workers was reported to be common by truckers participating in our study. The nature of the work that involves long absences from home was repeatedly reported as the main reason for having sexual relationships with sex workers. Bars/hotels and sex workers are found in abundance in most of the towns truckers pass by. According to some truckers, visiting sex workers is necessary for a truck driver to relieve tension from stressful work. Truckers are also known for having regular partnerships with sex workers in each and every town they pass by. There are reports of truckers having love affairs with sex workers, which may graduate to steady relationships and even marriage. In such relationships, sex workers reported to benefit substantially from regular cash and material support from truckers.

Sexual relationships with non-CSW (other women): It was also reported that nowadays truckers have better access to young women (non-sex workers) in most towns. It is believed that these young girls have "low" HIV risk and are less demanding and costly than sex workers. As a result of which truckers tend to resort to these women for their sexual desires. Participants said that these young women are now more accessible than ever through Khat/Shish corners and brokers. Some of these women also avail themselves to truckers by wandering around truck halting points, gas stations, and tire repairing sites. Young in-school or out-of-school youth, cashiers/waitresses in bars/hotels, and female mobile merchants especially women who are into the contraband business and often ride with truckers are among the common sexual partners of truckers. Theses truckers mostly meet these women through their town networks and brokers. Truck assistants (often young boys) working in tire repairing places and gas stations, truck/car washers and Khat/Shisha establishment owners are reported to play brokerage roles. There are also reports that these women present themselves and patrol around truck stations and places where truckers hang out in the towns. The sexual relationships with these women are said to be short-lived because truckers are mobile and their schedules are not always set and as a result partner change was reported to be very common. The type of relationships with these women often involve a transactional component. In a short term relationship, truckers reward partners in cash. Long term relationships involves cash and other material support such as grain, charcoal, firewood, sheep, goats and chickens during holidays.

> *"Most of us (truckers) have relationships with young girls in the towns. I myself used to have such relationships before I got married" Trucker, IDI participant, Alamata*

4.5.4. HIV risk perception and prevention

While some truckers saw themselves at risk for HIV others believed they were not different from the general population. The long absence from home and wives, having sex with different women, and inconsistent condom behavior were among the reasons for high risk perception.

Some truckers held the view that HIV is not a problem. The reasons suggested were avoidance of risky sexual behavior, consistent condom use and behavioral change towards safe sex as a result of intensive HIV/AIDS risk reduction programs targeting truckers since the advent of HIV in the country.

> *"I don't worry about HIV for a second. What worries me is the Traffic police; our HIV are traffic polices" Trucker, IDI participant, Fenote Selam*

Condom awareness and its efficacy in preventing HIV infection are universal among truckers. Truckers also reported to be well informed on how to use condoms correctly. Most truckers have good access to condoms and do not have problems in buying or carrying condoms. The sources of condoms for truckers reported were Kiosks, hotels, bars, and pharmacies. There are also places where condoms are distributed for truckers - at truck stops, gas stations, customs offices, tire repair places, and at shipment places.

Participants reported that condom use among truckers was high especially with sex workers though not universal. Inconsistent condom use with non-sex workers also surfaced. Truckers reported to be lenient in their condom behavior with young women who are not sex workers, with sex workers under the influence of alcohol, during casual sex inside the truck with mobile merchants and casual partners who ride with the truckers. Inconsistency in condom use with steady partners and frequently visited sex workers was also reported.

4.5.5. Alcohol and Khat habits

Alcohol use was reported almost universally among truckers. Alcohol was reported to be important in the lives of truckers mostly to relax after stressful days. Alcohol is also said to give good sleep to truckers. It is also a socializing event where truckers meet with fellow truckers, sex workers and other people in town.

The negative influence of alcohol on condom behavior was unanimously reported. When drunk most truckers do not have the ability to use a condom properly. Others insisted to have sex without condom. Condom use was reported to be virtually impossible when both a trucker and his sexual partner (a sex worker/other sexual partner) were drunk. Truckers reported to hang out and consume heavy amounts of alcohol with sexual partners including sex workers and this was repeatedly reported as the major deterrent to condom use.

> *"We always claim we are strict on condoms. But when we are drunk we forget about it and even remove it in the middle of sex" Trucker, FGD participant, Sashemene*

Khat use is common among truckers while driving and in the towns where they spend their leisure time. There are Khat/Shisha corners in most towns where truckers chew in groups as well as with female sexual partners. The reasons for using Khat, as reported by truckers, included to relieve themselves from fatigue and stressful work, to get high and to be in good mood.

Participants emphasized that the Khat habit is in particular more common among younger (20-40 years of age) truckers. The use of a Shisha-Khat combination was also reported to be a common practice among truckers.

We asked participants whether Khat use had any influence on their condom behavior. Responses were conflicting and summarized as follows:

- Khat use causes temporary impotence and reduces one's ability to perform sex. Some people prefer to be alone until the effect of Khat wears off.
- Khat use was reported to increase sexual desire but the lack of an erection was a common effect of Khat. In this situation it is difficult to put on a condom properly, and even when a condom is used, condom slippage can occur. There were also reports of oral sex in order to help penile erection. Truckers who use Khat together with a female sexual partner reported to encounter this problem.
- Khat use can distort ones judgment and there is a possibility that a condom is not used at all or improperly used.
- Drinking alcohol (heavy drinks) after Khat is a common practice in order to ease or break the influence of Khat (Known as *Chebse*). Most truckers reported the synergetic effect of Khat and alcohol use in distorting one's judgment and resulting in improper or lack of condom use.
- Some men do not have erection problems after Khat use. Condoms can be used properly and there is no physical or psychosocial barrier to properly using a condom.

4.5.6. Access to information and services

IEC/BCC: Truckers appear to be well aware of the sources of information and services for HIV/AIDS and related issues. Nevertheless, due to the lack of time and fatigue, most truckers couldn't easily access available information and services in health facilities. Efforts by some NGOs to provide IEC/BCC relevant to HIV/AIDS/STIs and condoms at truck halting points and gas stations were also reported. Condom promotion and distribution efforts for truckers were also reported though blamed for being intermittent. Truckers suggested that they used to have better access to HIV/AIDS information in previous years but recent efforts have been inadequate. Existing programs reported to have limited impact on truckers' behavior due to a lack of focus and the approaches are blamed for being "business as usual".

HCT: Testing for HIV was reported to be difficult for truckers because of a number of reasons. Fear of an HIV positive result was reported as the major barrier to testing for HIV. Lack of time to visit public or private facilities for HCT was also mentioned among the impediments. HCT service in public or private health facilities is not preferred mainly due to the truckers' lack of time and long waiting time.

STI: Interventions (information or services) concerning STIs that target truckers was reported to be very limited. Truckers, however, are well aware of the availability of STI diagnosis and treatment services in public and private health facilities intowns. In some towns, services provided by FGAE were also reported. Truckers unanimously reported that they rarely utilized STI services in these facilities due to their lack of time. Even when they had time to seek care, stigma and fear of confidentiality was reported to deter use.

4.6. Male out-of-school Youth

4.6.1. Socio-demographics

Seventy-four male out-of-school youth (OSY) participated in this study. Their ages ranged from 15-24 years. Almost all were never married. In terms of their educational status, these young boys were comprised of those who completed secondary school (10 or 12 grade), school dropouts, those who have done vocational training but non-working, and very few who have never been to school. Across the towns the number of OSY who completed high school were reported to be on the rise.

In terms of their economic activities, these male OSY can be broadly categorized as non-working/unemployed, working but intermittently in low wage work and the informal sector and working in an organized group. The type of economic activity varies in accordance with existing economic opportunities in the towns. A range of economic engagements were reported encompassing day labor in construction sites, market places, car washing, shoe shining, taxi assistants (*Weyala*), transporting goods (physically carrying or using wheeled carriages), attending some games like Pool, renting out bicycles from hotels/bars, working as broker in bus stations and market places and working as messenger boys for bar and hotel owners.

With micro-credit or support from the government or otherwise, the youth recently began to start up small businesses by being organized in groups. The common activities included garbage disposal, woodwork, brick work and carwashing.

