Indira Gandhi National Open University School of Social Work

Assessment of Service Provision of Transaction- Prevention and Care Services for Most at Risk Populations Project: The case of Integrated Services for AIDS Prevention and Support Organization and Pro Pride (Local NGOs)

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Assessment of Service Provision of Transaction- Prevention and Care services for Most at Risk Populations Project: The case of Integrated Services for AIDS Prevention and Support Organization and Pro Pride (Local NGOs)

A Thesis Submitted to Social Work of Indira Gandhi National Open University in Partial Fulfillment of the Requirements for the Degree of Masters of Social Work (MSW)

By

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Advisor: Ato Ephraim Mebrate (MA in Social Work)

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Certificate

This is to certify that Mr. Ermias Bekele Mojo , Student of MSW from Indira Ghandi National Open University (IGNOU), New Delhi was working Under my supervision and Guidance for his project work for the course MSWP_001. His project work, Entitled “Assessment of Service Provision of TransACTION- Prevention and Care Services for Most at Risk Populations Project: The case of Integrated Services for AIDS Prevention and Support Organization and Pro Pride (Local NGOs)” which he is submitting is genuine and original work.

Place- Addis-Ababa

Date- November 2013

Name: _____

Signature: _____

Address of Supervisor- Addis-Ababa

Declaration

I hereby declare that the dissertation Entitled "Assessment of Service Provision of TransACTION-Prevention and Care Services for Most at Risk Populations Project: The case of Integrated Services for AIDS Prevention and Support Organization and Pro Pride (Local NGOs)" Submitted by me for the partial fulfillment of MSW to Indira Ghandi National Open University (IGNOU), New Delhi, is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for fulfillment of the requirement of other program study.

I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or other.

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List of Acronyms

ABC -Abstinence, Be faithful, Condom use
AIDS -Acquired Immune Deficiency Syndrome
ANC -Antenatal Care
ART -Anti-Retroviral Treatment
BCC- Behavior Change Communication
CBO -Community Based Organization
CC - Community Conversation
CDC -Center for Diseases Control and Prevention
CHW- Community Health Workers
CSW -Commercial Sex Worker
DHS -Demographic and Health Surveys
E.C. -Ethiopian Calendar
EFHAPCO- Ethiopian Federal HIV AIDS Prevention and Control Office
EDHS -Ethiopian Demographic Health Survey
FBOs -Faith Based Organizations
FHAPCO -Federal HIV AIDS Prevention and Control Office
FP -Family Planning
FSW -Female Sex Worker
GBV -Gender Based Violence
MARPS and Vulnerable Groups-Sex Workers Mobile workers In School Youth (15-24 years) Uniformed services Inmates (prisoners)
HCT -HIV Counseling and Testing
HEWs- Health Extension Workers
HIV- Human Immunodeficiency Virus
HSV -Herpes simplex Virus
IDU- Injecting Drug User
IEC- Information Education Communication
IP- Infection Prevention
IPC-Information Prevention Center
ISAPSO-Integrated Services for AIDS Prevention & Support Organization
MARPs -Most At Risk Populations
M & E -Monitoring and Evaluation
MDG -Millennium Development Goal
MIS -Management Information System
MOH -Ministry of Health
MSM -Men who Have Sex with Men
MW -Mobile Worker
NGO -Non-Governmental Organization

PEP -Post Exposure Prophylaxis
PIHCT -Provider Initiated HIV Counseling and Testing
PLHIV- People Living with HIV
PMTCT -Prevention of Mother to Child Transmission
PHDP -Positive Health, Dignity and Prevention
RH -Reproductive Health
RHAPCO -Regional HIV AIDS Prevention and Control Office
SNNPR -Southern Nations, Nationalities and People's Region
SRH -Sexual Reproductive Health
STI -Sexually Transmitted Infection

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CHAPTER ONE: INTERODUCTION

1.1. Background of the Study

HIV and AIDS have a devastating impact on people in developing countries and inevitably, the epidemic has been affecting many of the programs of the country and the respective outcomes. It is important to recognize HIV/AIDS not only as a health related issue but also as a problem that has significant impact on social and economic conditions of a given country (UNAIDS World Aids Day Report 2011)

The world has been grappling with HIV/AIDS pandemic for almost three decades now. Dozens of countries are already in the grip of serious HIV/AIDS epidemic and many more are on the brink of losing their productive force (MacQuarrie et al., 2009). HIV/AIDS marks a sever crisis in sub Saharan Africa, which remains by far the worst affected region in the world (UNAIDS, 2010).

More than 34 million people now live with HIV/AIDS; 3.3 million of them are under the age of 15. In 2011, an estimated 2.5 million people were newly infected with HIV of which 330,000 were under the age of 15.Every day nearly 7,000 people contract HIV—nearly 300 every hour. In 2011, 1.7 million people died from AIDS; 230,000 of them were under the age of 15. Since the beginning of the epidemic, more than 60 million people have contracted HIV and nearly 30 million have died of HIV-related causes. (UNAIDS World AIDS Day Report 2012; UNAIDS Fact Sheet 2012).

It is estimated that close to 40 million people are currently living with HIV/AIDS infection (WHO, 2011). About 8,000 people die everyday and tense of millions more are under threat of this pandemic. The number of infected individuals keeps growing (MoH, 2010). The African continent is the most affected with about 70% of the world's HIV-positive population living on this continent. In Africa alone, over 29 million people are infected and over 20 million people have died since 1984 (Brown et.al, 2007).

With an estimated 1.2 million people living with AIDS/, Ethiopia has the largest populations of HIV infected people in the world (WHO, 2011). However, HIV prevalence among the adult population is lower than many sub Saharan African countries (UNAIDS, 2010).

According to the single point estimate in Ethiopia, the national adult HIV prevalence was estimated to be 2.4% in 2010. With over 1.2 million people living with HIV, Ethiopia carries one of the largest HIV disease burdens in the world. While the epidemic is generalized, available data reveals marked heterogeneity across different sub groups of the population, residence and region. In 2010, HIV prevalence was estimated to be 2.9% among females and 1.9% among males. Similar differentials by sex were found across all regions as well as urban and rural areas. (Federal HAPCO MARPs guideline, page 2, September 2011)

The strongest contrasts were found between urban and rural areas. Urban HIV prevalence was estimated to be 7.7% in 2010, compared to 0.9% rural HIV prevalence. Urban areas accounted for 16% of the total population but 62% of total people are living with HIV (PLHIV) in the country. Strong regional differences were also observed in both urban and rural areas. Urban HIV prevalence ranged from 2.3% in Somali region to 11% in Afar region, with substantial variation between the larger regions as well (Oromia 6.1%, SNNP 6.9%, Amahara 9.8%, and Tigray 10.9% (Federal HAPCO MARPs guideline, page 2, September 2011)

Similarly, rural HIV prevalence ranged from 0.4% in Somali region to 1.4% in Amhara region. Small towns were becoming hotspots with potential to spread the epidemic further into rural settings. Addis Ababa and four regions -Amhara, Tigray, Oromia, and SNNPR - account for 93.4% of the total PLWHA population in the country. Such marked demographic and geographic contrasts in exposure to HIV clearly points to the need for HIV prevention interventions to be targeted and tailored to a wide range of different contexts within the same country. (Federal HAPCO MARPs guideline, page 2, September 2011)

The strategic plan for intensifying multispectral HIV and AIDS response in Ethiopia II (SPM II) identifies female sex workers, long distance drivers, never-married sexually active females, discordant couples, migrant laborers, migrant groups (especially those in small towns), cross border populations and in-school youth (particularly at tertiary education) as most at-risk populations (MARPs) for HIV infection. However, ability to accurately measure epidemic spread to these groups and their potential role in passing infection on to others has been limited by gaps in available data. For example, information about men who have sex with men (MSM) is only known from small-scale qualitative studies, while systematic data is not available for injecting drug users (IDUs). Even among more established MARPs, much remains to be learned about risk behaviors and prevention responses to HIV. A patchwork of studies and anecdotal evidence indicate that low levels of comprehensive knowledge, perceived risk and threat of HIV and AIDS, increased population migration, high prevalence of unprotected sex, concurrent multiple partnerships, intergenerational and transactional sex, sexually transmitted infections (STIs), alcohol abuse and khat chewing, gender inequality and poverty may all fuel the epidemic in Ethiopia. (Federal HAPCO MARPs guideline, page 3-4, September 2011)

A particular challenge for prevention strategies have been the emergence of “hotspots” as an unintended byproduct of accelerated development schemes. Examples of these “hotspots” include large-scale commercial farms, infrastructure developments (such as road construction sites), hydroelectric power stations, factories, trade routes and new industrial zones. These “hotspots” attract mobile groups, money, and opportunities for sex trade –the key ingredients known to foster epidemic spread. National HIV Prevention Response and Challenges Key Interventions already in place or scaling up rapidly as part of the national HIV prevention response include community conversation (CC), HIV Counseling and Testing (HCT), prevention of mother-to-child-transmission (PMTCT), infection prevention (IP), post-exposure prophylaxis (PEP), condoms promotion and distribution, sexually transmitted infections (STI) prevention and control, provision of anti-retroviral treatment (ART), VCT and IGA for PLWHA.

Individual access to information and services supporting risk reduction and behavior change has all grown dramatically, but challenges remain. These include inconsistency of messages, failure to adequately contextualize HIV Prevention Package, MARPS and Vulnerable Groups-Sex Workers,

Mobile Workers in School Youth (15-24 years), uniformed services, Inmates (prisoners) behavior change and communication (BCC) materials, weak linkages between messages and services and uncoordinated approaches between different implementing partners. Other HIV prevention services may be too limited in scale to be effective, inaccessible to their intended audiences or inadequate in terms of scope of services and linkages between them. Mapping prevention activities and documenting behavioral outcomes remain core activities for a responsive MARPs HIV prevention programming at regional and district levels. The need to strengthen the sense of shared ownership over prevention agendas between the public, private and community sectors is also recognized. Without ownership, HIV prevention efforts will struggle to reach the scale, effectiveness and sustainability needed to curb the epidemic. (Federal HAPCO MARPs guideline, page 4, September 2011)

Despite the fact that MARP groups have been recognized in principle as primary targets for prevention outreach, existing targeted services remain limited in scale and intensity. Inadequate coordination among partners and lack of a standard package that can guide the design and implementation of combination HIV prevention services tailored to the needs of these groups of people has been identified as a gap in need of urgent attention. (EFHAPCO, 2010).

Implementing HIV prevention programs for MARPs and vulnerable groups requires understanding specific epidemic conditions and tailoring preventive strategies appropriate for the context in which programs are rolled out. Well thought-out action plans, implementation modalities, and a well coordinated and integrated effort by all implementing partners involved in HIV prevention is needed at all levels.

Currently, a wide range of partners in varying numbers are involved at national, regional and community levels supporting the implementation of HIV prevention efforts. However, lack of strong coordination efforts combined with lack of timely data have contributed to less efficient and less effective HIV programming targeted to most at risk and vulnerable groups.

The following are key essential steps required for establishing a targeted HIV prevention program of MARPs and vulnerable groups. Conduct mapping and need assessment: estimate the size of the population, asses needs, understand the risks and vulnerability factors, map existing partners working with the group and types of services provided, review the enabling environment (policies,

programs, guidelines, etc) Planning: set program goals, objectives and key outcomes; estimate the resource requirements (human and financial) of the interventions, involve all stakeholders. Capacity building: provide technical assistance and conduct capacity building workshops and trainings on HIV prevention program design, implementation and evaluation to program implementers and coordinators. Intervention package: based on evidence and the local context define the minimum intervention package for the specific targeted group. Monitoring and evaluation: follow up of activities and timely feedback are essential to continually guide and/or redirect the inputs and the overall direction of the program to reach program goals. (Federal HAPCO 2010)

Working with MARPs and Vulnerable groups needs special consideration of certain fundamental issues while designing and implementing HIV interventions. Combination prevention: not relying on any single intervention approach alone, but instead using a combination of behavioral, structural and biomedical interventions coordinated to achieve maximum effect distinguish effective prevention strategies.

Evidence based approaches: HIV prevention interventions should prioritize interventions that have been proven effective in scientific literature and adapted to meet local needs. All decisions and actions at the level of policymaking, planning or implementation should be based on the most up-to-date information and best practices adapted to local settings.

Coordination: Implementation and coordination of HIV prevention interventions among partners should be harmonized to avoid duplication of efforts and increase efficiency. Nationally recommended policy and programming guidelines should be adhered within the context of implementing the HIV prevention package for MARPs and vulnerable groups.

Partnership: All collaborates including public, private, NGOs, CBOs

HIV Prevention Package MARPS and Vulnerable Groups

Sex Workers Mobile workers In School Youth (15-24 years) uniformed services Inmates (prisoners) and civil societies should be involved in designing and implementing HIV prevention programs to maximize the coverage, scale and intensity of prevention services.

