UNIVERSITY OF IGNOU

SCHOOL OF GRADUATE STUDIES

HEALTH AND RELATED PSYCHOLOGICAL AND SOCIAL PROBLEMS OF FEMALE COMMERCIAL SEX WORKERS IN ARADA SUB-CITY, ADDIS ABABA

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF UNIVERSITY OF IGNOU IN PARTIAL FULLFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN SOCIAL WORK.

ADDIS ABABA, ETHIOPIA

ACKNOWLEDGMENTS

My cordial appreciation forwarded to my advisor, for his excellent scientific guidance and tireless efforts to make this work a reality. His comments and suggestions throughout my research time are of a highly prized value.

I gratefully acknowledge University of IGNOU for creating such a conducive learning environment.

I wish to thank Arada Sub-City Governors who gave me permission and support in conducting the research and also data collectors who participate in pre testing and data collection in this locality.

Finally, my heartfelt thank goes to my family, especially to my dad for giving all rounded support in the academic career, I wouldn’t reach here without his support and also special tanxs to my mom who is always there for me, last but not least thanks for my loving husband for his endless support and care.

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ABBREVIATIONS AND ACRONYMS

a.s.l - above sea level

AIDS - Acquired immunodeficiency syndrome

BCC - Behavioral change communication

BSS - Behavioral surveillance survey

CSW - Commercial sex worker

ETB - Ethiopian birr

FHI - Family Health International

FMOH - Federal Ministry of Health

FSW - Female sex worker

HIV- Human Immunodeficiency Virus

IDs - Identification Numbers

IEC - Information Education Communication

NGO - Non-governmental organization

NLCP - National Tuberculosis and Leprosy Control Program

PI - Principal Investigator

PTSD - post-traumatic stress disorder

SPSS - Statistical Package for Social Science

STD - Sexually Transmitted Disease

STI - Sexually transmitted infection

VD - Venereal Disease

WHO -World Health Organization

Abstract

Ethiopia is one of the developing countries. There are many marginalized people in both rural and urban areas and the country experiences considerable seasonal labor migration mostly from rural areas to urban. Female labor migrants seeking work in Ethiopia, in particular, mostly engage in commercial sex work, which expose them to different kinds of health and psychological-social problems. The objective of this study is to assess the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa. The study conducted in different bars, hotels and restaurants. This work employed both qualitative and quantitative methodology. It combined detailed one-to-one interviewing with personal observation to bring out the perspectives of the women themselves. The data collected by utilizing the designed questionnaire, checked for completeness and consistency by the researcher. Data entry and analysis carried out using SPSS version 20. Descriptive statistical methods were used to explore the characteristics of the study participants and their health, social and psychosocial problems. 50 female sex workers participated in the survey for this study. Participants' ages range from 18-47. 41 (82%) participants identified as Amhara, 3(6%) as Tigre, 2(4%) identified themselves as Oromo and the rest 4(8%) as mixed, Oromo and Amhara. According to the CSWs interviewed the common illnesses that the women suffer are STIs (66%) with syphilis (38%) and gonorrhea (36%) cited as the most common. Chancroid (10%) and HIV / AIDS (6%) were also mentioned. The following symptoms of depression had been observed, insomnia (60%), feelings of worthlessness or excessive inappropriate guilt (52%), diminished ability to think or concentrate (48%), and recurrent thoughts of death and suicidal ideation (22%). The findings of this study showed that most of CSW suffers from different types of health and psychosocial problems. STIs with syphilis and gonorrhea cited as the most common. Symptoms of depression had been observed. Moreover, the majority of the CSWs interviewed expressed that they suffered from Post traumatic stress disorder and have shown signs of anxiety disorder. Stigma and discrimination were stated as the commonest social problems of the CSWs.

CHAPTER ONE

1. INTRODUCTION

1.1. BACKGROUND

Ethiopia is one of the developing countries. There are many marginalized people in both rural and urban areas and the country experiences considerable seasonal labor migration mostly from rural areas to urban. Female labor migrants seeking work in Ethiopia, in particular, mostly engage in commercial sex work, which expose them to different kinds of health and psychological-social problems.