Non-working male OSY reported to spend most of their time idle and were blamed for being involved in robberies and other criminal activities. Several factors were reported to be responsible for these OSY becoming unproductive and failing to contribute their part to society. The following was allegedly reported to influence the poor work ethics of male OSY across the study towns.

- Setting high standards and expectations for themselves, resulting in a more sophisticated job preference and work environment.
- Being dependent on family and relatives resources
- Lack of self motivation and being indolent
- The belief that it is the government's or the community's responsibility to give them jobs
- Indulgence in Khat and alcohol playing negatively against the motivation to work

4.6.2. Spending time

The study clearly identified how the male OSY spend their time across the towns. The vast majority of OSY spend their time, leisure or otherwise, in an unproductive manner that often makes them vulnerable to many social and health problems. A few exceptions reported to spend their time reading, participating in sports and serving as volunteer community workers. For most non-working male OSY the common places to spend time include:

- Chewing Khat in groups in Khat chewing establishments/corners or in their houses
- Watching video films
- Watching football games (in places where DSTV services are available)
- Playing or watching others playing pool and other games
- Hanging out in cafes, pastry shops and local drink houses
- Roaming on the streets and hanging out in groups on corners, in market places, and in parks

4.6.3. Sexual behaviors (initiation of sex, concurrency and casual sex)

Dating, initiation of sex and age at sexual debut: Most participants did not see the difference between dating and having a sexual relationship. There is a general agreement among participants that dating is synonymous with having sex. Dating/having sex was reported to be common among male OSY in the study towns. The age at sexual debut for these youth was reported to be between 18-20 years. It was also reported that female OSY initiate sex at an earlier age than their boy counterparts. A recent declining trend of age at sexual debut was also reported. These male OSY reported to start sex with females of their own age or younger, the reverse was allegedly reported for the female OSY. There is no clear pattern in terms of dating and age at sexual debut by type/size of town.

Reason for having sex: Expectations of sexual gratification and love, peer pressure, mere interest to experience sex, influence of movies that show erotic behaviors, competition among peers, revealing masculinity and the influence of alcohol were all mentionedas reasons for having sex.

Concurrency and casual sex: In general, the practice of concurrent[28] relationships among the boys, though it exists, was not as common in the study towns. There were reports that some male OSY could visit more than one sex worker and at the same time have sex with a girlfriend in a short period of time such as one month or less.

Cross-generational and transactional sex: In general, cross-generational sex is uncommon among male OSY. There are, however, reports that some male OSY engage in such practices. Situations include, sex with older sex workers. Having sex with older women who could fall into temptation with boys was also reported. Some OSY who carry goods in market places and those working as painters and fixing household appliances such as

[28] A sexual relationship is considered concurrent where partnerships overlap in time, either where two or more partnerships continue over the same time period, or where one partnership begins before the other terminates. Often this overlap should exist within a month to be considered concurrent.

plumbing work reported to have engaged in sexual relationships with married or unmarried women who were much older than them. This type of relationship, though less common, involves some transactional component including cash benefits and food. Some male OSY reported feeling macho or mature when they formed this kind of relationship with older women, apart from the material benefits.

4.6.4. HIV/AIDS risk perception and prevention

Male OSY' understanding of ways of HIV transmission and ways of avoiding infection appeared to be universal although variation in the level of comprehensive knowledge dependson their education level. Perception of one's HIV risk was also reported to be common among OSY. Indeed, there was admittance by most of the male OSY of their risk of HIV. Multiple sexual relationships, unprotected sex (inconsistent condom use), substance (Khat, Shisha and Hashish) and alcohol use were repeatedly reported as factors that put OSY at risk for HIV.

According to most respondents, though OSY have a good understanding of their HIV risk and the severity of theAIDS disease, HIV is not the number of one concern to many of them. Rather, most suggested that their main concern was getting jobs, sustaining their lives and enjoying life to the maximum possible.

Abstinence: In general, OSY participating in this study saw sexual abstinence as the most difficult thing to do although a few suggested that abstinence can be possible but requires strong decision-making and self-efficacy. The reasons suggested for this included difficulty in controlling sexual desire due to their young age, peer pressure, joblessness and loss of hope which led to risk taking behavior, in addition to the influence of substances (Khat, Shish, Hashish) and alcohol. Nevertheless, some OSY held the belief that abstinence was possible. There were reports that self-motivated and far-sighted OSY can successfully abstain from sex. Living with God and strictly observing God's words and frequently attending church services can help any person effectively abstain until marriage.

Faithfulness: Faithfulness to one partner was also reported to be difficult for most OSY. Many believe that honesty is more difficult for males than females while some believe that it is equally difficult for both sexes. Reasons for lack of faithfulness reported varied by gender. In males, visiting sex workers was reported as the main reason for being unfaithful. For females, especially those involved in transactional sex, concurrent partnerships and frequent partner change was a way to increase and secure their income in exchange for sex. Suspicion of infidelity in relationships was reported to be common and prevented OSY of both sexes from being faithful without even bothering to know the truth.

Condom use: Condom use with sex workers was reported to be high. This was mainly due to the fact that sex workers insist on condom use. Another reason suggested was that male OSY fear getting HIV from sex workers. There is, however, no parallel HIV risk perception for non-sex workers and condom use is less common with non sex workers. In particular, in steady sexual relationships the tendency to avoid condom use as the relationship matures was repeatedly reported. On the whole, suggested reasons for the lack of condom use with non sex workers revolved around the following:

- A low HIV risk perception from sex with non-sex workers and trusting women they love
- Feeling that condoms reduce sexual gratification
- Being embarrassed to buy and carry condoms
- Inability to use condoms properly
- Having sex under the influence of alcohol
- Lack of money to buy condoms

When asked whose responsibility was to use condoms, participants were split into three groups by their opinion. A good portion of the participants mentioned that both males and females have the responsibility to protect themselves from the risks of HIV/STIs and unwanted pregnancies and thus are responsible for using condoms. Others believe it is the females' responsibility because they are the ones who bear more risks as a result of unprotected sex including unwanted pregnancy and HIV. There were also respondents who believed it was the boys who should take the lead in condom adoption and take the responsibility, as this is improper and often difficult for women.

In terms of access to condoms, participants knew places where condoms could be obtained. Almost all of the participants stated that OSY can obtain condoms from Kiosks, pharmacies, health centers and hotels, but due to fear of being seen buying or collecting condoms most do not keep condoms in their pockets or at home. The lack of condom provision in Khat/Shisha houses, Video/DSTV places and some recreation sites where young men can easily collect them without fear of being embarrassed was emphasized by most male MOSY participating in this study.

4.6.5. Access to information and services

IEC/BCC: Access to IEC/BCC information relevant to HIV/AIDS/STIs and condoms and other sexual reproductive health (RH) of the OSY reported varied by town. In big towns participants reported the presence of ample opportunities for OSY to access information and education concerning HIV/AIDS and RH. Youth clubs, FGAE clinics and information centers, Kebele offices (youth associations) and a number of NGOs were reported to provide information and services in the big towns. In small towns public health facilities were reported as the predominant source. Though limited in scope, NGOs and Kebeles in small towns were also reported to provide information for youth.

Of note, participants reported that there was an absence of peer education programs that are tailor-made to address the needs and concerns of OSY. According to some participants, existing information and services are seen as less informative since they are provided by untrained people. As a result of which, limited receptiveness to the interventions from the side of OSY was also emphasized. For instance, intervention efforts were blamed for failing to address the socio-economic aspects of youth vulnerability. Participants stressed the fact that the vulnerability of youth to HIV/AIDS and other RH problems is the result of the prevailing social and economic reality and lack of support.

HCT: Across the towns, OSY reported to be aware of places where HCT services are available. Public health facilities were reported repeatedly as the main sources of HCT

services. Mobile HCT services were also reported. In some of the towns, youth friendly HCT services within FGAE clinics were also reported. Most participants saw HCT services in public facilities as inconvenient. The main reasons for this included long waiting times, the shortage of health workers, and the fear of being seen by other people visiting the facilities. Since most OSY reported to engage in risky behaviors, they were very suspicious of themselves therefore testing for HIV is often difficult for the group. Most participants prefer mobile HCT services as well as HCT services provided solely for youth.