Participation: At all levels of HIV prevention, planning, programming and implementation, the participation of the community and target groups should be integral to achieve program impact.

Non-discrimination: Promotion, protection and respect of human rights including gender equality should always be integrated in HIV prevention programming for MARPs and vulnerable groups. All citizens have the right to access information and health services. Sustainability: HIV prevention programs should be designed based on long-term goals that foster and maintain sustainability. Linking prevention with treatment: Integration of behavioral intervention with HIV services is vital. (Federal HAPCO, 2010)

The purpose of this study is to assess and evaluate the service delivery system of HIV prevention services given for Most at Risk Populations (MARPs) by different local NGOs are effective and MARPs friendly. Therefore, the prevention services given to these Most at Risk Mobile Populations (MARPs) can minimize the number of new infections and which can in turn contributed to the overall prevention of HIV at national level.

1.2. Statement of the Problem

The scale of the human immunodeficiency virus (HIV)/AIDS epidemic has exceeded all expectations since its identification 20 years ago. It has created enormous challenges worldwide. Globally, an estimated 36 million people are currently living with HIV, and some 20 million people have already died, with the worst of the epidemic centered on sub-Saharan Africa. However, just as the spread of HIV has been greater than predicted, so too has been its impact on social capital, population structure and economic growth. Responding to AIDS on a scale commensurate with the epidemic is a global imperative, and the tools for an effective response are known. Nothing less than a sustained social mobilization is necessary to combat one of the most crises facing human development. (www.nature.com-global)

In rural area, it is likely that the HIV/AIDS is concentrated in sub-populations within the rural community such as migrant laborers, and workers, however, on the way to be well established within the general population. Thus, HIV/AIDS prevention activity in the rural agricultural community must not ignore rural. This is mainly because teachers are vital to the success of achieving education for all; they are also key role models in communities and as such have an important role to play in bringing down stereotype around HIV/AIDs. To do this, however, it is imperative that teachers

understand the true impact of the epidemic, both on the profession and upon those infected. Once this is more fully understood, it will be necessary to ensure the teachers feel protected and supported both to know their status and then to engage in efforts aimed at combating the epidemic at all levels (UNAIDS 2008).

Prevention is always better than cure and this principle holds an exceptional significance when it comes to HIV/AIDS. AIDS is one such disease that does not have any permanent cure as available treatment options are only effective in dropping the symptoms associated with the disease. In such situation, it is vital to have adequate protection so that you do not get the infection and there is uncoordinated and ineffective prevention service. In addition, early treatment and diagnosis can prolong the progression of the HIV. Getting routine tests at STD testing clinics would be advantageous to you if you are already sexually active. There is no as such strong coordination and network among different concerned organization, which are making intervention of HIV prevention and care services both at urban and rural settings. (Source: http://EzineArticles.com/3958240)

The above-indicated uncoordinated effort of the prevention services and lack of standard package of services leads me to assess the service delivery system of the organization and provide some suggestions that may help ISAPSO and Pro Pride to improve those gaps that hinder the proper delivery of the services and give some suggestions to standardize the service delivery system.

1.3. Significance of the Study

There is an urgent need for evidence generation and utilization about the known and emerging high-risk group. Prevention interventions targeting the general population are done at scale but there is limited scale of HIV prevention programs targeting the vulnerable and most at risk population groups.

A number of researches have been done on HIV/AIDS related topics and issue. These researches, however, have overwhelmingly focused on people in general and the youth and women in particular. Nevertheless, the fact that MARPs are the most marginalized and lack attention (HIV/AIDS, Mobility and poverty), there is a need to conduct practical research that show the vulnerability of these group of people and fill the gaps.

I believe this study will initiate the concerned bodies to redirect their attention towards most at risk mobile population and indicate best experiences. It also shed light how these best practices can be incorporated in the poverty alleviation program of the country. The study will also have the benefit for those who are the subject of the study by providing the real experience to different interventionist stakeholders like HIV/AIDS Prevention and Control Office (HAPCO),NGOs which are engaged in the intervention of HIV prevention, Civil Societies and other concerned bodies.

1.4. Objectives of the Study

1.4.1. General Objective of the Study

The general objective of the research is to assess the service delivery system on the HIV/AIDS prevention among Most at Risk Populations project focusing on Female Sex Workers (FSW), Waitress, Male and Female daily Laborers.

1.4.2. Specific objectives:

- To assess & understand clinical service utilization of Most At Risk Populations(MARPs)
- To asses major services given to MARPs and evaluate the delivering system
- To identify the risk factors of mobile MARPs to HIV infection
- To know how far the service delivered are comprehensive, accessible and MARPs friendly.

1.5. Limitation and Delimitation of the Study

1.5.1. Delimitation of the Study

The study was conducted in two towns. These are Ziway town from 'ISAPSO and Harar town from Pro Pride, local NGOs, working on HIV/AIDS prevention among MARPs. The study excludes other mobile workers like Military servants, house cleaner, Males who have sex with males, other high-risk and mobile groups, because these groups of population are not targeted by TransACTION program of ISAPSO and Pro Pride and I cannot able to assess the service provided to these group. The target populations include only mobile populations, such as Commercial Sex Workers (CSWs), Male Daily Laborers, Female Daily Laborers, and Waitress.

1.5.2. Limitation of the Study

Despite all the effort has been made to accomplish this study, some practical limitations were encountered to inevitably be part of it. The sensitive nature of HIV/AIDS and Mobile population has some challenges for the researcher during data collection. The first challenge was related to lack of financial support and time from CSWs and daily laborers who were engaged in construction work. Besides, all costs of this research was covered by the researcher himself so there was financial constraints in addition to time limitation to conduct the research.

1.6. Universe of the Study

The research was conducted in two towns- Ziway town, which is found in Oromia regional state, and Harar town, which is found in Harari regional state of Ethiopia. The study focused on the assessment of service provision of TransACTION-Prevention and Care services for Most At Risk Population (MARPs) project implemented by Pro Pride and ISAPSO (local NGOs) targeting Female Sex Workers, Waitress, Female and Male Daily Laborers.

CHAPTER II - LITRATURE REVIEW

2.1. Mobility and the Spread of HIV/AIDS in Most at Risk Populations (MARPs)

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 (MARP). 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, HIV sero status or risk practice of their sex partner(s) may place them at risk. (*www.avert.org/hiv-aids-vulnerable-groups.htm*)

Mobility: is the ability to move about especially to do work or take exercise. It is the ability of somebody to change from one social group or class to another as defined by English dictionary.
"*Mobile people* are those who move from one place to another temporarily, seasonally, or permanently for either voluntary or involuntary reasons. It is a broad term that describes the full range of mobility from short term movement, such as truck drivers, to long term or permanent relocation of people". In this definition, "mobile people" refers to *civilian* mobile populations. Much of the mobility associated with increased risk of HIV is driven by economic reasons, but increasing numbers of people are forced into movement for various other reasons.

Data on mobility are scarce in developing countries and so are the HIV sero-prevalence levels among these groups who are considered at high risk for HIV. A combination of social, physical and emotional factors can make mobile populations highly vulnerable to HIV infection. The relationship between population mobility and the spread of HIV has recently received increased attention in developing countries because livelihood mobility may be an important factor in HIV risk and the spread of HIV.

The relationship between population mobility and the spread of HIV has recently received increased attention in developing countries because livelihood mobility may be an important factor in HIV risk and the spread of HIV. Consequently, HIV/AIDS prevention interventions among mobile

populations have expanded around the world. HIV prevention interventions targeting mobile population has many challenges especially in resource-constrained settings. It demands time, persistence and financial resources to create conditions for mobile people to change reinforce and sustain their behavior (MARPs Guideline FHAPCO: 2011)

The National HIV/AIDS Policy's IEC Strategy 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 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 (Formative assessment conducted by TransACTION Program in Ethiopia by Save the Children USA, February 21, 2011).

The HIV prevention package of MARPs and vulnerable group was prepared to prevent new infection, standardize prevention work through combination prevention and harmonizing of implementing organizations. (Federal HAPCO, 2010)

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. An overview of available epidemiological data and information about each groups' vulnerability follows. The HIV prevalence among truck drivers, mobile merchants and daily laborers is considerably higher than the national adult population significant number of boys and girls migrate from rural to urban areas. They are vulnerable because they lack parental presence and schooling. Most mobile workers use condom rarely with their sexual partners Female migrants is more prone to gender based violence. (Source: FHAPCO-HIV Prevention Package of MARPs and Vulnerable Groups, September 2011-p32).

Commercial sex workers (CSWs) in bars and hotels were better educated than those in red light houses were. CSWs in red light houses were predominantly of rural origin and less educated. Commercial sex workers in all towns and all types of work establishments were highly mobile; the average length of stay in an establishment was six months. These women cited a number of factors for moving frequently including decline in the number of clients, disagreements with establishment owners and/or fellow CSWs, fatigue, and seasonal migration to cash crop areas to find more clients and/or meet higher paying ones. (Source: Behavior Change Strategy for TransACTION Program, February 22, 2011).

Within any HIV epidemic, sex workers have been one of the groups most vulnerable and at risk of HIV infection due to their multiple sexual partners spanning multiple sexual networks. High rates of other STIs and unsafe sexual practices further increase the probability of HIV transmission in sex workers. Because of the risks involved and their vulnerabilities, HIV prevalence among FSWs is often much higher than the general population. Because they constitute one of the largest MARPs groups, they should be one of the primary focuses of HIV prevention interventions. In addition, men who are both paying and non-paying clients play a major role in bringing HIV infection into the general population. Long distance drivers, mobile workers, uniformed services, and people who travel for business and professional work are easily identified as potential clients for commercial sex and are a key target for prevention activities.

Other important MARPs are the regular or non-paying clients of sex workers with whom condom use is low. Because of the key role these groups play in HIV transmission, targeting of HIV prevention interventions to these groups could have a considerable effect in slowing the spread of HIV epidemic. Sex workers face stigma and discrimination in different forms. It is also very common for female sex workers (FSWs) to face violence from a range of sources including clients, employers, community members, partners and other sex workers. Sex workers are broadly defined internationally as "female, male and transgender individuals who receive money or goods in exchange for sexual services, either regularly or occasionally". FSWs are defined in the Ethiopian context as females who regularly or occasionally trade sex for money in drinking establishments, night clubs, local drink houses, chat and ''shisha'' houses, "on the street", around military and refugee camps, construction sites, trade routes, red light districts, and at their homes. (*Source: FHAPCO-HIV Prevention Package of MARPs and Vulnerable Groups, September 2011-p16)*

2.2. Why are Mobile workers vulnerable and at risk of HIV infection

According to UNAIDS, populations most-at-risk (MARP) for becoming infected with HIV include injection drug users, sex workers and their clients, men who have sex with men, and prisoners. MARPs are considered at risk for HIV due to behaviors and practices that heighten their vulnerability to the virus. (UNAIDS, 2011)

Risk factors are activities that increase the likelihood of HIV/AIDS infection. There are no definite statistics that show the percentage distribution of risk factors in most at risk mobile population. This clearly indicates that an important problem has been overlooked for a long period to prevent the transmission of HIV/AIDS in the country.

Mobility contributes to the risk of HIV infection, because mobile workers are more likely to have multiple concurrent sexual partners, wide sexual networks and harder to reach with HIV prevention, treatment and follow up programs. Besides, mobile people are not well integrated into the communities where they live and they have less access to information and services in languages they can understand across the entire breadth of the routes those travels. HIV vulnerability is also

associated with displacement, disruption of families and social and community structures in the displaced, mobile and migrant populations and boys and girls are more vulnerable than adults in terms of lacking parental presence, schooling, and social connectedness. Moreover, most mobile people use of alcohol, khat, and other drugs expose them to unprotected sex. For instance, Truckers rarely use condoms with sexual partners and due to multiple sexual partners; truckers have high rates of STI and often use alcohol more often. On the other hand, Construction workers are highly mobile and long absences from families and home enhances the likelihood of high-risk behavior in construction sites. More often they are not married or not living with a sexual partners

As female migrants have little or no bargaining power during travel or at destination, they are prone to gender based violence. (Source: FHAPCO-HIV Prevention Package of MARPs and Vulnerable Groups, September 2011-p17)

2.2.1. Female Sex Workers and their high rate of vulnerability and risk for HIV infection

There is high HIV prevalence**,** most of them are young, Illiterate or low level of education and they have low socio economic status. Besides, female sex workers have high number of sexual partners both paying and non-paying**,** higher rates of STIs**,** experience of partner violence**,** low condom use with non-paying clients and have limited access to prevention. They have low care, treatment services due to stigma, use of alcohol, khat, and other drugs expose them to unprotected sex, and older widowed and divorced women who become FSW have higher HIV prevalence. (Source: FHAPCO-HIV Prevention Package of MARPs and Vulnerable Groups, September 2011-p17)

2.3. Prevention and strategies for addressing MARPs

Population movement is complex and dynamic. Understanding how it works and how it changes provides a starting point in planning, implementing and refining mobility and HIV/AIDS intervention. Identify risk environments and vulnerable populations (hot spot versus risk zone, migrants versus community) to create access to health services which should be based on equity, without any discrimination that could lead to the exclusion of displaced, migrant or mobile people. Displaced, migrant and mobile populations should have access to user-friendly services and levels of care equivalent to those provided to surrounding populations. Interventions to provide information

and education about prevention of HIV and other STI should be made available at points of departure and arrival of migrant and mobile populations, who may require information and education in their own languages. Universal access to antiretroviral treatment for those who need it should be available. Use combination prevention approach and link all HIV services at all level. Promoting partnerships to facilitate access to hard-to-reach people and places, to bring about policy improvements and help to create supportive environment for mobile people and draw upon diversified resources and encourage stakeholders to make interventions more effective and sustainable.