In the 1950s and 1960s, the number of hotels, bars/restaurants, '[2]tella', '[3]araki', '[1]tej', and other eating and drinking establishments and the number of sex workers increased markedly. These establishments were the primary sites where clients met sex workers. During the 1960s and 1970s, sex workers and waitresses working in hotels, bars, restaurants etc. were examined monthly for sexually transmitted infections (STI) and other communicable diseases at government health centers and clinics, as part of the 'weekly Venereal Diseases(VD) Control

[1] **Tej** – a local alcohol made of a mixture of honey and sugar

[2] **Tella** - local beer made of barely,

[3] **Araki** – local alcohol made of a mixture of grains,

Program. Nevertheless, this service was discontinued in the 1980s when the program was integrated into the general health services (FHI-ETHIOPIA, 2002).

Commercial sex workers are exposed to numerous adverse conditions such as poor living conditions/housing, social stigma and sexually transmitted infections, including HIV. Studies conducted between 1988 and 1991 by the Ministry of Health in 23 Ethiopian towns indicated the seriousness of both HIV and STI among female sex workers (Mehret1992; Workineh, 1994). In most urban areas, HIV prevalence among sex workers was over 20% and in some towns prevalence was as high as 50%. Nevertheless, efforts to address the problem amongst this target population have been limited. Moreover, the problem has been compounded by Ethiopia's poor socioeconomic conditions.

Women experience higher rates of depression and anxiety in the general population (Angst , Gamma , Neuenschwander et al, 2005). Some researchers linked increased anxiety or depression rates of women to health damaging psychosocial factors like high job demands and low decision latitude in work (Lennon, 1995). As a marginalized group, female commercial sex workers are normally expected to experience poorer health than comparable age groups of the general population. But because of the quasi-legal or illegal and stigmatizing character of sex work, sex workers do not fit into the public health framework of occupational health (Jones , 2007), although there is a growing demand for both legal and illegal sex work.

For example in the United Kingdom, where sex work is illegal, the proportion of men who reported paying for sex doubled in the decade from 1990 to 2000 (Ward , 2005). Given that public health is more concerned with the health of customers of sex workers, public health actions almost exclusively focus on risks associated with transmittable infectious diseases like human immunodeficiency virus / acquired immune deficiency syndrome rather than on health questions in general or in particular on the mental health consequences of sex work. But across all topics, articles expressing opinions or stereotypes about sex work seem to outweigh research articles (Day, 2007).Most women do not choose sex work; rather, they are forced into this type of work because of drug addiction, poverty, or lack of education (Romero-Daza, 1998–99 and Williamson, 2001; cited Sep 2002). These factors, in addition to their lives on the streets, expose sex workers to a number of health problems other than HIV/AIDS and sexually transmitted diseases (STDs). No studies have determined the general health problems of women whose occupation is sex work. In addition, little attention has been paid to the health information needs of sex workers, although sources of information about STDs and HIV/AIDS have been identified (Mak, 1991&Wolitski, 1996).

1.2. STATEMENT OF THE PROBLEM

A certain female becomes sex worker due to several problems. For instance, poverty and loss of parent or guardian can be taken as a major cause for becoming a sex worker. As Ethiopia is one of developing countries there are different kinds of social and economic problems that undermine the health status of sex workers. There are several factors that heighten sex workers' vulnerability to STD (FHI-ETHIOPIA, 2002). As many sex workers are migrants from different