STI: STI awareness among OSY was considered to be very low. Most do not know the symptoms of STIs. This was reported as a result of the lack of program interventions addressing STIs in the towns. Some participants reported to know that STI service was available in health facilities. For instance, participants in Sashemene singled out the ERCS where STI counseling and testing are delivered.

4.7. People Living with HIV/AIDS (PLHIV)

4.7.1. Socio-demographics and mobility

Information was collected via FGDs and IDIs from 85 PLHIV. Respondents were recruited through their PLHIV associations in the study towns. About 30% of the study participants were home-based care workers (HBCs), 8% worked in the associations' offices including the head of the associations. 11% did not have any job. The remaining 51% represented active members of the associations who were working in different places. The majority of participants, 50 (59.5%), were females. The mean age of the participants on the whole was 35 years. Females were on average 7 years younger than their male counterparts with mean ages of 32 and 39 years, respectively.

Information on the educational status of study participants revealed that 18% couldn't read or write, 30% had elementary education (1-6 graders), 35% had 7-9 years of schooling, 16% had completed high school and only 1% had college education. Overall, 45% of the participants reported to have at least one child.

Eighty-five percent of the PLHIV who participated in our study were born in places other than their current residence. For those coming from other places, the median duration in current residence was 12 years. Reports from participants indicated that most PLHIV were migrants from other urban areas. A few reported to come from rural areas. The main reason for leaving their original residence was fear of stigma and discrimination. Other reasons included leaving their originalresidence in search of better job opportunities, in anticipation of care and support services that are available for PLHIV in big towns, and to use ART in big hospitals without being noticed, among others. In particular, commercial sex workers living with HIV reported to change their place of work quite frequently.

4.7.2. PLHIV associations, social network and support

In order to understand the type and nature of social networks of PLHIV, it is important to make the following distinctions within the group: (1) PLHIV who are members of associations or those on ART (2) PLHIV who disclosed their HIV status to families but not members of associations or are not currently on ART and (3) PLHIV who did not disclose

their HIV status, and those who are neither a member of an association nor taking ART. Since we recruited our study participants through the associations, all respondents to this study were active members of the associations including HBC and office bearers of the associations. ART use was also reported universally among the active members of the associations. Findings on social networks and gatekeepers by this present study are thus relevant to this particular group and do not necessarily reflect the situation in the other groups of PLHIV who are not members of the associations and not using ART.

In general, PLHIV associations and their office premises are places where members meet fellows and friends who are in the same situation. The associations create several opportunities and services for their members. Most importantly, the associations create great opportunities for HIV infected individuals to extend love and care to others who need the same type of support as they do. Provision of group and individual counseling services to members was reported as the main activity of the associations. Members saw such psychosocial interventions as enabling them to cope with the various problems associated with being HIV positive. Care and support services available through the associations were also among their key services. Associations also facilitate jobs, IGA support, trainings, and provide legal support to members. PLHIV associations were also reported to work closely with community-based organizations (e.g. *Idirs*) and religious organizations such as the Ethiopian Orthodox Church, Islamic Affairs, and Mekaneyesus, among others in the provision of care and support activities as well as in IEC/BCC efforts. Home-based care workers and case managers who are themselves living with HIV are active in the community by providing house-to-house services to fellow PLHIV. These individuals often have good relationships with the community, *Idirs* and Kebeles. In the towns this study fielded, governmental and non-governmental organizations were reported to be closely working with PLHIV associations including HAPCO, health institutions, the Ethiopian Red Cross, OSSA, schools, universities, youth and women's associations, DPPA, CRDA, Tesfa Hiwot, WFP, and others.

Though the list is not exhaustive, the following PLHIV associations were reported to be active in the study towns.

- *Menor Tesfa, Hakegnaw Millennium and Ngat*- in Injibara
- *Addis Heiwoe*- in Fnote Selam
- T*wuld Adin*-in Maichew andAxum
- *Wegen Enadn and Mothers to Mothers*- in Alamata
- *Tesfa Goh*- in Debre Brhan, Adama and Hawassa
- *Tila and Msale* -in Hawassa
- *Mahbere Weldi Medihin*- in Mekele
- *Dibora, Arenguwade Raey, Addis Fana* -in Asayita
- *Tesfa Goh, Mekdim, Egna legna*- in Shashemene

Apart from activities through the associations, individual members are also involved in social activities in their community. Participating in *Idirs* and in some community events was repeatedly reported. Nevertheless, most reported fellow association members as their most trusted colleagues and genuine support was reported to come from friends.

4.7.3. Disclosure of HIV status

Disclosure of one's HIV status to spouses, close family members, and friends in general was reported to be uncommon across the towns. Likewise, disclosure of ART use to spouses/families was also reported to be difficult for most people on treatment. The lack of disclosure of ART use is said to lead to low treatment adherence and discontinuance of ART, participants emphasized. Fear of stigma, being blamed, and fear of accusation and violence wereidentified as the major barriers to disclosing one's HIV status.

Disclosure reported varied by gender, age and socio-economic status of the PLHIV. There appeared to be a general agreement among participants that females are more likely than their male counterparts to disclose their HIV status to spouses, family, and friends. Young people reported that they were less likely to disclose their HIV status than their older counterparts. It was also reported that people from the low socio-economic class were more likely than those better off to disclose their HIV status. Less educated people are also more likely than educated ones to disclose their HIV status. Participants saw sex workers, housemaids,women and men working in restaurants (e.g. cook), and those who sell food items as specific population groups who are less likely than others to disclose their HIV status.

The consequence of disclosure of HIV status to a spouse can be severe, especially when a woman breaks the news to her husband. Participants reported their accounts of witnessing violence such as beatings, evicting the woman from the house, threatening to kill her, and attempts of murder. Despite this, women are said to be more open and better in disclosing HIV status to spouses.

> *"My wife left me when I told her that I was HIV positive.....a friend of mine who is also HIV positive is still living with his wife because he did not tell her that he was HIV positive" PLHIV FGD participant, Debre Birhan*

> *"I know this man who died without telling he had the virus (HIV) to his wife" PLHIV FGD participant, Adama*

While this is the general pattern, participants were also of the opinion that disclosure of HIV status to spouses and close family is improving recently. The high numbers of patients accessing ART in the country (via the free ART program) and the decrease in the severity of HIV related morbidities and mortality result in the "normalization of the disease" which is a key factor in facilitating disclosure.

Although a number of barriers deterring disclosure were suggested (e.g. stigma, partner violence, etc), participants in general held positive attitudes towards disclosure of one's HIV status and one's taking ART in front of spouses/families. Most believe disclosure should be promoted and saw it as a responsible thing to do. The major benefits of disclosure suggested by participants included getting family support, care from a partner or close family member and to encourage their partners to test for HIV. Participants also associated the benefit of disclosure with having someone in the family who reminds a patient about the timing of ART and table making (i.e. treatment buddy,) thereby achieving high treatment adherence. A few participants also attempted to associate disclosure with discordance, suggesting that disclosure may prevent possible transmission of the virus in discordant couples.

4.7.4. Discordance in HIV status

Participants appeared to be well aware of the possibility of discordance in HIV status between couples. The noted high awareness of discordance in HIV status by participants of this study should not be overemphasized. This is because we recruited study participants through PLHIV associations who have better exposure to information, counseling and services related to HIV/AIDS. Participants recounted their knowledge of discordant couples and the associated consequences. They also suggested that the prevalence of discordance was not as common.

Based on their experiences and observations, most participants saw the consequences of discordance as severe. Accusations, verbal and physical abuse, divorce and possible homicides were the consequences of discordance. Participants explained that discordance is a sign of infidelity and that most people couldn't tolerate this.