Involving mobile populations in the design and delivery of HIV prevention interventions is important in ensuring the continuity of ownership of the programs and delivery of interventions in a sensitive and non-stigmatizing way. Programs that reach mobile groups should also target locations rather than exclusively focusing on a given population group. Migrant populations that are relatively settled or stayed in the same place for long periods are more likely to be reached in an ongoing way with traditional peer education, outreach and group discussion approaches.

On the contrast, new migrants who are arriving in unfamiliar surroundings and hence unaware of the risks they face and the services available require special attention. (MARPs Guideline FHAPCO-2011)

TransACTION Program planed to improve the economic security of the most-at-risk mobile groups by guiding the organization of self-help savings groups and transforming these groups into Income Generation Activities (IGAs). The objective is to build the skills of most at risk groups such as commercial sex workers, daily laborers and waitresses to build their skills to save money to enable them to withstand economic shocks (such as an increase in rent). As savings group members accumulate resources, they will be able to borrow from each other to start up new IGAs or expand existing businesses. TransACTION will provide support to transform these savings groups into IGAs by providing training in such areas as business opportunity identification and small business management. The Economic Strengthening Program will work with community-based Economic Strengthening Agents (ESA) who are community members and known for their business acumen, to promote involvement of MARPs in savings groups. TransACTION has also enlisted the support of Economic Strengthening Trainers (ESTs) at Woreda level who work with the Government's Micro and Small Scale Enterprise Development Agency who will support TransACTION to provide

trainings on the establishment of savings groups, micro-business identification to identify income-generating activities, provision of ongoing mentorship in business management. The program will also involve Economic Strengthening Trainers from each Woreda's Micro and Small Scale Enterprise Development Agency.

TransACTION has adapted and utilized the materials developed by Save the Children's PC3 Program for savings and income-generating activities, therefore, rapid implementation and scaling up of activities will be possible. Training workshops will be conducted and trainees will be given the opportunity to deposit their per diem into a savings account. Connected to this, savings groups will be encouraged and established for all our priority groups. Our goal is to especially support and encourage women to be involved in this activity. In order to help ensure healthy and effective savings groups, field visits will be conducted including in-depth observations and dialogue. It is hoped that through extensive and authentic motivation and encouragement, participants` eager and quick participation in this program will minimize the necessity for TransACTION to pay seed money or other start up monies. An issue that will need to be addressed is that of providing technical expertise. Training in this area will be needed. See the next section of this report for general implementation steps for TransACTION's Economic Strengthening component. (Source: behavior change strategy for the TransACTION Program, Final February 22, 2011 p54)

2.4. Package of Services provided for MARPs

2.4.1. Peer Education

TransACTION has developed peer education programs for most at risk groups, including the following, under the umbrella name **Addis Mela (New Solution)**

- Addis Mela le Siket for Daily Laborers (New Solution for Success)
- Addis Mela le Guzo for Long Distance Transport Workers (New Solution for Our Journeys)
- Addis Mela le Hiwot for Commercial Sex Workers (New Solution for Our Lives)
- Addis Mela le Tesfa for People Living with HIV (New Solution for Hope).

Structured peer education was designed by USAID in the initial TransACTION program design. Valuable research is available showing the potential for such an approach, if done systematically, with a good deal of support for the peer leaders (PLs). TransACTION uses peer led approaches to

create demand for use of HIV and STI prevention services among the priority groups. Peer leaders play an important role in many aspects of TransACTION's conceptual framework for change including Share information, Build skills (of themselves and of co-workers), Increase co-workers' access to services, Help create an enabling environment for change. Each PL will be a member (or past member) of the priority group, they are working with. They will be carefully selected because of their interest in working with their peers, concern about the issues of HIV and AIDS, and commitment to improving the health and lives of Co c workers/peers as well as their own. (Source: behavior change strategy for the TransACTION Program, Final February 22, 2011 p46, 48-49)

2.4.2. Establishment of Information and Prevention Centers (IPCs)

TransACTION plans to establish Information and Prevention Centers (IPCs) to support group Peer Education sessions with individual counseling sessions. The individual counseling coupled with group Peer Education will provide priority groups with a complete range of services to enable individuals to change and maintain behaviors. Peer education participants will be able to access professional and semiprofessional staff (e.g. nurses, lay counselors and spiritual counselors) that will be able to build on the work of the peer leader. For example, if a peer education group member has questions that s/he wants to discuss in confidentiality, s/he can find the necessary support at the IPCs. In addition, peer leaders will invite peer group participants to the individual counseling at IPCs to obtain additional information on topics they just discussed (e.g. condom use, STIs, alcohol abuse, economic strengthening service).

The IPCs will offer a weekly schedule of counseling sessions in collaboration with other PEPFAR partners operating in the towns. These IPCs will be an additional channel to the peer education for increasing access to these critical resources and information. Priority group members will also be able to access condoms, STI screening and management, and HIV testing at IPCs. TransACTION will enter into agreements with Health Network Members to offer scheduled, periodic STI and HCT services in towns with limited access to health facilities or even in large towns where a clinic's location may be far from areas where commercial sex workers, transport company workers, daily laborers live and work. It is hoped that transportation companies will express willingness to house IPCs within the company grounds. This we believe could be a good opportunity to build a meaningful and extended public-private partnership. IPCs will also serve as an assembly point for peer leaders to assemble, as well as pick up condoms and vouchers for distribution to peer group

members.(source: behavior change strategy for the TransACTION Program, Final February 22, 2011 p54)

2.4.3. Establishment of a Network of Private Health Providers

One of the strategies for expanding access to quality HIV Counseling and Testing (HCT), and diagnosis and treatment of sexually transmitted infections (STIs) for MARP groups is to establish a branded network of private health facilities. TransACTION, with its partner Marie Stops International Ethiopia (MSIE) taking the lead, has created a Health Network which includes private clinics and drug retail outlets where beneficiaries can use vouchers provided to them by peer educators to access subsidized HCT and STI diagnosis and treatment. Private providers benefit from being part of the Network as TransACTION refers beneficiaries to them and subsidizes the cost of the tests, diagnosis and treatment.

In exchange, private providers must provide quality services specifically tailored for most at risk groups, for example, services, which take into, account the schedules, locations, and preferences of MARPs groups. The Network has been branded as the Addis Mela Private Providers' Network building on the umbrella brand name, Addis Mela, used in other TransACTION Program components. To establish the Network, TransACTION first conducts rapid assessments of private health facilities to identify potential members. Private health facilities are screened and selected using different criteria including number and type of professional staff, length of working hours, willingness to be a member of the network, access to infrastructure etc.

As pharmacies, drug stores, and rural drug vendors are the first stop for a significant number of patients seeking information and STI diagnosis and treatment service, TransACTION conducted a rapid assessment of these facilities to understand how STI issues are handled to develop a strategy for inclusion of these private service providers in the Health Network. After the rapid assessments and selection, Network Establishment Meetings are held to discuss the benefits and requirements of membership. Moreover, the Detail Responsibilities of TransACTION, the Private Providers, and the Expected Standards to meet from the Private Providers' side were discussed and reached on consensus.

Once private facilities agree to become members and sign a memorandum of understanding (MOU), TransACTION provides them with trainings on provider initiated counseling and testing, STI

syndromic management, and rapid HIV testing, in collaboration with regional health bureau officials, and utilizing national guidelines. Once all the prerequisites are fulfilled and the sites are ready to start services, TransACTION will provides Health Network Member Clinics with HIV rapid test kits, STI syndromic management protocols, communication materials to post on site and provide to beneficiaries, as well as all needed monitoring and evaluation tools. In addition, the private providers will be oriented on the voucher system and introduced to all the M & E tools. Drug retail outlets are provided with Addis Cure Kits, which are used to syndromically treat STI syndromes: urethral discharge. Addis Cure Kits include antibiotics, condoms, partner referral cards, and communication materials. (Source: behavior change strategy for the TransACTION Program, Final February 22, 2011 p52)

In general, key interventions through **Addis Mela (New solution)** include group and individual sessions related to STI and HIV prevention facilitated by peer leaders, Condom distribution, Provision of subsidized vouchers for sexually transmitted infections (STI) and HIV counseling and testing (HCT) services. In addition, Establishment of a private sector health network of clinics and drug retail outlets providing STI diagnosis, treatment and HCT, Care and support for people living with HIV including group and individual, ongoing counseling focusing on prevention with positives and Economic strengthening activities including support for savings groups and income generation schemes. BCC messages through mass media such as radio and mini media, Peer education, Condom promotion and distribution, HIV testing and counseling, STI diagnosis and treatment, Workplace HIV policy, User-friendly health services, Referral linkage between services, Participation of mobile workers in HIV prevention programs and work place HCT service. (TransACTION project Document 2011).

Chapter Three: Research Design and Research Method

3.1. Research Design

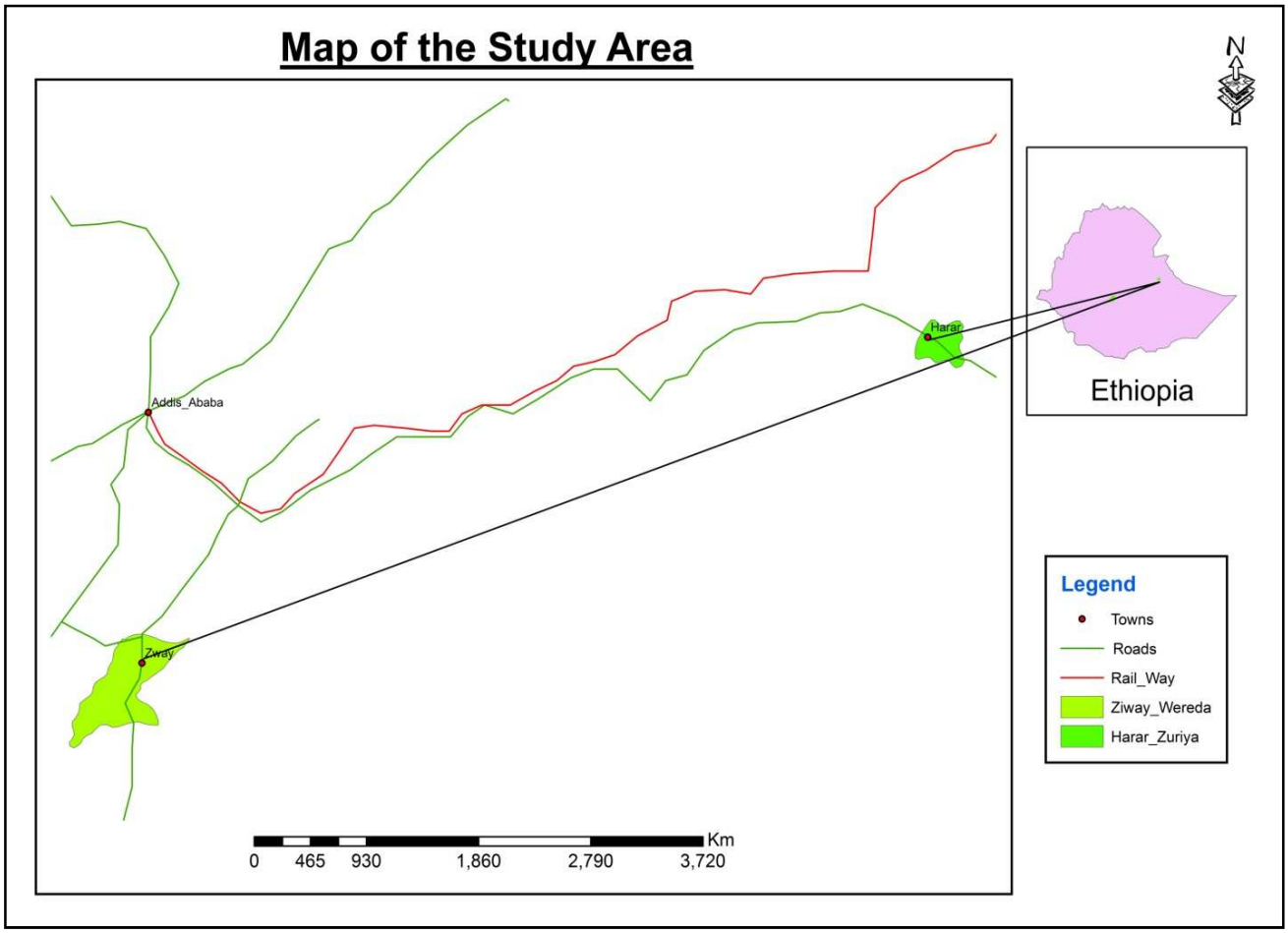
According to Padgett (2008), qualitative research is best suited for a topic, which is sensitive and emotional depth like HIV/AIDS that require empathy an understanding. According to Kothari (1995), discussion regarding what, where, when, how much, by what means concerning an enquiry of research study constitute research design. It consist the blue print for the collection, measurement and analysis of data.