rural areas to the city of Addis Ababa it is very difficult to reach through standard health service, and also their mobility highly spreads diseases. As a marginalized group, sex workers are normally expected to experience poorer health than comparable age groups of the general population. Moreover, because of the quasi-legal or illegal and stigmatizing character of sex work, sex workers do not fit into the public health framework of occupational health (Jones, 2007). Since commercial sex workers are part of the society, their problems specifically with regard to health, social and psychological aspects must be studied with great scrutiny. The researcher conducted the study in Arada sub city, one of the ten sub-cities of Addis Ababa. It is located at the center of the city. There are many Bars, Restaurants and Hotels which accommodate them. In countries and States where the government sanctions female commercial sex workers selling their services, sex workers are required to attend clinics on a regular basis to check for evidence of sexually transmitted disease. When diseases are found, treatment will be given so that transmission will be prevented. This all helps to minimize the infection in unwanted disease, some of which are more easily treated than others (Roxburgh , 2006). Due to several societal problems like poverty, illiteracy, family death, and other societal malignancies, young females are susceptible to sex work; in order to earn some sort of income. And this situation is highly hazardous to their health.

In Ethiopia the most repeatedly discussed issues have been “causes of Commercial sex worker”, “types of Commercial sex worker” and “consequences of Commercial sex worker” (Alemayehu., 1996; Alemayehu., 1973; Banchiyeleku, 1984; Habtamu, 1991; Seble, 1998, Tamene, 1993). The same themes have been tested over and over again with an ever increasing number of samples. It

appears that this happened partly for lack of research integration, poor archival research, and/or inaccessibility of earlier research reports.

This study focused on the health, related psychological and social issues of female commercial sex workers. Since socially and psychologically healthy society members are fit enough to be productive; this sub-topic is dedicated in raising the main problems in relation with the health, social and psychological issues of female commercial sex workers in Arada Sub-city, Addis Ababa.

Research Questions

The study was guided by the following questions:

1. What are the health related problems that commercial sex workers in Arada sub city face?
2. What are the social related problems that commercial sex workers in Arada sub city face?
3. What are the health social and psychological problems commercial sex workers in Arada sub city face?
4. What are the perceived barriers to commercial sex workers' access to health care services?
5. What information do commercial sex workers in the study area need to tackle their health, social and psychological problems?

1.3. OBJECTIVES

1.3.1. GENERAL OBJECTIVE

To assess the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa.

1.3.2. SPECIFIC OBJECTIVE

The specific objectives of this study are to:

- assess the health problems of female commercial sex workers, in Arada sub-city, Addis Ababa.
- examine the health related psychological problems in female commercial sex workers, in Arada sub-city, Addis Ababa.
- assess the social problems of female commercial sex workers in Arada sub-city, Addis Ababa.
- explain factors that influence health among female commercial sex workers in Arada sub-city, Addis Ababa.
- assess the barriers to health care services among female commercial sex workers in Arada sub-city, Addis Ababa.

1.4. SIGNIFICANCE OF THE STUDY

The health, social, and economic consequences of HIV/AIDS have prompted numerous studies about the risk factors, transmission and knowledge about this disease among female commercial sex workers. Although scanty reports are available about sex workers and the social context of sex work in Addis Ababa, little is known about the health, related psychological and social problems of female commercial sex workers in the city.

- The findings of this study are worthwhile to women and children affair office of Arada sub-city to design comprehensive and holistic approaches by integrating the prevention, protection and rehabilitation strategies at micro and macro levels of interventions.

- In addition to this, the results of this study could be helpful in establishing an integrated medical and psycho-social support services within the health institutions (hospitals and health centers) in order to address the medical, psycho- social and emotional needs of commercial sex workers.

Therefore, this study is aimed to assess the aforementioned issues and provide relevant information to policy makers and other stake holders that are interested on the intervention of this kind of scope.

1.5. DELIMITATION OF THE STUDY

This study is delimited to assessment of the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa.

1.6. LIMITATIONS OF THE STUDY

- There could be a possibility of social desirability biases in responding their cultural sensitive sexual issues and information obtained on the socio-cultural and demographic characteristic could be changed over a time, not reflecting the true pictures.
- There could be a possibility of recall biases during determination of event related to psychological problems occurring in the past and there would be potential biased conclusions.
- High non-response rate as results of commercial sex workers fatigue since there is no incentive in this study and the information in the study variables required are culturally sensitive and time consuming.
- There was a financial problem to include all the sex workers in the study area.