> *"…. a man killed his wife when he knew that she was positive while he was not" PLHIV FGD participant, Debre Birhan*

> *".....my husband was negative but I was positive. I left him because I could not tolerate his hatred and discriminatory actions' PLHIV FGD participant, Adama*

> *"During my pregnancy follow up I was found HIV positive. I told the news to my husband and encouraged him to be tested. His result turned out to be negative. He left me." PLHIV FGD participant, Maichew*

There were also reports that a few couples continue with their marriage and family despite their discordant HIV status. Suggested reasons for this were love, strong faith in God, and the intention to raise children together.

> *"The name of our association 'Menor Tesfa' called after a baby girl born to a couple who have different HIV status - husband positive and wife negative. This couple lives together and gave birth to a baby girl who is known by the name 'Menor Tesfa'. The husband is the organizer and chairperson of this association (Menor Tesfa)" PLHIV IDI participant, Injibara*

> *"I advised my husband to test for HIV soon after I learned that I was positive. Fortunately his result was negative. We are still living together; we use condom strictly" PLHIV FGD participant, Maichew*

4.7.5. Sexual behaviors of PLHIV

This section and the subsequent sections refer to only those PLHIV who know their HIV status. The findings and discussion below may not necessarily reflect the behaviors of the vast majority of PLHIV in the country who are not tested and do not know their HIV status as well as those who are not members of PLHIV associations.

Most PLHIV participating in this study reported that they were sexually active except those who were bedridden and severely ill. It was emphasized by participants that PLHIV who were in the asymptomatic disease stage should not be seen differently in their sexual desire

and behaviors from other population groups. There was also the opinion that with many people using ART in recent years, their health and emotional wellbeing has improved significantly. As a result of which, most have become sexually capable and active after recovering from severe health and psychological problems. Thus, we can postulate that PLHIV who are sexually active is on the rise in the country with an ever increasing number of PLHIV using ART[29], coupled with the recorded significant decline in AIDS related mortality[30] in the country.

In general, participants believed that the prevalence of multiple and concurrent sexual relationships among PLHIV was not different from the pattern seen in other population groups. There are, however, reports of frequent sexual mixing with association members. Partner change and infidelity also surfaced within associations. Men, youth, people who are unmarried, and sex workers were implicated among the PLHIV engaging most frequently in multiple and concurrent sexual relationships.

4.7.6. Condoms: awareness and use

Awareness about condoms: PLHIV participating in this study did not dispute over the importance of condom use in any sexual encounter within or outside a marital relationship. Suggested reasons for condom use included the fear of infection by other types of HIV strains, fear of infection with STIs and to prevent unintended pregnancies.

Of note, participants' knowledge of the possibility of being infected with more than one type of HIV strain and rapid disease progression associated with being infected with multiple strains appeared to be reasonably high. This level of awareness of the disease may not be held in the general PLHIV population who are not members of associations and/or who are not on ART. We suggest this interesting finding should not be overemphasized since association members and those on ART have better access to such information.

It should be emphasized that the PLHIV participating in our study did not report, among the benefits of condoms, an intention to avert possible HIV transmission from them to other people (to the HIV uninfected).

Condom use: Despite the noted reasonably high awareness of the benefits of condoms, most PLHIV reported to be inconsistent in their condom behavior. It was reported that males are more lenient in their condom behaviors while women were said to be strict. Women reported that they were concerned about unintended pregnancies and giving birth to an infected child. Young men were among the group with inconsistent condom use with steady and casual partners. Condom use in marital unions was reported as the most difficult. This is also related to the intention of couples to have children. There was, however, opinions by a few participants that condom use is not as necessary after being HIV positive. There were also a few who believe that condom use reduces sexual gratification. Others, especially Muslims, avoid condoms for religious reasons.

[29] According to HPACO by the end of Sep. 2009, 210,000 have ever started on ART. About 500 health centers and hospitals are currently providing free ART throughout the country

[30] Seyoum E, Mekonnen Y, Kassu A. et al. ART scale up in Ethiopia: successes and challenges. HAPCO. January 2009

'As I am a house to house care and support provider, I usually hear stories that husbands do not want to use condoms" PLHIV FGD participant, Debre Birhan

"Health workers usually advise us to use condom to prevent multiple infection and they also provide us with condoms. Most of us do not use condom and I have never used condoms" PLHIV FGD participant, Sashemene

The participants argued that they were actively involved in educating the public about the benefits of condoms, which they themselves have strong faith in and dedication to consistent condom use.

"A woman divorced her husband because he refused to use condoms. Both were HIV positive" PLHIV FGD participant, Mekelle

Intervention on condom use: A general lack of intensive promotional activities concerning consistent and correct condom use among PLHIV surfaced across the towns. Participants argued that existing intervention efforts by PLHIV was weighed towards care, support and treatment and ART promotion.

4.7.7. Pregnancy and child birth

There is a general intention among PLHIV to have children mostly because they want to see their generation continue. However, responses concerning preferences and the intention to have children were not uniform and varied in accordance with marital status, the number of children alive and individual economic situations. The advent of effective drugs that prevent mother-to-child transmission of HIV and free ART access become the major sources of optimism for PLHIV to have children. There was also a general understanding among PLHIV participating in this study that they had a high chance of giving birth to an HIV negative child with the use of drugs for PMTCT. They also believed that ARTs can make them healthy and productive enough to raise a child.

The fact that reproductive health services are available in hospitals and health centers and that the services are convenient for PLHIV was mentioned by most PLHIV. The views regarding strict follow-up in health institutions when pregnant, and that delivery should take place in health institutions were reported for their successful outcomes. Avoiding breastfeeding for infants was also mentioned by participants to prevent possible MTCT. Some NGOs such as *I-TECH*, *Tuwled Adin* and *Mother to Mother* support groups, OSSA and FGAE were reported to be involved in the provision of information and services on reproductive health to PLHIV across the towns.

"Most HIV positive women are young and want to have at least one child. They want to see their generation continue" PLHIV IDI participant, Alamata

"I have a child who is 2 years old and HIV negative" PLHIV FGD participant, Debre Birhan

"I want to marry because I want to have a child. We have been told that with strict follow up and with the help of drug (PMTCT) we can give birth to uninfected children" PLHIV FGD participant, Adama

V. CONCLUSION AND RECOMMENDATIONS

5.1. Sex workers

Findings suggest that sex workers in the study towns need to be empowered to appreciate and use condoms in all types of sexual relationships. The lack of condom use with non-paying partners, working under the influence of alcohol, anticipating getting more money from clients and because of violent clients is of great concern. Besides, sex workers need to gain greater control over their own health, especially in seeking care for STIs and HCT. Based on the findings of the study, the following recommendations are put forward:

Increase consistent condom use:

Barriers to using condoms are different by type of sexual partner. Sex workers find it most difficult to use condoms with non-paying partners due to their "trusting for love". With paying clients, barriers to condom use include clients' refusal to use condoms, having sex under the influence of alcohol, avoiding condoms for more pay, lack of awareness, belief of low HIV risk from some (e.g. rural) clients, negligence and the use of family planning methods other than condoms.

- The program should increase sex workers' ability to negotiate condom use with all types of clients and these negotiation skills need to be adapted for different circumstances – i.e. with non-paying partners and paying clients.
- Findings of this study revealed that the lack of knowledge and misconceptions are among the barriers to condom use especially among sex workers operating in small establishments (local drink houses and red light houses). Dispelling misconceptions and incorrect perceptions about condom use should be a priority within the intervention.
- Beliefs that clients from rural areas/farmers were "at low risk of HIV" appeared among the common misconceptions that prevent consistent condom use among sex workers with such clients. Program needs to inform sex workers about such misconceptions and risk perceptions.
- This study found contraceptive use (other than condoms) by sex workers among the deterrents to consistent condom use. Promoting the dual purposes of condoms would help improve consistent condom use.
- The program needs to work towards creating a supportive environment for consistent condom use by involving important gatekeepers identified by this study including non-paying partners, establishment owners, and clients. In particular, targeting behavior change efforts on non-paying partners/boyfriends of sex workers is a critical part of tackling inconsistent condom use among sex workers and their sexual partners.