Qualitative research is used to get in-depth situation of phenomena and it is not rigidly limited to definable variables. The qualitative method helps to understand the meaning of situation, event, experiences, and actions of participants (Maxwell, 2005).

A descriptive study was conducted to assess the service provision of Transaction Prevention and Care Services Project for MARPs. It also aimed at examining and assessing the extent of the services provided to the clients. A qualitative method was employed to collect relevant data on the service provision. The qualitative research has the ability to provide complex textual descriptions of how people experience a give research issue. It provides information about the human contradictory behaviors, beliefs, opinions, emotions and relationship of individuals. Qualitative methods are also effective in assessing intangible factors, such as social norms, socio-economic status, gender roles, ethnicity and religion whose role in the research issue may not be readily apparent (Natasha et al., 2005:5)

3.2. Research Area

The research area included two towns that are in different transportation corridors of TransACTION Program. Harar town from the eastern corridor that is from Pro Pride intervention area and Ziway town from southern corridor that is from ISAPSO intervention area of TransACTION program. These towns were selected because they are found in two different corridors, which helped us to see the comparison of the service delivery system in two different contexts. The two towns are the implementation site of TransATION project by two different local NGOs that have different implementation capacities and there are some cultural difference between the two communities that also have an effect on the lives and behaviors of MARPs.



3.2.1. Ziway town

Ziway or Zway is a town and separate woreda in central Ethiopia. It is located on the road connecting Addis Ababa to Nairobi in the Misraq Shewa Zone of the Oromia Region of Ethiopia, Ziway has a latitude and longitude of 7°56′N 38°43′E with an elevation of 1643 meters above sea level.

Adjacent to Lake Ziway, the economy of the town is based on fishing and horticulture. Ziway is also home to a prison and a caustic soda factory.

The 2007 national census reported a total population for Ziway of 43,660, of whom 22,956 were men and 20,704 were women. The majority of the inhabitants said they practised Ethiopian Orthodox Christianity, with 51.04% of the population reporting they observed this belief, while 24.69% of the population were Muslim, 0.42% practiced traditional beliefs, and 22.07% of the population were Protestant. The 1994 national census reported this town had a total population of 20,056 of whom 10,323 were males and 9,733 were females. (Desta *et. al,2002.*)

3.2.2. Harar Town

Harar is an eastern city of Ethiopia formerly the capital of Hararghe and now the capital of Harari regional State, the modern Ethio political division of Ethiopia. The city is located on a hilltop in the eastern extension of the Ethiopian highland about five hundred kilometers from Addis Ababa at an elevation of 1,885 meters. Based on figures from the Central Statistical Agency in 2005, Harar has an estimated total population of 122,000, of whom 60,000 were males and 62,000 were females. According to the census of 1994, on which this estimate is based, the city has a population of 76,378. For centuries, Harar has been a major commercial centre, linked by the trade routes with the rest of Ethiopia, the entire Horn of Africa, the Arabian Peninsula, and, through its ports, the outside world. Harar Jugol, the old walled city, was included in the World heritage list in 2006 by UNESCO in recognition of its cultural heritage. According to UNESCO, it is "considered 'the fourth holy city' of Islam" with 82 mosques, three of which date from the 10th century, and 102 shrines.

Founded in the 7th century by Arab immigrants from Yemen it was chosen as the capital of the Adal Sultanate from 1554 to 1557. Harar saw a political decline during the Sultanate of Harar, only regaining some significance in the Khedivate of Egypt period. During Abyssinian rule, the city decayed while maintaining a certain cultural prestige. Today, it is the seat of the Harari ethno-political division. (Source: Desta *et. al, 2002*).

3.3. Sampling Techniques and Procedures

The study used non-probability sampling technique. Purposive sampling techniques was used to select participants of the research due to the complex nature of the problem under consideration.

Purposive sampling is the most common sampling strategies assumed, where participants of the study are selected according to pre-set criteria relevant to a particular research question (Natasha et al., 2005:6). Key informants were selected purposively from Pro Pride and ISAPSO-local NGOs that implement the project. The list of beneficiaries that includes Female Sex Workers (FSW), Waitresses, Female and Male Daily Laborers of Pro Pride and ISAPSO TransACTION project at Harar and Ziway town were 45 registered in number. Out of this total number, 40 were considered as samples for this study. This sample size was taken directly from the IGNOU Social Work Research student textbook that is calculated based on the formula. In order to make sure that respondents meet the right criteria for the study, the researcher selected research participants based on age, sex and type of mobile population.

3.4. Data Collection Techniques and Procedures

The main technique to collect data for this research was in-depth interview. Data collected through interview is interactive, whereby the researcher describes as accurately as possible ones' understanding and interpretation (CresWell, 2007).One interview per participant guided by open-ended and closed ended questions were conducted with voluntary participants who fulfill the inclusion criteria and confirmed their participation in a written and verbal form. Since, mobile workers for this research include Male & Female daily laborers, Female Sex Workers and Waitresses, each category members was interviewed differently at different time and place based on their preferences. Most of them were mobiles; the interview was carried out at their respective work place. The total number of interviewees was 40 who were selected from both towns considering different segments of MARPS. There were **12** female sex workers, **10** waitresses, **10** female daily laborers and **8** female daily laborers participated on the interview process. The study, therefore, used

in-depth interview as the main tool for data collection, which enabled the researcher to achieve and attain validity and reliability of the data collected for this particular study of the research.

3.5. Data Collection Tools

3.5.1. In-depth Interview

In-depth interviews were conducted with an open framework, which allow for focused, conversational, two-way communication. They can be used to both give and receive information. In addition, it was used to observe the feeling and emotion of the participants.

Individual in-depth interviews were conducted with ***40*** *(forty*) Most at Risk Populations (MARPs) from two (2) local NGOs namely Pro Pride and ISAPSO of the target towns to understand and assess the service provision system in the study areas. **20** MARPs from Harar town of Pro Pride intervention and the remaining **20** from Ziway town of ISAPSO intervention areas were included. The four categories of MARPs (Female Sex Workers, Waitresses, and Female & Male daily Laborers) were considered from both towns. In the selection of respondents, demographic characteristics were considered. Not all questions were designed and phrased ahead of time. The majority of questions were created during the interview, allowing both the interviewer and the person being interviewed the flexibility to probe for details or discuss issues. Therefore, in-depth interview was used for collecting the relevant data for analysis purpose. Pro Pride and Integrated Service for AIDS Prevention and Support Organization (ISAPSO) TransACTION project coordinators and the community Mobilizers under close supervision of the researcher facilitated the selection process before actual interview.

Therefore, I used to explore the meanings of survey findings that cannot be explained statistically, the range of opinions/views on a topic of interest and to collect a wide variety of local terms. This tool was especially appropriate to collect valuable information from peer members.

3.6. Data analysis Process

Data analysis is the process of systematically applying statistical and/or logical techniques to describe and illustrate, condense and recap, and evaluate data. Various analytic procedures “provide a way of drawing inductive inferences from data and distinguishing the signal (the phenomenon of interest) from the noise (statistical fluctuations) present in the data” (Shamoo and Resnik (2003).

During data analysis process, the following procedures and activities were carried out. Once I have made consensus to the organization in which I was conducting this research, I collected the data via semi-structured interview. In this research, the specific type of qualitative data analysis that I have undertaken was content analysis. The data was put in a systematic manner based on questions used in the interview to probe the interviewee on the service delivery system of the project. I was trying to assess its effectiveness in order to provide possible recommendations on how to improve both the clinical and non-clinical service delivery system to prevent HIV/AIDS transmission and reduce the vulnerability of the Most at Risk Populations.

3.7. Ethical Considerations

Informed consent is the major ethical issue in conducting research. According to Armiger: "it means that a person knowingly, voluntarily and intelligently, and in a clear and manifest way, gives his/her consent" .Informed consent is one of the means by which a patient's right to autonomy is protected. Beauchamp and Childress define autonomy as the ability for self-determination in action according to a personal plan. Informed consent seeks to incorporate the rights of autonomous individuals through self- determination. It also seeks to prevent assaults on the integrity of the patient and protect personal liberty and veracity (chemeng.iisc.ernet.in pdf).

Written and verbal consent was obtained from MARPs group who fulfilled the inclusion criteria to let them know that they were researched and protected them from participating involuntarily. The inclusion criteria were those MARPs group that were considered more vulnerable for HIV than the other and at the same time easily accessible to conduct the interview for this research. In addition, those MARPs group that were only targeted by transaction project and whose age were 16 and above. On the other hand, the exclusion criteria include those MARPs group that were not targeted by transaction project, those MARPs group that were considered as less vulnerable for HIV than the

other and those MARPs that were not easily accessible to conduct the interview for this research. The informed consent incorporated the information such as the voluntary nature of research, purpose of the research, extent and procedures of confidentiality and anonymity. The informed consent also indicated the associated risks and how it was planned to handle it through none of the participants were demanding such type of arrangements.

Participants who completed interview were received 'Thank You' card and refreshment costs were covered in order to indicate the appreciation of their valuable time and contribution to the existing literature through sharing their lived experience. The right to withdraw from the interview at any time with no loss of benefits was also part of the consent form.

3.8. Organization of the Thesis

The thesis was classified in to five chapters. The first chapter was introductory part that defines, describes, explains and locates the distribution of HIV/AIDS and Most At Risk Mobile Populations (MARPs). This chapter provided highlights on the statement of the problem, Significance of the study, Objective of the study, Limitation and Delimitation of the Study. The second chapter demonstrated and devoted to literature Review on HIV/AIDS and Most At Risk Populations (MARPs) and its conceptual framework with its description. The third chapter depicted the methods and methodological approaches applied in the research. The forth chapter presented the major analysis and discussion of findings of the study. The fifth and the final chapter dealt with summary and Recommendation part of the study.

3.9. Trustworthiness of the Study

In order to fully describe how participants view and fell the phenomenon and counter early categorization, researchers must bracket out their own preconception and experience and this enable us to suspend belief through out data collection and analysis (Creswell, 2007). To ensure the trustworthiness of the research, it was crucial to know the possible threats and how to deal with that. The major challenges for trustworthiness of qualitative study were the researcher and respondent's biases. Therefore, to minimize the respondent's bias, rapport building was the alternative solution to bring engagement in structured interview.

3.10. Definition of Key Terms and Concepts

- **Hotspots: -** is a small village containing a high concentration of the particular target group, e.g. sex workers, waitresses, etc.
- **Commercial sex partner: -** A partner who was paid money in exchange for sex.
- **Commercial sex:-** A sexual relationship where money was paid in exchange for sex (paid sex).
- **Consistent condom use**: - Used a condom every time sexual relations took place.
- **Cross-generational sex**: - A relationship between a man and a woman is considered cross-generational if a young woman has a partner that is ten or more years older.
- **Lay Counselos**:- are community based volunteers that are HIV positive who are assigned and responsible to provide pre and post counseling for MARPs at the networked clinic of TransACTION program.
- **Most At Risk Population: -** 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 behavior; in some cases the behaviors or HIV sero-status of their sex partner may place them at risk.
- **Multiple sexual partners**: - having more than one sexual partner during a specified period (e.g. 12 months).
- **Non-paying partner: -** Sex partners of female sex workers who do not pay money in exchange for sex.
- **Non-regular partner**: - Sex neither partner who is neither respondent's spouse nor live-in partner.
- **Paying client**: Sex partner of a female sex worker who paid money in exchange for sex.
- **Regular partner:** Spouse or cohabiting (live-in) sex partner.
- **Transactional sex:** refers to situations, including those in on-going relationships, where sex is exchanged for money/gifts and where there is an understanding that if the money/gifts are not forthcoming, the sex will stop.
- **Study Area** is the place where the research was carried out

Chapter Four: Analysis and Discussion of the Findings

In this chapter, analysis of the data and detail discussion of the findings are presented. In the first section, an attempt is made to present and analyze the demographic and socio economic characteristics of the study population. The description of background characteristics is presented to make the reader to easily understand the sampled population. In the second section, detail discussion on the findings was carried out in relation with the literatures.