1.7. OPERATIONAL DEFINITIONS

Araki bet/house - A house where local alcohol (araki) is sold. Many araki sellers also sell sex.

Bar/ restaurant- An establishment where drinks and/or food are served. This definition limits bar/restaurants to those establishments that do not provide accommodation. Nightclubs, pubs, kebele recreation centers and groceries that primarily serve drinks are included in this category.

Bar/restaurant-based sex workers - Women, sometimes employed as barmaids by the bar/restaurant, who use the establishment to make contact with sex clients.

Brothel - An establishment with a number of rooms that acts as a base for sex workers. Sex clients visit the brothel to make contact with the sex workers. The sex client may use a room at the brothel or may take the sex worker to another place. The brothel owner takes a good share of the money paid to each sex worker in the house.

Café house - An establishment where coffee, cakes and cold drinks are served. It is similar to a pastry house.

Establishment- A house, building (big or small), recreation center or other place where food and drinks are served for clients or customers. Rooms for accommodation may also be available.

Grocery - A kind of liquor store that also serves drinks to its customers. Usually, it has long bench seats and employs male waiting staff to serve drinks to customers.

Home based sex workers - Women who sell sex from the building or house where they live. This includes sex workers in brothels, red-light houses, tella, araki and tej bets, zigchilots, shiro bets and others. This category excludes sex workers based in hotels, bars and restaurants.

Hotel - An establishment where food and drinks are served for clients; rooms for accommodation are also available. To meet the needs of differing clientele, hotels range from small low-cost establishments to large five-star buildings.

Hotel-based sex workers - Sex workers, sometimes also employed by the hotel toserve food and drinks, who sell sex to the hotel clients, with or without the hotel's permission.

Pastry shop - An establishment where cold drinks, coffee, tea and cakes are served to clients.

Red-light house- Usually, a single room for residence and for commercial sex. Sometimes two sex workers share a room.

Sex work - Sex work is defined as work completed by any person who exchanges sexual services for economic compensation, such as money, drugs or alcohol. Bernstein (2007).

Sex worker - A commercial sex worker; an individual who is paid money in exchange for sex.

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

Tella bet/house - A house where local beer (tella) is served. Some but not all tella sellers are sex workers.

Woreda - The second level administrative unit of the government structure. A woreda is composed of two or more kebeles.

Zigchilot - The living quarters of sex workers who retain some anonymity within the community. Since these are hidden houses, they are usually identified through pimps or friends.

CHAPTER TWO

2. LITERATURE REVIEW

The health, social, and economic consequences of HIV/AIDS have prompted numerous studies about the risk factors, transmission and knowledge about this disease among female commercial sex workers. In some of the studies about this disease, other health problems have been identified.

In their study of risk behaviors for HIV, Faugier, Cranfield, and Sargeant, 1997 interviewed 100 drug-using and 50 non-drug-using female commercial sex workers in Manchester, England. The authors noted that while many women were aware of the risks of HIV, 33% of drug users and 12% of non-drug users were willing to dispense with condoms if they could get more money from their clients. General health problems identified by these authors were poor antenatal care, hepatitis, malnutrition, and many different types of infections that were resistant to treatment.

Identifying the need for more research on the general health-related concerns of commercial sex workers, Valera, Sawyer, and Schiraldi interviewed 100 individuals (42 females, 32 males, and 26 male trans-genders) who worked as street prostitutes in Washington DC (Valera, Sawyer, and Schiraldi, 2001). Data were collected through the use of two established instruments: the post-traumatic stress disorder (PTSD) checklist and a thirty-two-item instrument that "examined demographic information, life experiences as a commercial sex worker, and perceived health needs

and health status”(Valera, Sawyer, and Schiraldi, 2001). The authors listed sixteen different physical health problems and reported the percentages of respondents in each of the three groups who acknowledged having a particular health condition. Thirty women reported being raped since entering commercial sex work. Of the forty-two females interviewed, twelve (28.6%) were listed as having physical health needs, four women (9.5%) as having general body pains, and three women (7.1%) as having anemia. Very small percentages (2.4%) of the forty-two women were listed for each of the following diseases: sickle cell anemia, asthma, high blood pressure, diabetes, syphilis, hepatitis B, dizzy spells, or positive HIV status. From the description of the results, it was difficult to determine whether a woman had more than one ailment or what was included in the category “physical health needs.”