Increase uptake of HCT services:

Seeking HCT by sex workers was reported to be quite low across the towns irrespective of the socio-demographics of sex workers. Fear of HIV positive results and associated stigma prevent sex workers from testing. Most sex workers considered themselves already infected and HIV testing was seen as irrelevant. Other sex workers suggested that they wouldn't want to be tested because they had no plan to abandon sex work. Below are recommendations:

- The program needs to increase sex workers' acceptance of HCT by educating them about the benefits of testing, positive living and ART use if positive.
- Sex workers' perception that "we are already infected with HIV" emerged as a major barrier for HIV testing. The program needs to communicate to sex workers the fact that not all sex workers are HIV positive and that HCT is critical to clear doubts. And, if positive, one should be informed on how to live positively with HIV and access the free ART that is available in public health facilities.
- Most sex workers preferred private facilities for HCT although cost was reported among the potential barriers. Thus, improving access to and quality of HCT services in private facilities and encouraging sex workers to regularly test for HIV is recommended.
- Promote disclosure of HIV status to partners, especially to non-paying partners/boyfriends

Increase uptake of STI services:

STI awareness varies in accordance with the type of sex worker. Sex workers in large-sized towns and those working in bars/hotels appeared to be relatively better informed about STIs including the symptoms, risk perception and places where services are rendered. On the other hand, sex workers in small towns and those working in local drink /red light houses appeared less informed about STIs and places of service. Even when they know the symptoms, most sex workers in small establishments fail to seek care for fear of stigma, shame and harassment by health professionals. Financial problems not allowing them to buy STD drugs was also suggested among the key barriers.

- The program needs to increase sex workers' awareness of STIs including the major symptoms, the link between HIV and STIs, places where services are rendered, re-infection if partners are untreated, among others. While such efforts should target all sex workers, greater attention should be given to sex workers operating in local drink and red light houses.
- Fear of stigma and judgmental health workers were reported among the major barriers to accessing STI services in public health facilities. Health workers should be oriented and well-informed on how to handle and counsel STI patients and maintain confidentiality.
- Most sex workers preferred private facilities for STI diagnosis and testing although service and drug costs were seen among the potential deterrents. The program should work with private facilities on this and find ways to help sex workers access STD drugs with reduced prices.
- Promote STI disclosure and partner referral

Programmatic entry points and cross-cutting issues:

- <u>Audience segmentation:</u>
    - Sex workers operating in bars/hotels and in local drink /red light houses are different in their socio-demographics, awareness, risk perception, condom use and STI awareness. Thus, the program needs to segment sex workers by type of establishment as part of the intervention entry points.
- <u>Intervention approaches:</u>
    - Peer education (structured) – should be intensive and take into account the mobility of sex workers. This study found that on average sex workers stay in

a town for 6 months. They may stay even for a shorter duration in an establishment.
    - Information/education activities – use varying approaches including posters/leaflets/booklets (stories etc)/visuals/video. Of note, most sex workers in local drink/red light houses and small towns cannot read/write/ or have low education. Message development should acknowledge this reality.
    - Beyond HIV/STIs/Condoms – the program should address other social problems of sex workers including self identity, connectedness, and collective efficacy, among others.
- Involve key actors and gatekeepers:
    - The program should involve gatekeepers including owners, non-paying partners, clients, establishments' guards and brokers that are identified by this study as having great influence in the daily lives of sex workers.
    - Health institutions and health workers – private and public
    - Social sector offices
    - Women's affair offices
    - NGOs working with sex workers in the towns
    - Law enforcement bodies, especially the police force and Kebele administration
- Involve sex workers as partners:
    - Sex workers should be actively involved in all program activities as key partners including the development of intervention materials and as peer educators and volunteer outreach workers.

5.2. Waitresses

This is perhaps the first study that attempts to understand the sexual behavior and related problems of females working as waitresses in the country. With stipulation of the limitations of this formative evaluation, findings in this study seem to endorse the widely held belief that these young women are exposed to risky sexual behaviors including multiple sexual partnerships and low condom use. Cross-generational and transactional sex characterize the nature of their sexual relationships. Despite their high perception of HIV risk, most waitresses reported to lack self-efficacy in dealing with their risk and vulnerability to HIV and other sexual and reproductive health problems. Poverty and the desire to increase one's earnings were reported to overshadow their ability to avert risky sexual behaviors. Their work environment, which involves meeting new people everyday coupled with low wage work often leads to transactional sex. One of the main features of transactional sex is that girls have little or no control over their sexual behavior and mostly play a passive role in such relationships. Below are the key recommendations for programming:

Increase awareness about HIV/STI and RH issues

- On the whole, this study found a lack of intervention activities targeting waitresses in the study towns. The program should find ways to reach out to these women through information and services relevant to addressing their risk and vulnerability to HIV/STIs and other sexual/reproductive health problems.

- Multiple and concurrent sexual relationships were reported to be common among waitresses across the towns. This was found more apparent among those waitresses operating in large-sized, vibrant towns and commercial centers. These women should be taught how to assess their personal risks and develop self-efficacy in reducing their number of sexual partners and avoiding concurrency.

Increase awareness of the risk associated with transactional and cross-generational sex

- Transactional sex emerges as the central driver of waitresses' risky sexual behavior and vulnerability to HIV across the study towns. These women should thus be informed of the risk they are in while engaging in transactional relationships. Increasing their ability to negotiate for safer sex, including condom use and their assertiveness in relationships should be a priority within the intervention.
- One of the barriers to condom use in this group is their frequent sexual engagements in cross-generational sex with older people. This study revealed that waitresses are inconsistent in their condom use behaviors with older and married men due to a perception of lower risk from such partners. Likewise, older men saw low risk from young women such as waitresses. On the contrary, cross-generational sex is known to carry the greatest HIV risk for young women. It is therefore imperative that these women are well-informed about the risk they are in while engaging in cross-generational sex and the need to adapt consistent and correct condom use with any partner, including older men.

Increase uptake of HCT services:

Despite awareness of HCT and places where the services are rendered, testing for HIV for these women was reported to be difficult for a number of reasons. Fear of positive results, stigma and being alienated if HIV positive were repeatedly mentioned as the main concerns for not testing for HIV. For some, HCT is not as necessary due to their low HIV risk perception. As most of these women are from the low socio-economic class and involved in low wage work, their primary concern is how to get out of the trap of poverty and hopelessness. HIV is not seen as their primary concern, as repeatedly reported by most study participants.

- The program needs to increase waitresses' acceptance of HCT by educating them about the benefits of testing and dispelling stigma associated with being positive.
- Health institutions – public or otherwise – were the most preferred places to get HCT services by most of the waitresses participating in our study. They were of the opinion that stand alone services for youth are less convenient and stigmatizing. There is a need to strengthen public health facilities to make them appealing to these women to use HCT services without fear of being stigmatized. Referral linkages with public health facilities should be carried out as part of promoting HCT for these women.
- Promote disclosure of HIV status to partners

Increase uptake of STI services:

Awareness of STIs was reported to be extremely low and most waitresses participating in this study were not sufficiently informed of the common symptoms of STIs and were unable to mention some of the major STDs.