4.1. Background Characteristics of the Study Population

The target populations for this study were mobile populations that frequently move from place to place to find jobs that include Commercial Sex Workers (CSW), Waitress and Female & Male daily laborers who are especially engaged in construction and big farms including flower farms. These population groups are the direct beneficiaries of Pro Pride and Integrated Service for AIDS Prevention and Support Organization (ISAPSO). Three community mobilizers and two project coordinators from both Pro Pride and ISAPSO were participated. In addition, four community Information Prevention Center (IPC) volunteers were also participated in the study process. The study population were selected by purposive and convenience sampling process rather than through random sampling method. In order to avoid any bias, attempt were made to include ranges of possible demographic categories such as sex, age, educational and marital status by considering the above different MARPs categories.

4.1.1. Demographic and Socio-economic Characteristic of the Respondents

4.1.1.1. Demographic Characteristic of the Respondents

4.1.1.1.1. Sex composition

The total number of MARPs participated in this study were 40 (Forty). As indicated in table 1 below, among the total respondents covered in the study, 30 (75 percent) were females and the remaining 10 (25 percent) were males. Thus, three-forth of the sampled respondent were females. This might shows most females were engaged in daily income generation to sustain their life.

Table 1- percentage distribution of sampled population by sex

MARPs Categories	Sex	Frequency	Percentage	Remark
CSW	Female	12	30	
Waitress	Female	10	25	
Daily Laborers	Male	8	20	
	Female	10	25	
Total Sample		40	100	

4.1.1.1.2. Age composition

Table 2 below shows that out of the total 40 (forty) sampled population, 15 (17.5%) of them are found between the age 20-25 which is the highest young group who were followed by 8 (20%) whose age group is between 26-30. On the other hand, 7(17.5%) of the research respondents were below 20 and 4 (10%) of the research respondents were between the age 31-35. The number of respondents whose age was between the ages 36-40, 41-45 and above 46 years accounts the same percentage point (5 percent). Considering the total number of respondents of the study, the highest age reported was 47 among male daily laborers while the lowest age was 16 years from the respondents of female sex workers.

Table 2-Percentage distribution of sampled population by Age

MARPs Categories	Age Interval in years							Total	Remark
	below 20	20-25	26-30	31-35	36-40	41-45	Above 46		
Commercial Sex Worker (CSW)	4	5	1	-	-	-	-	10	
Waitress	2	4	3	1	-	-	-	10	
Male Daily Laborer (MDL)	-	1	2	2	1	1	1	8	
Female Daily Laborer (FDL)	1	3	2	1	1	1	1	10	
Total	7	15	8	4	2	2	2	40	
Percentage	17.5 %	37.5%	20%	10%	5%	5%	5%	100%	

4.1.1.1.3. Marital Status

With regards of the marital status as shown on the table 3 below, from the total 12 (30 percent) respondents of female sex workers 12.5 percent, 10 percent and 7.5 percent are divorced, single and separated respectively. From the total 10 (25 percent) respondents of waitress 20 percent, 2.5 percent and 2.5 percent are single, currently married and divorced respectively. From the total 8 (20 percent) respondents of Male Daily Laborers 10 percent, 7.5 percent and 2.5 percent are single, currently married and divorced respectively. On the other hand, from the total 10 (25 percent) respondents of Female daily Laborers are single and those who are currently married, divorced and separated accounted the same percentage point (5 percent). Considering the marital status, from the total 40 (100 percent) respondents, the majority of the respondents from all categories are single.

Table 3-Percentage distribution of sampled population by Marital Status

Demographic Characteristics		Frequency	Percentage	Remark
MARPs Categories	Status			
CSW	Single	4	10%	
	currently Married	-	-	
	Widow	-	-	
	Divorced	5	12.5%	
	Separated	3	7.5%	
	Total	12	30%	
Waitress	Single	8	20%	
	currently Married	1	2.5%	
	Widow	-	-	
	Divorced	1	2.5%	
	Separated	-	-	
	Total	10	25%	
MDL	Single	4	10%	
	currently Married	3	7.5%	
	Widow	-	-	
	Divorced	1	2.5%	
	Separated	-	%	
	Total	8	20%	
FDL	Single	4	10%	
	currently Married	2	5%	
	Widow	-	-	
	Divorced	2	5%	
	Separated	2	5%	
	Total	10	25%	
Total		40	100%	

4.1.1.2. Socio-economic Characteristic of the Respondents

4.1.1.2.1. Household Size

With regards to the household size as shown on the table 4 below, from the total 12 (30 percent) respondents of female sex workers, 12.5 percent, 10 percent and 7.5 percent have 4-6, 1-3 and more than 7 household size respectively. From the total 10 (25 percent) respondents of waitress 20 percent, 2.5 percent and 2.5 percent have 1-3, 4-6 and more than 7 household size respectively. From the total 8 (20 percent) respondents of Male daily Laborers, 10 percent, 7.5 percent and 2.5 percent of them have 1-3, 4-6 and more than 7 household size respectively. From the total 10 (25 percent) respondents of Female daily Laborers, 10 percent, 10 percent and 5 percent of them have 1-3, 4-6 and more than 7 household size respectively at the time of survey.

Table 4-Percentage distribution of sampled population by Household Size

Demographic Characteristics		Frequency	Percentage	Remark
MARPs Categories	Status			
CSW	1-3 household size	4	10%	
	4-6 household size	5	12.5%	
	More than 7 household size	3	7.5%	
	Total	12	30%	
Waitress	1-3 household size	8	20%	
	4-6 household size	1	2.5	
	More than 7 household size	1	2.5%	
	Total	10	25%	
MDL	1-3 household size	4	10%	
	4-6 household size	3	7.5%	
	More than 7 household size	1	2.5%	
	Total	8	20%	
FDL	1-3 household size	4	10%	
	4-6 household size	4	10%	
	More than 7 household size	2	5%	
	Total	10	25%	
Total		40	100%	

4.1.1.2.2. Religion

Considering the religion background of the study population explained in the table 5 below, out of the total 12 (30 percent) Commercial Sex Workers respondents, 22.5 percent of them were from Orthodox Christian and the remaining 7.5 percent were from Muslim religion. When we see the Waitress, among the total 8 respondents, 12.5 percent were from Orthodox Christian, 7.5 percent were from Muslim, 2.5 percent from Protestant and the rest 2.5 percent of the respondents were from Catholic religion. Concerning the male daily laborers, from the total 8 respondents, 10 percent, 7.5 percent and 2.5 percent were from Orthodox Christian, Protestant and Catholic religion. On the other hand, out of the total 10 female daily laborer's respondents, 10 percent, 7.5 percent , 5 percent and 2.5 percent belongs to Orthodox Christian, Muslim, Catholic and Protestant religion followers respectively.

Table 5-Percentage distribution of sampled population by Religion

Socio-economic Characteristics		Frequency	Percentage	Remark
MARPs Categories	Type of Religion			
CSW	Orthodox Christian	9	22.5%	
	Protestant	-	-	
	Muslim	3	7.5%	
	Catholic	-	-	
	Total	12	30%	
Waitress	Orthodox Christian	5	12.5%	
	Protestant	1	2.5%	
	Muslim	3	7.5%	
	Catholic	1	2.5%	
	Total	10	25%	
MDL	Orthodox Christian	4	10%	
	Protestant	3	7.5%	
	Muslim	1	2.5%	
	Catholic	-	-	
	Total	8	20%	
FDL	Orthodox Christian	4	10%	
	Protestant	1	2.5%	
	Muslim	3	7.5%	
	Catholic	2	5%	
	Total	10	25%	
Total		40	100%	

4.1.1.2.3. Educational Status

With regards to educational status as shown on the table 6 below, from the total 12 (30 percent) respondents of female sex workers, 15 percent and 10 percent of them attended 1-3 grades and 5-8 grades respectively and 5 percent of them have not attended formal education. From the total 10 (25 percent) respondents of waitress, 20 percent and 5 percent of them have attended 5-8 grades and 9-10 grades respectively. Concerning Male Daily Laborers, out of the total 8 (20 percent) respondents, 10 percent of them have not attended formal education and the rest 7.5 percent and 2.5 percent of the respondents have attended 5-8 grades and 11-12 grades (preparatory) respectively. On the other hand, from the total 10 (25 percent) female daily laborers respondents, 15 percent of them have not attended formal education and the rest 7.5 percent and 5 percent of the respondents have attended 1-4 grades and 5-8 grades) respectively. From the table 6 below, one can observe that the majority of the respondents (10 percent and 15 percent from male and female daily laborers respectively) have not attended formal education. However, some of the respondents from waitress, male and female daily laborers were attending the night school to continue their further education.

Table 6-Percentage distribution of sampled population by Education Status

Demographic Characteristics		Frequency	Percentage	Remark
MARPs Categories	Grade Level			
CSW	Not attended formal education	2	5%	
	1-4 grade	6	15%	
	5-8 grade	4	10%	
	9-10 grade			
	Preparatory (11-12 grade) & above			
	Total	12	30%	
Waitress	Not attended formal education	-	-	
	1-4 grade	-	-	
	5-8 grade	8	20%	
	9-10 grade	2	5%	
	Preparatory (11-12 grade) & above			
	Total	10	25%	
MDL	Not attended formal education	4	10%	
	1-4 grade			
	5-8 grade	3	7.5%	
	9-10 grade			
	Preparatory (11-12 grade) & above	1	2.5%	
	Total	8	20%	
FDL	Not attended formal education	5	12.5%	
	1-4 grade	3	7.5%	
	5-8 grade	2	5%	
	9-10 grade	-	-	
	Preparatory (11-12 grade) & above	-	-	
	Total	10	25%	
Total		40	100%	

4.1.1.2.4. Source of Income

With regard to income situation of the respondents as shown on the table 7 below, from the total 12 (30 percent) respondents of Female Sex workers, all of them have their income on daily basis. Concerning waitress, from the total 10 (25 percent) respondents, 15 percent and 10 percent of them were engaged in temporarily contractual basis and daily basis respectively. Concerning Male Daily Laborers, out of the total 8 (20 percent) respondents, 12.5 percent and 7.5 percent of them were engaged in daily basis and temporarily on contractual basis respectively. On the other hand, from the total 10 (25 percent) female daily laborer's respondents, 20 percent and 5 percent of them were engaged in a daily basis and temporarily contractual basis.

Table 7- Percentage distribution of sampled population by Source of Income

Demographic Characteristics		Frequency	Percentage	Remark
MARPs Categories	Income Situation			
CSW	Daily basis	12	30%	
	Temporary on contractual basis	-	-	
	Permanently employed	-	-	
	Total	12	30%	
Waitress	Daily basis	4	10%	
	Temporary on contractual basis	6	15%	
	Permanently employed	-	-	
	Total	10	25%	
MDL	Daily basis	5	12.5%	
	Temporary on contractual basis	3	7.5	
	Permanently employed	-	-	
	Total	8	20%	
FDL	Daily basis	8	20	
	Temporary on contractual basis	2	5%	
	Permanently employed			
	Total	10	25%	
Total		40	100%	

4.2. Discussions on the findings of service provision under TransACTION Project Experienced by Commercial Sex Workers, Waitress, Male & Female Daily Laborers

4.2.1. General knowledge and Information on HIV/AIDS and STIs related services provided in the two study towns

Concerning the general knowledge of participants about HIV/AIDS and related service provision, government facilities were frequently identifies. According to respondents from TransACTION,HIV related services are freely provided in the town of Harar and ZiwayThere are also private organizations like private Hospital recently constructed; private clinic that was networked with TransACTION Project in which they were getting clinical services and Family Guidance Association which provides family planning services. There were thee drug stores (pharmacy).

Concerning the type of communicable diseases in the town, almost all the respondents have mentioned that HIV/AIDS, sexually transmitted disease (such as Syphilis, gonorrhea, Chankroyid), TB, influenza and diarrhea as the most common kind of communicable diseases that are experienced by the community. Concerning HIV/AIDS prevention services, all the respondents explained that the most common services given for the community includes counseling and testing, condom promotion and distribution, Prevention of Mothers-to-Child Transmissions (PMTCT), different trainings on HIV, peer education and community conversation.

4.2.2. Peer Education

Peer education has become very popular in the broad field of HIV prevention programs. It is the process of sharing information among members of a specific community to achieve positive health outcomes. The peer has to be someone who belongs to the same societal group, stays in the same geographic area, and is usually of a similar economic background.