Weiner studied the social and medical needs of 1,963 streetwalking sex workers in New York. Using an ex-post facto design, she analyzed sex workers’ responses on a two-page questionnaire that gathered information about demographics, sex and drug practices, risk reduction, and health history. Gonorrhea, syphilis, tuberculosis, and hepatitis were the diseases mentioned by the women (Weiner, 1996). Implication from this study suggests that there are barriers to treatment due to a woman’s status as a sex worker. Certain drug treatment facilities exclude sex workers from entering into programs, believing that the women will continue to trade sex for money or drugs and undermine the program. Weiner (1996) also identifies the vulnerability of sex workers loss of social services due to disclosing their status as sex workers. Women who disclose their sex work status risk the removal of their children from their homes, loss of parental rights, and expulsion from social support systems, such as their families or church. Weiner (1996) advises social workers to be sensitive to the

difficulty sex workers have in trusting workers and revealing information related to their sex work status.

In a study conducted by Seugio Aral and his colleagues in 2002 in Moscow, in response to ever increasing economic deprivation, informal economies associated with crime, sex work, and drugs emerged and rapidly expanded. The economic situation of women deteriorated and domestic and international trafficking of women in the sex trade increased. In addition, sex work became less covert and more visible in public venues. Age at first sex has dropped and a more permissive attitude to multiple sex more common (Seugio Aral et al., 2002). In the same study, interviews and observations suggest that the behavior of many health care providers towards sex workers reflect negative social attitudes toward marginalized populations and affects both the quality of care that is provided and sex workers willingness to approach public health care facilities, female sex workers consistently described differences in their interaction with the physicians according to whether the providers were aware of the type of work that preformed. One informant described observing a physician who was examining another sex worker by using a pen to avoid touching her (Seugio Aral et al., 2002).

In a study conducted in New Zealand examined the mental and physical health of female sex workers, findings described mental health seeking behaviors of female sex workers. This study points to the difficult issues sex workers face in disclosing their status as sex workers to health professionals, arising as a result of the marginalized position of sex work in society (Romans, Potter, Martin, & Herbison, 2001). The study looked at the participants' professional mental health

help seeking behaviors as well as their social support seeking behaviors. Of the 29 participants interviewed, in relation to their lifetime experiences in therapy, almost half of participants (n=14) had seen a counselor, one third had seen a psychologist (n=9), and one fifth (n=6) had seen a psychiatrist at least once (Romans, Potter, Martin, & Herbison, 2001). In regards to non-professional emotional support, over 90% (n=27) of participants said that they had someone to talk to if something was troubling them. Participants named a partner or a female friend (28%), a fellow sex worker (17%) another person (17%), and parent (n=1) as people they talked to when something was troubling them (Romans, Potter, Martin, & Herbison, 2001).

Given that public health is more concerned with the health of customers of sex workers, public health actions almost exclusively focus on risks associated with transmittable infectious diseases like human immunodeficiency virus ⁄acquired immune deficiency syndrome rather than on health questions in general or in particular on the mental health consequences of sex work. But across all topics, articles expressing opinions or stereotypes about sex work seem to outweigh research articles (Day & Ward, 2007). Rigorous research is therefore needed to understand the precise context of sex work (Brooks-Gordon, 2008).