- The program needs to increase waitresses' awareness of STIs including the major symptoms, the link between HIV and STIs, places where services are rendered, re-infection if partners are left untreated, among others.
- Fear of stigma and judgmental health workers were reported among the major barriers to accessing STI services in public health facilities. Health workers should be oriented and well-informed on how to handle and counsel STI patients and maintain confidentiality.
- The program should work with public and private facilities, as part of promoting STI diagnosis and treatment among waitresses. Due to low wage work, waitresses may not be able to cover the cost for drugs and therefore, the program should find ways to help these women access STD drugs with a reduced price.
- Promote STI disclosure and partner referral

Cross-cutting issues and suggested program entry pints

- Audience segmentation:
  - The program needs to focus on waitresses in pastry shops/cafes
  - In other establishments (e.g. bars/hotels and sex work establishments) there is an overlap between waitresses and sex workers. Such women need to be accommodated as part of the intervention activities targeting sex workers.
- Intervention approaches:
  - Peer education (structured) – Involve waitresses in the design of peer education activities, material development and as active leaders of peer education activities.
  - Information/education programs – Messages should be tailored to address different groups simultaneously including waitresses, establishment owners/bosses, male waiters and customers. Posters and leaflets can be distributed in workplaces to reach out to different audiences.
  - Go beyond HIV/STIs/Condoms – one of the key concerns of these women is poverty, hopelessness and how to get better career opportunities. The program needs to address these social problems and concerns of waitresses via life skills education, IGA support, increasing self identity, connectedness, and collective efficacy, among others.
- Involve key actors – supportive environment:
  - Involve gatekeepers such as establishment owners, brokers, customers and gangs as part of the intervention efforts
  - Work closely with the women's affairs offices, NGOs working with youth, and law enforcement bodies
- Involve waitresses as partners:
  - Waitresses should be actively involved in all intervention activities as key partners

5.3. Female daily laborers

The female daily laborers we studied were predominantly young, less educated, unmarried and of rural origin who were characterized by high mobility and risky sexual behavior. HIV risk perception was high but not universal among these women. Having multiple sexual

partnerships, low and inconsistent condom use, "forced" sex or "rape" in the workplace/on the site and having sex under the influence of alcohol, mostly local drinks such as *tella, areke* with partners and high mobility were included among the factors that put female daily laborers at risk for HIV. Transactional sex also emerged as the major type of sexual relationship these women were engaging in. On the other hand, these women lack access to information and services concerning HIV/STIs. Based on findings, the following recommendations are put forward for programming.

Increase awareness about HIV/STI and RH issues

- Multiple sexual relationships and frequent change of partners were reported to be common among female daily laborers. These women should be well informed about the risk they are engaging in and on how to assess their personal risks and also help develop self-efficacy in reducing the number of sexual partners and risky sexual behavior.

Address casual and unsafe sex practices:

- Findings of this study indicate that these women are frequently involved in casual sexual relationships with fellow male daily laborers in different circumstances. These include casual sex in the workplace/on site, meeting men through their peer network and in their living quarters as most share living arrangements with fellow female daily laborers, in local drink houses mostly under the influence of alcohol, and in night schools, among others. It is therefore critical that the program addresses such unhealthy sexual norms of the group.

Increase awareness of the risk associated with transactional sex

- Most of these women reported to be involved in transactional sex. The program thus needs to inform women of the risk they are in while engaging in transactional relationships. Increasing their ability to negotiate for safer sex, including condom use and their assertiveness in relationships should be apriority within the intervention.

Increase uptake of HCT services:

Most female daily laborers appeared to be aware of the presence of HCT services mostly in health institutions. The intention to know one's HIV status, especially when having risky sexual behavior and unprotected sex was reported to be difficult for fear of positive results. Lack of time for testing also emerged among the barriers. Most of all, poverty and the unpredictable nature of their work is their primary concern and seeking HCT is not seen as important.

- The program needs to increase female daily laborers' acceptance of HCT by educating them about the benefits of testing and dispelling stigma associated with being positive.
- Lack of time emerged as a barrier for HCT due to the nature of their work. Missing one work day means losing their daily salary. Alternative HCT service delivery models should be solicited that is convenient to the group. It may well be that the program seeks ways to compensate these women for the time lost due to attending HCT services.
- Promote disclosure of HIV status to partners

Increase uptake of STI services:

On the whole, this study revealed that knowledge of STIs is extremely low amongst female daily laborers. Most do not know the major symptoms of STIs although it varied by town. Likewise, STI testing and diagnosis were reported to be very rare among the group. In the first place, most lack the knowledge of the symptoms. Even when they know about it, stigma prevents most from seeking care in health facilities. It was reported that some female daily laborers held the belief that STIs do not exist any longer because it was an old disease and that they couldn't still be infected with the STI. Self treatment, getting advice from close friends and using drugs from pharmacies are alternatives to seeking care in health facilities.

- The program needs to educate female daily laborers with the basics about STIs including the existence of many different types of STIs in the population, the routes of transmission, the consequences and severity, and the fact that they are susceptible to and can be infected by STIs. Major STI symptoms, the link between HIV and STIs, places where services are rendered, re-infection if partners are untreated, among others should also be communicated to these women.
- Fear of stigma and judgmental health workers were reported among the major barriers to accessing STI services in public health facilities. Health workers should be trained and well informed on how to handle and counsel STI patients and maintain confidentiality.
- Due to low wage work, female daily laborers may not be able to cover the cost for drugs and the program should find ways to help these women access STD drugs with a reduced price.
- Promote STI disclosure and partner referral

Cross-cutting issues and suggested program entry points

- <u>Entry points</u>
    - This study found frequent change of workplaces and even types of day labor work by the female daily laborers mainly due to the temporary nature of their work as well as due to recurrent shortages of construction materials. Although most are seen to be involved in construction sites, they most often swing between different workplaces, including construction sites (road/building), market places, flower farms (in some towns), among others based on job availability and better wages. An intervention program thus needs to encompass the different workplaces where the daily laborers are found in abundance for high and effective coverage.
- <u>Intervention approaches:</u>
    - Peer education (structured) – Involve female daily laborers in the design of peer education activities, material development and as active leaders of peer education activities.
    - Information/education programs – Messages should be tailored to address different groups simultaneously including female daily laborers, male daily laborers and owners/bosses. Posters and leaflets can be distributed in workplaces to address different audiences.
    - Go beyond HIV/STIs/Condoms – some of the key concerns of these women are poverty, hopelessness and how to get better career opportunities. The program needs to address these social problems and concerns of daily

laborers via life skills education, IGA support, increasing self identity, connectedness, and collective efficacy, among others.

- Involve key actors – supportive environment:
  - Involve gatekeepers such as construction company owners, male daily laborers, brokers and others as part of the intervention efforts
  - Work closely with the women's affairs offices and NGOs working with daily laborers
- Involve female daily laborers as partners:
  - Female daily laborers should be actively involved in all intervention activities as key partners

5.4. Male daily laborers

Unequivocally, the vast majority of male daily laborers can be considered sexually active and are exposed to risky sexual behaviors. The nature of their work, which often involves high mobility and meeting new women in workplaces were included in the reasons for their involvement in multiple and unsafe sexual relationships. Besides, across the towns this study fielded, the male daily laborers were blamed for being the primary clients of sex workers operating in local drink and red light houses. The limited access to workplace interventions concerning HIV/AIDS and sexual health to the group further exacerbates the problem. Below are key recommendations.

Address casual and unsafe sex practices:

- Multiple sexual relationships with paid and unpaid partners were reported to be common among the male daily laborers. It is imperative that these men are informed about the risk they are engaging in. The program should educate them on how to assess their personal risks and also help develop self-efficacy in reducing the number of sexual partners and dealing with risky sexual behavior.

Increase consistent condom use:

Condom use by male daily laborers, especially with non sex workers (steady or casual partners) was reported to be low and inconsistent. The perception that women from rural origins and those that are healthy-looking and chubby are at low risk for HIV emerged among the barriers to condom use. Lack of awareness of HIV in general and condoms in particular also emerged among the challenges to condom use, especially among daily laborers of rural origin and recent migration. Although condom use with sex workers was reported to be relatively better, there were typical situations in which condoms were not used. Condoms are less used with regular sex work partners and with any sex worker under the influence of alcohol.

- There is a need to increase male daily laborers' awareness of condoms and their benefits. Such efforts should give due emphasis to those male daily laborers who are recent migrants and have low education.
- The program needs to promote condom use among male daily laborers with casual partners and sex workers. There is a need to address the knowledge of barriers and dispel the incorrect beliefs that women of rural origins and those who are healthy-looking and chubby women are not at risk for HIV.

- Address the effect of alcohol on consistent condom use with sex workers and other partners.
- Address low condom use with regular sex work partners
- Make condoms available in workplaces

Increase uptake of HCT services:

This study revealed that most male daily laborers did not know their HIV status. Fear of positive results and stigma prevented most daily laborers from testing for HIV. Some avoid testing as they consider themselves already infected with HIV. Of note, awareness of places where HCT services are rendered was found to be high and the male daily laborers participating in our study preferred public health facilities for HIV testing.