In the literature review part of this study, it is indicated that access to health services should be based on equity, without any discrimination that could lead to the exclusion of displaced, migrant or mobile populations that should have access to user-friendly services including peer education and levels of care equivalent to those provided to surrounding populations. Concerning peer education, the response of the respondents in this study showed that all of them participated in peer education

session. Most of the respondents (**76** percent) have participated for last 2 to 3 months but the rest of the participants (**24** percent) have been participating for last one year. In relation to their interest during peer education session, all of them were more interested and the session was more attractive; this is because each topic of the cue card is presented in an interested way.

Most of the stories of the episodes were touchy that depict the practical situations of each categories of the respondents. The other interesting part of the peer education session was the questions presented for discussion after each episode request each of the peer education members to freely express their ideas, feelings and emotions without fear and shame. Almost all the respondents explained that they have not faced any challenge on the cue card content that make them confused rather new information, ideas, experience and knowledge was obtained on how to take part in the prevention of HIV/AIDS and STI. All the respondents explained that their respective peer educators have clearly explained how to utilize the coupon, the place where the selected clinic was found and take HIV Counseling and Testing (HCT) service from the clinic that was selected by the project. Among the respondents interviewed, **94** percent of them have taken coupons at least one time and the rest **8** percent have not taken at all for testing of HIV/AIDS &STIs.

A female daily laborers with 26 years old expressed:

> *"I have been working in one construction site for the last two consecutive years. It possible to say that I have no full information & idea about HIV/AIDS and STI. In addition to this, my husband and I have no information about how to use condom even though we have seen and heard of it. This time after the peer education has initiated us to get access to HIV/STI services. As everybody knows, we, construction workers, have no time to get such information and services. So, TransACTION program provide as the above service through peer education program. Therefore, this time I and my husband have better knowledge about HIV/STI, and this time we have regular testing of HIV/STI through referral service from the clinic. We have also started to use condom regularly not to bear additional child."*

To sum up, the interest of target beneficiaries in peer education session was very high and they were attracted by the discussions because all topics of the cue card were presented in an impressive way. Most of the stories of the episodes were touchy that depict the practical situations of each categories

of the respondents. According to the responses of participants, the peer members free to express their ideas, feelings and emotions with out fear and shame. In peer education, new information, ideas, experience and knowledge was obtained on how to take part in the prevention of HIV/AIDS and STI. Therefore, the service delivery system in peer education was effective which make all peer members acquire new information, knowledge and experience concerning condom utilization & promotion, HIV Counseling & Testing (HCT), HIV/STI prevention and the like.

4.2.3. HIV Counseling and Testing (HCT) and STI Diagnosis in Private Clinic

Lay counselors were recruited by TransACTION program to provide counseling at TransACTION supported private clinics and homes. A beneficiary who tests positive or negative will receive post-test counseling from a clinician after which the clinician will encourage the beneficiary to meet with the lay counselor so s/he can provide additional counseling and referrals. The main objective of locating the lay counselor in the clinic is to ensure that:

1) HIV+ clients are linked with a lay counselor, who can provide immediate and ongoing counseling, including providing and following up on referrals. It is critical that this link is made at the time of Behavior Change Strategy for the TransACTION Program receiving test results so that HIV+ clients feel that they have a support system they can easily access. Since most lay, counselors will be HIV +, patients will be able to learn from their experiences and modeling.

2) HIV– clients are provided with strong risk reduction counseling, especially tailored to MARPs groups. In addition to counseling clients at the clinic, lay counselors will also meet clients at home to provide ongoing counseling, including family members. This ongoing counseling at home is especially critical to clients who are not ready to be referred to PLHA associations, as they are not ready to disclose their status. Ongoing counseling will focus on prevention with PLHIV including disclosure, partner testing, using condoms, pre-ART counseling, treatment adherence, and referrals to PLHA especially peer education groups. When HIV+ clients are sick and need advanced care, the lay counselor will contact the nurse supervisor to provide outreach services. (Source: Behavior Change Strategy for TransACTION program, February 22, 2011, p.55)

With regard to HIV/AIDS counseling and testing and STIs service delivery, this research finding confirm that all the respondent were clearly informed by peer educators that HCT and STI service is free of charge that was covered by the project. Among the total respondents, **95** percent of the

participants have taken coupon and the remaining **5** percent of them have not taken any coupon for HIV/AIDS counseling and testing & STIs diagnosis. Among the respondents who have taken coupon, **65** percent of them have taken more than two and more than 2 times and the rest **35** percent of the respondents have taken only once. The lay counselors assigned by the project in the private clinic were in fact giving pre and post counseling for the target beneficiaries but their service provision was not satisfactory because most of the lay counselors were sitting in an open space or shared room with other staffs of the clinic and they were not effectively giving the service.

In addition, the counselors were mostly giving pre counseling and they did not give post counseling. With regard to the general satisfaction of respondents on the service provision, most of them have explained that the service delivered by the private health center (clinic) was not satisfactory. The private clinic, which was selected by TransACTION project, has problems on hospitality and the clinic only focused on business. The service delivery system was not given on time and it was unfriendly treatment. The clinic gave priority for other clients of the institution and the beneficiaries under the project were not treated equality compared to other clients/customer of the clinic.

An elderly respondent with code number 04, and 34 years old expressed her feeling as follows:

> *"One day when I have received the coupon from the peer education facilitator and decided to go to the clinic. After I have arrived there, I have communicated with lay counselors, they have told me to wait until the person who has been assigned to diagnose this case, and I stayed on a bench. While waiting there a minimum of two hours have passed. After some time, I have communicated with lay counselors and the lay counselors have asked the owner and manager of the clinic and he told to me to wait and other member of our peer education who were willing to be tested came to the clinic and both of us again stayed for long time. By the time my friend and I was waiting for the service, I have heard the owner's response saying I and my friend to come to the clinic the following day. I was completely upset because the owner of the clinic knew our job and it was very difficult that most of the time we tried to go to clinic may be after the job around 5:30 local time. This type of unfriendly service delivery system makes me and my friends to refrain and can be the cause for lack of interest to take the service from this type of clinic."*

Another respondent with code no. 01 expressed her feeling as:

> *"Two weeks before, I have received coupon from peer educator for third time to be tested for STI. I have faced a challenge from the clinic. I was waiting for testing. There were 12 beneficiaries and I was the ninth from our peer education group. After I have stayed for one hour, the nurse who have been assigned told me that she was not in a position to allow me to get the service because the number of beneficiaries who should have received the service from among code no o1 for that day have reached its maximum number. Therefore, she told me that I must return back the following day and that was a challenge I faced to incur additional transport fee more than once."*

Concerning the convenience of the location of the clinic, almost all the respondents replied that the clinic is located at convenient place but the time allocated for the beneficiaries was not comfortable. For example, the time allocated for code number one was fixed and different from code number two and the time allocated for code number two is different from that of code number three and four. Based on the responses of the respondent's, assigning fixed time for each categories of MARPs can create problems to go to the clinic since they are mobile and their livelihood is dependent on the daily basis.

A respondent code no 01 and 18 years old from Harar town explained that:

> "*The time that assigned for code no. 01 beneficiaries by the clinic was every day at 2:00 pm which is very difficult for us to go to the clinic; due to this reason, most of the time I will not go to clinic even if I have received the coupon from peer educators." This clearly showed that the time the operation hours assigned for each MARP's category by selected clinic was not convenient.*

Concerning the registration process, most of the respondents have explained that the process was not so bad but a few of the respondents explained that the registration process was bad; because the clinic may order them to wait and stay long time in the clinic while giving priorities for other clients of the clinic who were other than MARPs categories. With regard to the counseling process, **69** percent of the respondents have rated the counseling service as bad and explained that proper pre and post-counseling service was not provided by clinic. The reason was as soon as they entered to the counseling room, the nurse almost rushes to take sample blood while talking about the

advantage and disadvantage of testing and almost there is no post counseling given to the beneficiaries. The rest **31** percent of the respondents rated the counseling process as good.

In connection with the reasons for peers not going to the clinic to receive HCT/STI service, the respondents expressed the following points as the cause for some peers to refrain from getting the service: fear, worry about their status thinking that HIV might be in their blood. Besides, they have already experienced unprotected sex, lack of experience for testing, inconvenience on the operation hours of service provision and lack of awareness. However, still few of the respondents did not want to guess the reasons why their peer members not going to the clinic and nothing to say about their friend.

Concerning those **5** percent who have not received a voucher to date, they were willing to take the coupon again and visit the clinic in few days to take both HIV and STI testing by the time this research/interview was conducted.

A respondent with code no 04 and 41 years old explained work place intervention in relation to clinical services and has showed his feeling of happiness on his face while direct observation and he said:

> *"During the campaign/outreach HCT/STI service, the tent was planted around the construction site of the our work place and different kinds of activities carried out such as question and answer contest on HIV/STI, awareness raising & information exchange on HIV/STI prevention methods, distribution of leaflets, brochures,* Pamphlet *and life testimony of peer members. All these activities were accompanied and supported by local music band to make the workers motivated to take the service. This day, I was very much impressed with the whole process that the service was friendly and it did not cost us transport fee, time and other resources."*

In addition to the above, the other respondent with code no.03, age 25, said:

> *"The campaign/outreach HCT/STI service that was conducted in our construction site area was very important because as we know, the job in the construction site ended at 5.30 pm in the afternoon which is very difficult to go to the selected private clinic and get served. Therefore, the campaign creates an opportunity for us to benefit more from the service provided. it was very important for construction workers in the provision of condom to those who are engaged in sexual activities. Besides, this campaign/outreach also creates common understanding among peer educators and their boss. Most of the time, the Forman and other supervisors were not part of the peer education session so that the female daily laborers faced great challenge to convince their immediate supervisors to minimize sexual contact and really this campaign has great importance and benefited us more. If you ask me to rate this service, I can say that the service provided was very fine."*

To sum up, concerning HIV Testing (HCT) and STI diagnosis in private Clinic, this research finding indicate that HCT service was provided freely with the coupon provided from TransACTION project. The peer educators and lay counselors were motivating the target beneficiaries to take HCT service. The lay counselors assigned by the project in the private clinic were giving pre, post counseling for the target beneficiaries but their service provision was not satisfactory and they were mostly giving pre counseling, and they did not give post counseling. The counseling service in the clinic was poor and proper pre and post-counseling service was not provided by the assigned nurse I the clinic. The clinic is located at convenient place but the time allocated for the beneficiaries was not comfortable. Fear, worry about their status thinking that HIV might be in their blood, experience in unprotected sex, lack of experience for testing, inconvenience on the operation hours of service provision and lack of awareness were the causes for some peers to refrain from getting the service.

4.2.4. Information Prevention Center (IPC) and Condom distribution

Concerning condom distribution, most of the respondents explained that they have received condom from peer education sessions and Information Prevention Center whereas few of the respondents explained that they only receive from peer education sessions and other NGOs engaged in condom promotion.

A respondent with code no.01 and 20 years expressed her feeling as:

> *"Sometimes the peer educators forget to bring condoms during peer sessions and when this happened, I tried to get condoms from nearby DKT and family guidance because you do not know what will happen since our business is on daily basis and our customer are different."*

With regard to how to use condoms, one of the basic concepts included in peer education was proper and appropriate utilization of condoms. Most of the respondents have said that they have learned how to use condom in the peer education sessions. In the cue card, major steps were listed while using condoms. Every one of the peer members would practice those steps in the peer education sessions, and feedback would be given to the one who was practicing.

A respondent with code no.03 and age 40 said that:

> *"I have touched condom in my life for the first time during this peer education session. I was feeling a banned to touch or teach about condom but now am teaching the youths about the use of condom and its appropriate use"*

A respondent with code no.01 age 18, have also said:

> *"I never forget my first day I engaged in this business [sex work industry]… My first customer refused to use the condom I brought from Family guidance and insisted me to use double condom… After two days, I experienced a serious pain… During the peer session, I openly shared my case that I had sex with one customer two days before…. All the peer members have explained that this case has side effect on womb. Immediately, I become nervous and started screaming. All of the peer education session participants have shocked and asked me why am crying…. The peer members took me to hospital. The physician had treated me…. and he counseled me not to drink any alcohol before sexual intercourse. This time, thanks to my friends and the peer education program that makes me clear on the proper use of condom. Therefore, now I know how to use condom properly and I am also teaching to the other peers specially those who are newly coming to this business."*

Another respondent with code no 01 of age 18 shared her feeling saying:

> *"I was always suffering from condom breakage. After I have negotiated, I went to my business and I always found split condom and created conflict with my customers. Unfortunately, one day when I have invited to participate on peer education, I have heard the proper use of condom and I easily figured out why I was suffering for the last years in splitting of condom. From that time on, still now I am attending peer education sessions and later I become peer educator."*

Concerning the distribution of condom in the IPC, most of the respondents explained that they knew about the distribution of condom in the IPC but very few of the participants have answered, as they did not know the place where the IPC center was established. In addition, regarding the operation hour of the IPC center, most of the clients have expressed that:

> *"Most of the time when we need support from the IPC center, we always found the volunteer who are voluntarily assigned to work there. If one person works at morning, the other will work at afternoon. So that it is always open to provide support."*

From most respondents of this research, it was explained that the services delivered in the IPC includes group and individual counseling, Coupon provision, condom distribution and IEC & BCC materials (like leaflets, brochures) that explain about prevention of HIV/STI and healthy relationship between individuals, groups and communities. There are enough condoms available in the IPC and the IPC volunteers were inviting us to take condoms when need.