In another study, El-Bassel et al. assessed levels of psychological distress in a sample of poor, inner city women from Harlem. Of the 346 women interviewed, 176 were classified as sex traders (those who had traded sex for money or drugs within the 30 days prior to the interview) and 170 as non-sex traders (women who had never traded sex for money or drugs or who had not done so in the 30 days

prior to the interview). The authors found that more sex traders than non-sex traders were homeless and had been raped within the past year. The former group also had significantly higher mean scores of psychological distress (e.g. anxiety, depression, hostility) as measured by the Brief Symptom Inventory subscales and the General Severity Index (El-Bassel et al., 1997).

The vast majority of research related to sex workers addresses the physical health and safety of sex workers, but does not discuss their psychosocial needs. Research has shown that such workers maintain high rates of HIV risk behaviors, substance abuse, and are often victims of violence. (Nemoto et al, 2005). Much of the research has been derived from a public health perspective with less of an emphasis on psychological factors. Literature pertaining to the psychological impact of sex work has centered on the notion that sex work is seen as a form of emotional labor (Giner-Sorolla, 2006) with the use of such techniques as identity boundaries and disassociation (Chapkis, 1997) to cope with work related stress and prevent burnout (Vanwesenbeeck, 2005).

In most studies of sub-Saharan Africa the burden of STIs other than HIV among FSW is high, with half to two-thirds typically having a curable STI at any one time. In some settings, 10% or more have an active genital ulcer and over 30% have reactive syphilis serology (Dunkle, 2005 & Feldblum, 2005). Gonorrhea and Chlamydia infection may be found in a third or more of sex workers, trichomoniasis is common, and many women have multiple infections (Alary, 2002 & Laurent, 2003). Where testing has been done, as reported by a study in Tanzania, about two-thirds of FSW have evidence of herpes infection (Riedner, 2003). Significantly, FSW with ulcerative STIs,

such as herpes simplex virus type 2 and chancroid are more likely to transmit HIV, particularly in settings where men are uncircumcised, although an STI in either partner facilitates HIV transmission. Sex workers commonly report that economic necessity or fear of violence makes it difficult for them to avoid or refuse male clients with an obvious STI, such as a genital ulcer (Elmore-Meegan, 2004).

Many young African women who trade sex for food, money or shelter come from disadvantaged backgrounds, are poorly educated, divorced, and lack the skills required for other types of formal or informal employment. A startling proportion of FSW in West and East Africa have received no formal education; well more than 10% in most of these studies and above a third in several. Economic and food insecurity may make sex work the sole survival option for women, particularly those with dependents or whose parents have died (Campbell, 2000). Food insecurity, in particular, may predict unsafe sexual behavior among sex workers, as found in Nigeria (Oyefara, 2007 & Gysels et al., 2002).

In Ethiopia, interest in Commercial sex workers, goes back to the 1960s (Mayor, 1962, 1963, Andargachew, 1967; Lema, 1968), has increased in leaps and bounds since the end of the 1970s and the beginning of the 1980s (Laketch, 1991; Bethlehem, 2002). However, with a few outstanding exceptions, notably that of Laketch (1991), Andargatchew (1988), and Bethlehem, 2002,), these studies displayed common characteristics in terms of themes, approaches, and conclusions (Bethlehem, 2005).

One study found that 63% of sex workers in Addis Ababa cited poverty as the major factor that influenced them to become sex workers (Bethlehem, 2005). As Bethlehem argues, this seems like an underestimate, perhaps because mutually exclusive choices of answer were offered. Sex workers all said that it is difficult to attract enough customers to make sustained changes to their economic status and this is presumably a direct consequence of oversupply and subsequent low prices and other unfavorable conditions for the seller. Sex is cheap even by local standards. This distinguishes the situation of sex workers in Ethiopia who tend to stay poor, from their counterparts in middle income countries where poverty is relative and sex work is in fact a route to a more prosperous life for many women (Bethlehem, 2005).