- Program needs to increase male daily laborers' acceptance of HCT by educating them about the benefits of testing, positive living, and ART use if positive.
- The perception by some daily laborers that "I am already infected with HIV" emerged among the deterrents to HIV testing. Such daily laborers should be encouraged to use HCT by increasing their awareness of how HIV is transmitted and not transmitted. The benefits of testing should be communicated as it helps to clear doubts. And, if positive, one should be informed of how to live positively with HIV and access the free ART that is available in public health facilities.
- Most male daily laborers preferred public health facilities for HCT. Thus, the program needs to improve access to and quality of HCT services in public health facilities and establish referral linkages with such facilities.
- Promote disclosure of HIV status to partners

Increase uptake of STI services:

Male daily laborers appeared better informed about STIs than their female counterparts. However, they still have incomplete knowledge about the major symptoms. Knowledge varied by age and educational status of the daily laborers. Older daily laborers and the better educated appeared relatively well informed about STIs. On the whole, lack of adequate knowledge about STIs and their symptoms coupled with fear of stigma and judgmental health workers were reported to limit seeking care for STIs in health facilities. Self treatment with drugs available in the drug shops and pharmacies without prescriptions were considered the most viable alternative to treating STIs. Lack of money to pay for the drugs also emerged among the barriers to seeking care for STIs.

- The program needs to educate male daily laborers with the basics about STIs including the existence of many different types of STIs in the population, the routes of transmission, the consequences and severity, and the fact that they are susceptible to and can be infected by STIs. Major STI symptoms, the link between HIV and STIs, places where services are rendered, re-infection if partners are untreated, among others should also be communicated to these men. Such efforts should give due emphasis to daily laborers who are young, less educated and recent migrants.
- Fear of stigma and judgmental health workers were reported as important challenges to accessing STI services in public health facilities. Health workers should be oriented and well-informed on how to handle and counsel STI patients, and maintain confidentiality.

- The program should work with public and private facilities, as part of promoting STI diagnosis and treatment among these men. Due to their low wage work, male daily laborers may not be able to cover the cost for drugs and the program should find ways to help these men access STD drugs with a reduced price.
- Promote STI disclosure and partner referral

Cross-cutting issues and suggested program entry points

- Entry points
    - This study found frequent change of workplaces and even types of day labor work by male daily laborers were mainly due to the temporary nature of their work as well as due to recurrent shortages of construction materials. Although most are seen to be involved in construction sites, they often swing between different workplaces, including construction sites (road/building), market places, flower farms (in some towns), among others based on job availability and better wages. An intervention program thus needs to encompass the different workplaces where the daily laborers are found in abundance for high and effective coverage.
- Intervention approaches:
    - Peer education (structured) – Involve male daily laborers in the design of peer education activities, material development and as active leaders of peer education activities.
    - Information/education programs – Messages should be tailored to address different groups simultaneously including male daily laborers, female daily laborers and owners/bosses. Posters and leaflets can be distributed in workplaces to address different audiences.
    - Go beyond HIV/STIs/Condoms – some of the key concerns of these men are poverty, hopelessness and how to get better career opportunities. The program needs to address these social problems and concerns of daily laborers via life skills education, increasing self identity, connectedness and collective efficacy, among others.
- Involve key actors – supportive environment:
    - Involve gatekeepers such as construction company owners, female daily laborers, brokers as part of the intervention efforts
- Involve male daily laborers as partners:
    - Male daily laborers should be actively involved in all intervention activities as key partners

5.5. Truckers

This formative research confirms previous findings that truckers are among the most at-risk population for HIV in Ethiopia. Due to the nature of their work, truckers spend a significant amount of their time away from their homes, families and wives, resulting in higher numbers of sexual encounters with commercial sex workers and casual partners. This study in particular revealed that was an emerging sexual mixing pattern between truckers and young girls (non-sex workers) in most of the towns this study fielded. In fact, young women have recently been more accessible than ever to truckers through *Khat/Shish* corners, brokers and in some instances these girls stalk truckers in gas stations, truck halting points, tire repair

sites, and other places that are frequented by truckers in the towns. Of particular concern to the prevention of HIV and STIs, most truckers reported to be lenient about their condom behavior with these young girls. Below are the recommendations:

Increase consistent condom use:

- The program needs to promote condom use among truckers with casual partners and sex workers. In particular, the program needs to inform truckers of how to adopt condomuse in every casual sex encounter with non-sex worker partners.
- One of the deterrents to condom use with young girls by truckers was the "low" HIV risk perception from these girls. The program should dispel this incorrect belief about HIV risk.
- Address the effect of alcohol in consistent and correct condom use with sex workers and other partners.
- Condom promotion and distribution activities should be intensified in dry ports, customs offices, gas stations, tire repair sites, and hotels/bars/restaurants/cafes frequented by truckers and Khat/Shisha corners.

Increase uptake of HCT services:

Testing for HIV was reported to be difficult for truckers because of a number of reasons. Fear of an HIV positive result was reported as the major barrier to testing for HIV. Lack of time to visit public or private facilities for HCT was also mentioned among the barriers. HCT services in public or private health facilities are less preferred mainly due to lack of time of truckers and long waiting times. Truckers suggested that HCT services should be made available in specific spots and sites of major towns that are convenient to them.

- The program needs to increase truckers' acceptance of HCT by educating them about the benefits of testing, positive living, and ART use if positive.
- There is a need to make HCT services available in the vicinity of customs offices, main dry ports and near petrol stations. This can be organized as an outreach program in partnership with public and private health facilities.
- Promote disclosure of HIV status to regular partners

Increase uptake of STI services:

Intervention (information or service) concerning STIs targeting truckers was reported to be very limited. Truckers, however, are well aware of the availability of STI diagnosis and treatment services in public and private health facilities of the towns. Truckers unanimously reported that they rarely utilized STI services in these facilities due to lack of time. Even when they had time to seek care, stigma and fear of confidentiality were reported to deter use.

- Fear of stigma and judgmental health workers were reported among the major barriers to accessing STI services in public health facilities. Health workers should be oriented and well-informed on how to handle and counsel STI patients, and maintain confidentiality.
- STI services need to be available in the vicinity of customs offices, main dry ports and near petrol stations. This can be organized as an outreach program in partnership with public and private health facilities. The possibility of integrating HCT and STI services should be provided.

- Promote STI disclosure and partner referral

Cross-cutting issues and suggested program entry pints

- Entry points
  - Interventions for truckers should be prioritized in key areas where truckers spend a majority of their leisure or rest time, specifically in the following towns – i.e. *(Northwest route)→ Dejen, Debre Markos, Fnote Selam, Dangla, Bahr Dar, Gonder, and Woreta. (Eastern-Ethio-Djibouti route) →Nazareth, Welenchiti, Awash Arba, Metehara, Adayitu, Indafo, Milie, Logiya, Wuha Lmat, and Chifra. (Northern route) → Shewa Robit, Woldiya, Alamata, Mehoni, Hewani, Mekele, Axum, Shirie, and Humera. (Southern route) → Dukem, Mojo, Ziway, and Sheshemene*
  - The specific spots/sites for reaching out to truckers include custom offices, gas stations, tire repair sites, hotels/bars/restaurants/cafes frequented by truckers, Khat/Shisha corners and dry ports.
- Intervention approaches:
  - Peer education (structured) – Involve truckers in the design of peer education activities, material development and as active leaders of peer education activities.
  - Information/education and condom distribution activities – HIV/AIDS messages and condom distribution can target different groups simultaneously including truckers, their assistants, people working in gas stations, tire repairers and those working in customs offices. Messages can be recorded on tapes, can be prepared in the form of leaflets, manuals, etc and distributed in the specific spots indicated above.
  - Intervention approaches should be innovative and participatory, as suggested by truckers' participating in this study. Such activities can be delivered to truckers as part of entertaining sessions and Q&A.
- Involve key actors – supportive environment:
  - Involve gatekeepers such as truck companies, customs offices, gas stations, tire repair places, bars/hotels/cafes most frequented by truckers, among others.
- Involve truckers as key partners:
  - Truckers should be actively involved in all intervention activities as key partners

5.6. Out-of-school youth

The findings documented by this study for OSY are not easily interpretable due to the difficulty in clearly delineating OSY by their work status and activities. Initially we envisaged studying OSY that were non-working but later on during data collection we discovered that most OSY, though occasionally, are engaged in low wage work. There were also overlaps between OSY and the other population groups included in this study such as waitresses and male and female daily laborers. Furthermore, the vast majority of OSY participating in our study turned out to be males (74 out of 84) because, by design, we recruited our study participants from recreation places, roadside corners, DSTV places, Khat/Shisha houses,

parks and the like that are more frequented by males. As a result, the findings are more pertinent to male OSY.