In relation to group-counseling service, one of the respondents said:

> *"I was in great confusion of what to do before starting session. I was engaged in unsafe sex with multiple sexual partners due to this case, I always fear and give up to test to know my status. I always challenge the peer educator about HIV transmission and unsafe sex because of my previous experience. One day, at the end of the session, the peer educator took me to the IPC volunteers and a female IPC volunteer has arrange session with me and other peer who has the same*

confusion like me. This volunteer has helped me to realize that knowing one sero status is a very vital thing rather than worrying inside. And after the end of the group discussion, I have understood that every one can live if he/she is positive after listening the experience of many other people from the explanation of the IPC volunteer and I received coupon from the IPC volunteer and get tested."

Concerning the service delivery system of the IPC center, most respondents have mentioned that the services delivered in the IPC are good. However, the counseling rooms are to narrow for counseling process and there are disturbances and noise from the surrounding that disturb both the attention of the counselor and the counselee. Few of the respondents have explained that the IPC is not opened sometimes especially after 7 pm at night and better if service continues until 8 pm at night.

A respondent with code no. 01 and age 20 explained:

"Our job is at night and most of the time the customer challenged as not to use condom. One of the reasons might be lack of access and I may have finished the condom I have. Therefore, if the IPC center was opened at night, it might be good for as to get additional condom and get prevented".

To sum up, concerning Information and Prevention Center (IPC) and Condom Distribution, the information & prevention center was the place where condom distribution and its appropriate use, individual and group counseling was carried out. It is also the place where the majority of the target beneficiaries and peer educators meet together and discuss on their social problems. Volunteers were assigned by the project to serve the target beneficiaries. With regard to the service delivery system, the IPC was providing its service in good way but the counseling rooms need to be expanded and free from disturbances. The IPC also need to continue to serve up to 2:00 pm in the evening to make the services access to MARPs.

4.2.5. Vulnerability of MARPS

Research findings indicated that mobility contributes to the risk of HIV infection, because mobile workers are more likely to have multiple concurrent sexual partners and wide sexual networks that are harder to reach with HIV prevention, treatment and follow up programs. These section of the community are not well integrated into the communities where they live; and have less access to information and services in languages they can understand across the entire breadth of the routes

those travels. HIV vulnerability is also associated with displacement, disruption of families and social and community structures in the displaced, mobile and migrant populations. Furthermore, boys and girls are more vulnerable than adults in terms of lacking parental presence, schooling, and social connectedness and they addicted to alcohol, khat, and other drugs which expose them to unprotected sex. For example, Truckers rarely use condoms with sexual partners and due to multiple sexual partners; truckers have high rates of STI and often use alcohol more often. Construction workers and big private or state farm workers are highly mobile and long absences from families and home enhances the likelihood of high-risk behavior in construction sites. More often, they are not married or not living with sexual partners and as the same time female migrants have little or no bargaining power during travel or at destination, they are prone to gender based violence. (Source: FHAPCO-HIV Prevention Package of MARPs and Vulnerable Groups, September 2011-p17)

Concerning the vulnerability of MARPs to HIV/AIDS in relation with how long they stayed in their current job, the majority of the respondents of this study explained that they started to be employed in the current job ranging from one week up to six month. On the other hand, with regard to their previous job, some of the respondents stayed from one month and others said for one year. When we saw their plan during this interview, to stay in their current job of the town that they were living, most of the participants said that they did not know when they would leave because if they got a better job with attractive wage, they could leave the town within short period. A very few of the respondents did not want to leave the town because they have already started night school.

One of the respondents with code no.03, age 19, said that

> *"It is not easy to predict when I will leave but if I can't agree with the owner of the house, I may leave today and also if I hear as there is good job in other town, definitely, I will go to night."*

Similarly, another respondent with Code no 03 expressed her feeling saying:

> *"My mobility depends on the Construction if there is no Construction here where am living for the sake of existence and survival I should have to live."*

When we consider the response of the sampled population regarding the issue that mobility could expose MARPs to HIV, almost all respondents have explained their thought that if a person were mobile, there would be a high probability for that individual to be victim and risk for HIV/STI. This is to say, the decision on the sexual contact might be on the hands of other people. Only two respondents expressed that even though mobility could expose an individual for HIV, the decision might depend on the strength and weakness of that individual

A respondent with code no 03 and 26 years old explained that:

> *"We are females. Therefore, we are victims especially for sexual harassment during our mobility place-to-place in search of jobs. I remember one of my friends who moved to find a job to other town, which she did not know before. After she arrived there, she has got a person who wants to help her to find a job and he promised her to provide her passport to send her to Dubai and he deceives her then after she have slept with him with out condom. After a while, she got a job and started to participate in the pear education program. After few months, she decided to test for HIV. The result of this woman was positive. Due to this case, she was cried and left the town with out telling anyone"*

Concerning the issue that more than one sexual partners increase the vulnerability to HIV/STI, all the respondents expressed that having, multiple sexual partner has a great risk for unwanted pregnancy and STI&HIV/AIDS. In relation with this, the majority of the respondents have expressed that those who have multiple sexual partners have higher probability to experience unsaved sexual practice and in turn exposed to HIV/STI. Only few of the respondents explained that if those MARPS that have multiple sexual partners used condoms all the time and with all partners, they might minimize the risk.

The experience of respondents with regard to having boy/girl friend or not, Most of the respondents replied that they have lover (boy/girl friend) and some of them have no girl/boy friend at all. From those respondents who have lover (boy/girl friend), very few of them have used condom to avoid unwanted pregnancy and HIV/STI and others do not use condom with their lover or boy/girl friend because they have trust on their friends.

A respondent with the code no. 1, age 23 has said:

> *"Before we have started boy/girl friend, he was my costumer and we were using condom. After he has spent so many months, he became my boy friend so after that, he is still my boy friend and we stopped using condom. If I told him to use now, he will beat me. It is the same for all us that none of us use condom with our boy friend."*

When we generally saw the alcohol consumption of response of sampled population, all the respondents with code no. 01 are highly alcohol consumers and all of them are alcohol consumers than the rest categories. All the respondents with code no. 02 with the exception of one replied that they are occasional and moderate drinkers. All code no.03 and code no 04 response showed that majority of them are occasional drinkers but few of them never drink.

With regard to the response of the respondents on the issue that whether drinking too much alcohol can negatively affect the decision to use condom or not, All of the respondent expressed that drinking too much alcohol before sexual intercourse can negatively affect the decision to use condom. Even though both the man and the woman decided to use condom while making sexual intercourse, if both of them took too much condom, they would not be able to use properly.

A respondent with code no.02 and 27 years old said that:

> *"I have the experience related to my best friend. She has told me that she used to use condom with her friend but one day she has chewed khat too much and for the first time she had drunk a lot then after she did not remember to use condom during the sexual intercourse. Later on, she has checked and she was pregnant and to abort the child she went to Mari stops clinic. After that, she aborted the child but she was very sick due to the abortion process. In the end, she has lost her job and suffered serious problem."*

To sum up, concerning the vulnerability of MARPs, most of the respondents frequently moved from one place to another in search of jobs than settling in one permanent place, which can contribute for vulnerability of MARPs for HIV/STI. In addition, most respondents expressed that they did not use condom regularly and this can be linked with in ability to decide to use condom while taking too much alcohol before sexual intercourse. Therefore, MARPs are more vulnerable to HIV/STI than the

general population because of interrelated situations that negatively affect the negotiation skills on deciding sexual contacts.

Chapter Five: Summary and Recommendation

5.1. Summary

The study has focused on assessing the service delivery system of TransACTION-Prevention and Care Services for Most at Risk Populations (MARPs) Project the case of two local NGOs. To reduce the HIV vulnerability of mobile populations in the long term, the socioeconomic and political factors that drive mobility should be addressed, including the uneven distribution of resources, unemployment, socio-economic insecurity, economic instability and socio-cultural influences. Similarly, the characteristics and underlying conditions of mobility should be addressed. Program that train peer educators in the workplace and that distribute IEC materials and condoms are extremely important. However, they do not address the root causes of vulnerability. Therefore, such program needs to be implemented in tandem with efforts that protect basic human rights and improve the living and working conditions of mobile workers. If these workers feel valued and have their basic human rights protected, they would be more likely to value their own lives enough to practice safe sex and improve their negotiation skills. Heeding and implementing them can address some of the structural causes of HIV vulnerability among mobile Populations (Source: John Snow International, HIV/AIDS interventions for Sex Workers and Mobile populations in Zimbabwe, November 2011). Therefore, most workplace programs cover peer education, condom distribution, dissemination of Information, Education and Communication (IEC) materials, HIV/AIDS awareness programs and support to Voluntary Counseling and Testing (VCT).

Most of the sampled respondents of TransACTION project have replied that there are health related services in the town, which are given by the government health center. There are also Private organizations like private Hospital recently constructed, private clinic including the Clinic that is currently networked with TransACTION Project in which they were getting clinical services and Family Guidance Association that was giving family planning services. There are drug stores (pharmacies). Concerning the type of communicable diseases in the town, almost all the respondents have mentioned that HIV/AIDS, sexually transmitted disease (such as Syphilis, gonorrhea, Chankroyid), TB, influenza and diarrhea as the most common kind of communicable diseases that were experienced by the community. Concerning HIV/AIDS prevention services, all the respondents explained that the most common services given for the community includes counseling and testing,

condom promotion and distribution, Prevention of Mothers-to-child Transmissions (PMTCT), different trainings on HIV, peer education and community conversation.

Concerning peer education, the response of the respondents in this study showed that all of them participated in peer education session. Most of the respondents (**76** percent) have participated for last 2 to 3 months but the rest of the participants (**24** percent) have been participating for last one year. In relation to their interest during peer education session, all of them were more interested and the session was more attractive; this is because each topic of the cue card was presented in an impressive way. Most of the stories of the episodes were touchy that depict the practical situations of each categories of the respondents. The other interesting part of the peer education session was the questions presented for discussion after each episode request each of the peer education members to freely express their ideas, feelings and emotions with out fear and shame. Almost all the respondents explained that they have not faced any challenge on the cue card content that make them confused rather new information, ideas, experience and knowledge was obtained on how to take part in the prevention of HIV/AIDS and STI. All the respondents explained that their respective peer educators have clearly explained how to utilize the coupon, the place where the selected clinic was found and take HIV Counseling and Testing (HCT) service from the clinic that was selected by the project. Among the respondents interviewed, **94** percent of them have taken coupons at least one time and the rest **8** percent have not taken at all for testing of HIV/AIDS &STIs.

With regard to peer education, the interest of target beneficiaries in peer education session was very high and they were attracted by the discussions because all topics of the cue card were presented in an impressive way. Most of the stories of the episodes were touchy that depict the practical situations of each categories of the respondents. The peer members were free to express their ideas, feelings and emotions with out fear and shame. In peer education, new information, ideas, experience and knowledge was obtained on how to take part in the prevention of HIV/AIDS and STI. Therefore, the service delivery system in peer education was effective which make all peer members acquire new information, knowledge and experience concerning condom utilization & promotion, HIV Counseling & Testing (HCT), HIV/STI prevention and the like.

When it comes to HIV Counseling and Testing (HCT) and STIs service delivery, this research finding confirm that all the respondent were clearly informed by peer educators that HCT and STI service was free of charge that was covered by the project. Among the total respondents, **95** percent of the participants have taken coupon and the remaining **5** percent of them have not taken any coupon for HIV/AIDS counseling and testing & STIs diagnosis. Among the respondents who have taken coupon, **65** percent of them have taken more than two and more than 2 times and the rest **35** percent of the respondents have taken only once. The lay counselors assigned by the project in the private clinic were in fact giving pre and post counseling for the target beneficiaries but their service provision was not satisfactory because most of the lay counselors were sitting in an open space or shared room with other staffs of the clinic and they were not effectively giving the service. In addition, the counselors were mostly giving pre counseling and they did not give post counseling. With regard to the general satisfaction of respondents on the service provision, most of them have explained that the service delivered by the private health center (clinic) was not satisfactory. The private clinic, which was selected by Transaction project, has problems on hospitality and the clinic only focused on business.