Another study in Ethiopia indicate that, amongst those FSWs who Knew/remembered the age at which they first had sex, 90.8% reported that they were less than or equals to 19 year old. Worryingly, 49.9% reported that they were less than or equals to 15 years old. Age when respondents first received money for sex ranged from 10 to 40 years old. A small group of FSWS (8.2%) started to sell sex when they were less than or equals to 15 years old. The most commonly mentioned reasons for becoming a sex worker were financial problems (36%), divorce /separation (18.4%) and disagreement with people they lived with (18.4%)(Getnet et al., 2002).

The same study indicates that, 4.9% of the FSWS reported having had STIs (genital discharge or ulcer/sore). FSWs that had experienced an STI during the previous 12 months were asked what

treatment they had received. In general, 83.5% of the FSWs had sought medical care from health service institutions. Actions mentioned other than treatment included: stopping sexual activities at the time when symptoms were present (20.8%); seeking advice from peers/friends about the symptoms (19.2%); and seeking advice/medicine from a private pharmacy (14.9%). About one in ten (9.2%) of the FSWs with a history of STI sought advice/medicine from a traditional healer or took traditional medicine they had at home (Getnet et al., 2002).

CHAPTER THREE

3. METHODOLOGY

3.1. STUDY DESIGN

This study was carried out in different bars, hotels and restaurants of Arada sub-city, Addis Ababa, the capital city of Ethiopia. It employed both qualitative and quantitative methodology. The study combined detailed one-to-one interviewing with personal observation to bring out the perspectives of the women themselves. Quantitative and qualitative data was collected from different bars, hotels and restaurants from the selected sub-city. The study focused on Female Sex Workers (FSWs) aged 18-50 years who have involved in the sex trade in exchanging sex for money or equivalent at least for the past one year prior to the survey and willing to participate in the study.

3.2. STUDY SETTING

This study was carried out in different bars, hotels and restaurants of Arada sub-city, Addis Ababa, the capital city of Ethiopia. Addis Ababa has a surface area of 540 Square kilometer of which 11.56 Km^2 areas is defined by Arada sub city (AAAMPSC, 2004). In the year 2007 the population of the city was about 2.74 million, 5046 people live per Square kilometer, and 52.4%

of the residents were females (CSA, 2007). Administratively, the city is divided into 10 sub-cities and 116 *Woreda* which are the lowest administrative units. The Addis Ababa city administrations had potential health service coverage of 21% in 2009 G.C. (FMOH, 2009).

The altitude of Arada sub city ranges between 2300 m and 2,500 m a.s.l (EMA, 1982). The lowest and the highest annual average temperature of Addis Ababa, Arada Sub city, are about 10 ^{0}c and 25 ^{0}c (Tilaye Nugussie and Mesfin Tilaye, 1998). The climate is divided in to three distinct seasons. The period of heavy rains (*Kiremt*) occurs between June and September, The dry period (*Bega*) is between October and January, and the small rains (*Belg*) occurs between March and May (MAA, 2002).

According to CSA (2007), Arada Sub City, one of the 10 Sub Cities of Addis Ababa, has about 37,897 housing unit. Based on the information extracted from Addis Ababa Trade and Industry Bureau data base in May (2007), there are around 13,396 commercial establishments or centers in Arada Sub City and among which 48.78 % of them are retailers shops, 20.58 % of them are business centers, 20.24 % of them are Bar and Restaurants, 5.87 % of them are wholesalers shops and 4.53 % of them are Repair service providers.

3.3. STUDY UNIVERSE AND SAMPLES

All female commercial sex workers working sex as a means of living at Arada sub-city were sample universe of the study. The exact number of female commercial sex workers working sex as a means of living at the sub-city is not known. The study focused on female sex workers(FSWs) aged 18-50 years who have involved in the sex trade in exchanging sex for money or equivalent, at least for the past one year prior to the survey. 50 female sex workers participated in the survey for this study. A 'quota' approach was used to sample the respondents. This approach specifies that a proportional number of interviews were conducted in each bar/hotel or site. The quota was determined based on the total number of FSWs selected, as well as the minimum number of FSWs estimated to be found in a particular bar/hotel or site. However, in bars where it was anticipated that only a few sex workers were present, all of the sex workers were contacted. In contrast, when large numbers of sex workers were expected, a fixed number of sex workers were selected randomly.