The male OSY we studied were not easily reachable for any organized intervention efforts because they are not readily associated with distinct places or establishments. These OSY were also reported to be occasionally engaging themselves in diverse economic activities[31].

In conclusion, we suggest that the TransACTION program may need to evaluate the practicality and relevance of targeting OSY in its program intervention and come up with a more lucid youth group that is reachable and convenient.

5.7. People living with HIV/AIDS

The part of this assessment on PLHIV mainly concerned disclosure of HIV status, discordance and sexual behaviors of PLHIV. We recruited PLHIV to participate in this study through the associations of PLHIV in study towns and all participants were active members of these associations. Some even served as home-based care workers, while a few others were office bearers of the associations. ART use among participants was reported to be universal. Findings from this group should thus be interpreted with caution, as it is relevant to this particular group and does not necessarily reflect the situation of people in the general PLHIV population who are not members of these associations.

Below are key findings and recommendations that revolve around disclosure, discordance and the sexual behavior of PLHIV.

Promote disclosure of HIV status

With the caveat of the limitations, findings revealed a lack of disclosure of one's HIV status to spouses, close family members and friends by most PLHIV. Likewise, disclosure of ART use to spouses/families was also reported to be difficult for most PLHIV on treatment. Disclosure was reported in particular to be the most difficult among youth, better educated, those from a better socio-economic class, sex workers, housemaids, women and men working in restaurants (e.g. cook), and those who sell food items.

- The program should increase PLHIV' and communities' awareness of the benefits of disclosure of HIV test results to spouses and close family members.
- Disclosure counseling of PLHIV should be a priority within the intervention. Health workers should be appropriately oriented to encourage disclosure.
- Disclosure counseling should give due attention to youth, men and better educated PLHIV who in particular have difficulty disclosing their HIV status.

[31] A range of intermittent economic engagements encompassing daily labor in construction sites, market places, car washing, shoe shining, taxi assistants (*Weyala*), transporting goods (physically carrying or using wheeled carriages), attending some games like Pool, renting bicycle in hotels/bars, work as broker in bus stations and market places and working as messenger boys for bar and hotel owners were reported.

Address the needs and concerns of discordant couples

Based on their experience and observations, most participants saw the consequences of discordance in HIV status either in marital or steady relationships as severe. Accusations, verbal and physical abuse, divorce and possible homicides were included among the consequences of discordance. Participants also saw discordance as a sign of infidelity and that most people find it difficult to endure.

- The program should be able to address the special needs and concerns of discordant couples. Health education, information on healthy living and HIV testing should be directed at couples. It is also critical that health workers, counselors and those service providers working with PLHIV are properly orientated about the needs of couples in the context of discordance. They should also be trained on couple counseling.
- Appropriate discordant couple counseling guidelines should be developed and implemented.
- The program should provide continuing information and counseling on safer sex behaviors with emphasis on correcting consistent condom use and any other alternative low-risk sexual practices for discordant couples.
- There is a need to involve discordant couples as part of the response in promoting healthy living among discordant couples.
- Address stigma and discrimination surrounding discordance at the community level. At the couple's level, it is central to address their psycho-social needs through continuing counseling and support services.

Address risky sexual behaviors and increase consistent condom use

Multiple sexual partnerships and frequent sexual mixing within PLHIV associations were reported to be common by PLHIV participating in our study. Partner change and infidelity also surfaced within association members' reports. Men, youth, unmarried people and sex workers PLHIV were included amongst those engaging most in such risky behavior. There were also opinions of participants that with many people using ART in recent years, their health and emotional wellbeing have improved significantly, which led to an increase of PLHIV who are sexually active in the country. Thus, prevention of the further spread of HIV in the general population and possible infection with multiple strains among PLHIV are among the major challenges in the current response to the HIV/AIDS epidemic.

Interestingly, most PLHIV participating in this study did not dispute the importance of condom use in any sexual encounter within or outside marital relationships. Suggested reasons for condom use included fear of infection by other types of HIV strains, fear of infection with STIs and to prevent unintended pregnancies. Despite these, however, most PLHIV reported to be less consistent in their condom behavior. Males and young PLHIV were reported to be more lenient in their condom behavior. Condom use within marital unions was also reported to be the most difficult to adopt especially in sero-concordant couples.

- The program should devise a risk reduction strategy for PLHIV including partner reduction, avoidance of casual sex and adoption of condoms. PLHIV should also be informed and encouraged to be responsible and contribute their part in halting the further spread of HIV in their community by avoiding risky sexual behavior.

- Condom use should be promoted in all types of sexual relationships including within marital and steady relationships
- Behavior change activities should give emphasis to men, youth, unmarried people, sex workers and PLHIV who are believed to be excessively engaged in multiple sexual relationships and also are less careful in their condom behavior.

Address the sexual reproductive needs of PLHIV

There is a general intention by PLHIV to have children mostly because they want to see their generation continue. The advent of effective drugs that prevent mother-to-child transmission of HIV and free ART access become the major sources of motivation for PLHIV to have children.

- The program should respect the reproductive rights and fertility preferences of PLHIV
- There is a need to provide information and counseling to PLHIV about their reproductive rights with emphasis on fertility intentions and choices. PLHIV should be given complete and correct information on pregnancy planning. Such counseling efforts should be tailored to address the reproductive needs of sero-concordant and discordant couples.
- The program should promote condoms as a dual protection method
- For those couples who choose to have children, comprehensive PMTCT services and follow up should be provided
- Prevention of STIs and partner referral should also be emphasized along with the other major aspects of addressing the sexual/reproductive needs of PLHIV

Cross-cutting interventions and suggested program entry pints

- <u>Audience segmentation:</u>
    - PLHIV who are active members of PLHIV associations – this group can be reached via their associations
    - PLHIV who are not members of the PLHIV associations - this group can be reached via health facilities, if on ART or enrolled in the pre-ART. If not on ART, they can be accessed through home-based care workers, CBOs/NGOs working on care and support and Kebele administrations.

- <u>Intervention approaches:</u>
    - Peer education / support group activities - to address all aspects of sexual and reproductive health of PLHIV including disclosure, discordance, sexual behavior, and condoms, among others.
    - Information/education to PLHIV – behavior change activities should focus on disclosure, discordance, condoms, sexual behavior, STIs, and reproductive health
    - Couple counseling – a guideline for disclosure and discordant couple counseling needs to be developed. PLHIV, health institutions, counselors, and PLHIV associations should be involved as part of this effort.
    - Referral and linkages with health facilities – create a strong and workable referral linkage with RH services, PMTCT, ART, and care and support services.

- Life skills education and IGA support – PLHIV' greater concerns, apart from their health, include poverty, hopelessness, lack of support and how to get better career opportunities, among others. The program needs to address these important social problems and concerns of the PLHIV via life skills education, IGA support, promoting healthy lives, increasing self-identity, connectedness, group cohesiveness and collective efficacy.

- Involve key actors – supportive environment:
  - Involve gatekeepers such as PLHIV associations, health institutions, health workers, home based care workers, and CBOs/NGOs working with PLHIV.

- Involve PLHIV as key partners:
  - PLHIV should be actively involved in all intervention activities as key partners, including peer education, support groups, discordant couple counseling and promotion of disclosure, risk reduction and condom promotion activities.

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