The service delivery system was not given on time and it was unfriendly treatment. The clinic gave priority for other clients of the institution and the beneficiaries under the project were not treated fairly compared to other clients/customer of the clinic. The peer educators and lay counselors were motivating the target beneficiaries to take HCT service. The lay counselors assigned by the project in the private clinic were giving pre and post counseling for the target beneficiaries but their service provision was not satisfactory and they were mostly giving pre counseling, and they did not give post counseling. The counseling service in the clinic was bad and proper pre and post-counseling service was not provided by the assigned nurse of the clinic. In fact, the clinic was located at convenient place but the time allocated for the beneficiaries was not comfortable. Fear, worry about their status thinking that HIV might be in their blood, experience in unprotected sex, lack of experience for testing, inconvenience on the operation hours of service provision and lack of awareness were the causes for some peers to refrain from getting HCT service.

With regard to Information and Prevention Center (IPC) and Condom Distribution, the information & prevention center was the place where condom distribution and its appropriate use was shown, individual and group counseling was carried out. IPC is also the place where the majority of the

target beneficiaries, peer educators and volunteers meet together and discuss on their best experience and social problems. Volunteers were assigned by the project to serve the target beneficiaries. With regard to the service delivery system, the IPC was providing its service in good manner but the counseling rooms need to be expanded and free from any type of noise/disturbances. The IPC also need to continue to serve up to 2:00 pm in the evening to make the services access to MARPs.

When it comes to multiple sexual partners and vulnerability to HIV/STI, all the respondents expressed that having, multiple sexual partner has a great risk for unwanted pregnancy and STI&HIV/AIDS. In relation with this, the majority of the respondents have expressed that those who have multiple sexual partners have higher probability to experience unsaved sexual practice and in turn exposed to HIV/STI. Only few of the respondents explained that if those MARPS that have multiple sexual partners used condoms all the time and with all partners, they might minimize the risk.

The experience of respondents with regard to having boy/girl friend or not, Most of the respondents replied that they have lover (boy/girl friend) and some of them have no girl/boy friend at all. From those respondents who have lover (boy/girl friend), very few of them have used condom to avoid unwanted pregnancy and HIV/STI and others do not use condom with their lover or boy/girl friend because they have trust on their friends.

When we generally saw the alcohol consumption of response of sampled population, all the respondents with code no. 01 were highly alcohol consumers and all of them were alcohol consumers than the rest categories of MARPs. All the respondents with code no. 02 with the exception of one replied that they were occasional and moderate drinkers. All code no.03 and code no 04 response showed that majority of them were occasional drinkers but few of them never drink.

With regard to the response of the respondents on the issue that whether drinking too much alcohol can negatively affect the decision to use condom or not, the entire respondent expressed that drinking too much alcohol before sexual intercourse can negatively affect the decision to use condom. Even though both the man and the woman decided to use condom before sexual intercourse, if both of them took too much alcohol, they would not be able to use properly.

As to the vulnerability of MARPs, most of the respondents frequently moved from one place to another in search of jobs than settling in one permanent place, which can contribute for vulnerability

of MARPs for HIV/STI. In addition, most respondents expressed that they did not use condom regularly and this can be linked with in ability to decide to use condom while taking too much alcohol before sexual intercourse. Therefore, MARPs were more vulnerable to HIV/STI than the general population because of interrelated situations that negatively affect the negotiation skills on deciding sexual contacts.

5.2. Recommendations

TransACTION is a PEPFAR/ USAID/Ethiopia-funded collaborative effort of the Save the Children Federation, Inc. (SC/USA) and its partners, the Academy for Educational Development (AED), Population Services International (PSI), Marie Stopes International/Ethiopia, and many local implementing NGOs (partners) including ISAPSO and Pro Pride. TransACTION aimed at preventing new HIV infections among most at-risk populations (MARP) and strengthens linkages to care and support services in 120 towns and commercial hotspots along or linked with major transportation Corridors. MARPs are group of people who have higher risk for HIV/AIDS due to mobility and other related issues than the general population. These group of people include; Female Sex Workers, Waitress, Truck drivers, Female and Male Daily Laborers and other vulnerable groups.

The major services provided for this project beneficiaries includes: Awareness creation on HIV/AIDS and STI, condom distribution and promotion, Peer education, HIV Counseling and Testing (HCT) and STI treatment through network with private clinic and Information and Prevention Center (IPC) where information, BCC materials, individual and group counseling was carried out.

The effect of HIV/AIDS appropriate service delivery system of prevention and intervention programs on MARPs can positively contribute to the reduction of HIV/AIDS at family, community, institutional, regional, national and international level. Therefore, based on the findings, the following recommendations are provided.

1. The approach of TransACTION program focuses on prevention, which is good because it emphasizes on targeted populations that are more at risk for HIV than the general populations to

prevent the spread of the virus. But the program need to include other vulnerable groups such as military, high school and out of school youths, Truck drivers, drug users, etc

2. The care and support component of the program focuses on peer support than financial and material support. However, there are people who have been affected by livelihood problem that need material and financial support. The linkage of beneficiaries with government hospital to get food by prescription is very low that need to be improved.
3. The economic strengthening component of the project focuses on giving matching fund based on the saving amount of the each member of target groups. The matching fund is not satisfactory to help the beneficiaries to be engaged in Income Generating Activities (IGA). All the target beneficiaries were informed that they would be organized in Self Saving Group (SSG) after completing peer education sessions. Therefore, in order to make the target populations to start business, they should be provided sufficient amount of matching fund.
4. The Information and Prevention Centers (IPCs) are providing important services in TransACTION program such as group and individual counseling, condom promotion and distribution, distribution of IEC/BCC materials and Information. It would be better if these IPCs are expanded to serve as referral linkage and health professionals/nurses are assigned in it to provide standardized services. Therefore, it would be better if IPCs were made to serve various services and it can be the place where different MARPs categories meet and discuss their problems and issues.
5. The topics included in the peer education are fine; but family planning issues were not emphasized. Except condom promotion, long-term contraceptive methods of family planning methods were not included that need to be emphasized in the future.
6. There is no negotiation that the service provision system for MARPs should be friendly. Those MARPs peer group members who go to private clinic for HCT service. Since the private clinics were established for profit maximization, the project should increase the unit price to cover the cost the service per individual. The clinic health professionals should emphasize on post counseling because this time most people have information on testing for HCT.
7. Sexually Transmitted Infections (STI) in TransACTION project focus on syndrome Management that focus on the clients life history and the physician can find the drug that attack similar group of STI types. However, there might exist beneficiaries that could not explain themselves and there might be a problem on the capacity of the nurse to identify the type of STI via syndromic

management method. Therefore, sometimes, the clinics need to take clinical diagnosis through laboratory to solve the problem of both the nose and the client.

Since MARPs are more vulnerable to HIV/STI than the general population, the prevention services especially those that are more accessible & work place intervention such as peer education, condom distribution, HCT service should continue to address MARPs. In addition, intensive and extensive information provision, awareness creation and education towards establishing structured intervention need to be continued in the future.

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APPENDIX 1

Semi-structured Interview questions for Assessment of Service Provision of Transaction-Prevention and Care services for Most at Risk Populations (MARPs) Project.

INFORMED CONSENT

Dear Respondent,

Good morning/good afternoon. My name is Ermias Bekele and MSW student at IGNOU, which is hosted by St.Mary's University College. I am studying the experience of Female Sex Worker (FSW), Waitress, Male and Female daily laborers who are the beneficiaries of TransACTION Project with regard to identifying HIV/AIDS related services in the town, the service delivery on peer education, HIV Counseling and Testing (HCT) at private clinic and Information and Prevention Center (IPC). My role in this interview will be facilitating the whole interview session. The overall objective of this study is to ask you some questions and conduct assessment related to service delivery system of TransACTION-prevention and care services for MARPs project you experienced. This interview questions are designed to collect primary data from *Female Sex Worker (FSW), Waitress, Male and Female daily laborers. The selection of the respondent is based on the proportionate of different MARPs categories (FSW, waitress, Male and Female Daily laborers) that also consider the sex balance in order to get different practical experiences on the service provision. Participation in this study is voluntary and everything you say will remain confidential. The response given by the respondents will be primarily used for academic purposes. Thus, your genuine and complete response is of paramount importance for the success of the study and help to understand the quality, accessibility and friendliness of the service provided by the MARPs project in Ziway and Harar towns and make some recommendations in the same regard.*

Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any of the questions that you do not feel comfortable with, and you may end this talk at any time you want to. You will be contacted again if the researcher needs additional information. We would greatly appreciate your help in responding to the interview. The interview will take 20-30 minutes. Would you be willing to participate?

Agree [ ] Disagree [ ]

General Information

- Respondent's Code_____
- Time of Commencement of an interview-------
- Ending Time----------
- Interviewer's Name-------
- Name of the coordinator ------------------------------

I. Demographic and Socio-Economic variables

1. sex:_____
2. Age:_____
3. Marital status:_____
4. Household size:_____
5. Religion:_____
6. educational background:_____
7. Occupation:_____
8. How long have you been working here?_____
9. Source of income:_____
10. Do you have Mobile Phone to contact you?(Yes/No), If No, do you have other mobile phone to contact you?(Yes/No)

II. General Understanding on different services in Ziway and Harar towns including HIV/AIDS and STI

1. What are the services provided in your town in relation with family planning HIV/AIDS and STIs?

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2. Does government or private sector provide these services?

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3. Do you name communicable diseases in your area?

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4. Can you please identify HIV/AIDS related services in your town?

III. Peer Education(PE)

1. Could you please tell me how long have you been participating in peer education? ----------
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2. Do you enjoy the peer education sessions? ----------

   -----
3. Do you have difficulty in using/understanding the cue cards? (Yes, No) if yes, please, cite the main challenges in using/understanding the cue cards
   ---

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4. Is the content on the cue cards about using/understanding vouchers for testing clear? ----------
   ---

   ---.
5. Have you been offered a voucher to date?

   ---.
6. Has the peer educator fully explained how to use the voucher? ----------
   ---

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7. Do you know where the clinic is? ----------

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8. Is the clinical service provided in the clinic in general satisfactory? ----------
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IV. HIV Counseling and Testing (HCT) and STI diagnosis in selected private Clinic/Hospital for the project beneficiaries

1. Do you know that the testing services for STI/HIV are free?

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2. How many vouchers have you received to date? ----------

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3. Are lay counselors providing Pre and post counseling in the selected clinic/hospital?

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4. If you have attended the clinic for services, how you rate the service you were provided at the clinic? (Bad, good, excellent) if bad, why? ----------
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5. Is the location of the clinic convenient for you? (yes, No) ----------
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6. Are the operation hours convenient for you? ----------

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7. How would you rate the registration process? (bad, good, excellent)

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8. How would you rate the counseling process? (Bad, good excellent) if bad, why? ----------
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9. What are the reasons for peers not going to the clinic to receive HCT/STI service? ----------
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10. If you have not received a voucher to date, would you be willing to visit the clinic? (Yes, No)

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11. Would you be interested in an STI counseling and diagnosis? (Yes, No) ----------
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12. Is there a chance for you to get clinical services at your work place? (yes, No) If yes, when and how do you rate the service delivery? (Bad, Good, Excellent) and explain the reason. -----
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V. Information Prevention Center (IPC) and Condom distribution

1. Is there condom distribution? (Yes, No) if yes, from where do you get (during peer education, IPC) ----------
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2. Are you well informed on proper use of condoms? (Yes, No) ----------
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3. Are there sufficient numbers of condoms in the IPC? ----------
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4. Is the IPC opened daily (Yes, No) ----------
5. What services are provided in the IPC? ----------
6. Are BCC messages provided in the IPC through mass media, leaflets, brushers, etc? ----------
7. Is counseling (individual, group) given in the IPC? (Yes, No) if yes, how do you rate the service delivery? (bad, good, excellent) ----------
8. In your opinion, what will be your suggestions to improve the service? ----------

VI. Mobile and Most at risk people vulnerability to HIV/AIDS

1. How long have you been in your current work place? ----------

2. How long have you stayed in your previous job place? ----------
3. How long do you think to stay in this country? ----------
4. Do you think moving from one place to other place will make the person more vulnerable to HIV/AIDS? If you answer is yes, how could it be? ----------
5. Dou you think that having more than one sexual partners in crease the vulnerability to HIV /AIDS? Why? ----------
6. How many times do you have experience of un save sex (with out condom)?if you have sexual experiences with how many peoples?(one, two, three, money people ,so many people)
7. Do you have boy/girl friend? ----------
8. If your answer if yes ,do you have sexual experience with him/her?(yes ,no) if yes, do you use condom during sexual intercourse?(never, sometimes ,always ----------

9. If your answer is sometimes or never for the question no.8 , do not you experienced a problem during sexual intercourse?(yes, no) if yes ,what type of problem? ----------
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10. Do you drink alcohol?(never, little ,moderate ,high) ----------
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11. Do you thing drinking alcohol highly will affect the decision of the person to use condom during sexual intercourse? ----------
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