3.4. INCLUSION AND EXCLUSION CRITERIA

All participants between the ages of 18 years and 50 years old having all the necessary information were included in the study.

3.5. DATA COLLECTION INSTRUMENT

An instrument was developed through the modification of questionnaires used by the World Health Organization. The questionnaire was firstly developed in English and then translated into Amharic language.

Interviewing was appropriate in situations where sensitive issues were addressed. Conducting semi-structured interviews allowed the researcher to hold some elements of control over the line of questioning, whilst still leaving scope for respondents to cover issues not directly addressed in the interview schedule.

3.6. PILOT STUDY

The questionnaires were first developed in English and then translated in to Amharic, which was the common language of the study subjects. A standard questionnaire that addresses all important variables were prepared and pre-tested in areas similar to the study area in other parts of Addis Ababa to avoid contamination; and feedback was used to make modifications to the questionnaires.

3.7. DATA COLLECTION PROCEDURE

Data were collected from different bars, hotels and restaurants where the female commercial sex workers could be found. Data of all female commercial sex workers was collected by health

professionals recruited for this study with possible experience in data collection in previous similar studies

Ten interviewers (five female and five male) were trained to conduct the round I interviews. All were at least diploma holders. Thus, interviewers were instructed to make the highest possible care during interview session to record response correctly and completely.

Interviews were conducted at a convenient location chosen by the respondent, usually in a public area due to fear of disclosure of their occupation. Questionnaire completion took 45 minute to two hours. The in-depth interviews were completed by the first interviewer that lasted between two to five hours and several visits were made to complete one case history as needed.

To ensure standard (uniform) transformation of information, the principal investigator was around to respond to questions that may arise from misunderstanding or doubts. The investigator tried her best to avoid incompletely filled questionnaires and/or implausible answer that may cause misunderstanding. Supervision was conducted by the principal investigator during data collection for timely edition of the data and feedback.

3.8. DATA QUALITY ASSURANCE

To ensure quality of the data the following measures were taken. A one day training was given for data collectors before the start of data collection. The overall activities of data collection were monitored by the principal investigator, and there was strict supervision during data collection. This was done by cross checking about 10 % of the collected data with the actual source. All completed questionnaire was examined for completeness and double data entry systems were used. Besides, consistency of the collected data was checked during analysis.

3.9. DATA PROCESSING AND ANALYSIS

The data collected by utilizing the designed questionnaire was checked for completeness and consistency by the researcher. Data entry and analysis was carried out using SPSS version 20. Descriptive statistical methods were used to explore the characteristics of the study participants and their health social and psychosocial problems. The computer program, SPSS, summarizes the data and calculates the percentages and responses for each question.

3.10. ETHICAL CONSIDERATION

Ethically, informed consent of the respondent should be obtained first. To this end, the rights of the respondents to refuse to answer for few or all questions were respected. The interview was conducted in a way that it would not violate their privacy and confidentiality of information. In

order to ensure confidentiality of the information, names or other identifications of study participants were not included in the data sheet.

CHAPTER FOUR

4. FINDINGS

4.1. DEMOGRAPHIC CHARACTERISTICS

4.1.1. SOCIO-DEMOGRAPHICS

50 female sex workers participated in the survey for this study. Participants' ages range from 18-47. 28 (56%) of the participants ages ranged from 24 to 32, 14 (28%) participants' age ranged from 18 to 24, 7 (14%) participants' age ranged from 33 to 40 and 1(2%) of participants' age ranged from 41 to 46. No participants' ages fell under the age range of 47-50.41 (82%) participants identified as Amhara, 3(6%) as Tigre, 2(4%) identified themselves as Oromo and the rest 4(8%) as mixed, Oromo and Amhara.

When asked to describe their work, participants were asked to check all that apply. 43(86%) participants described their work as bar lady, 5 (10%) participants described their work as street worker and the rest 2 (4%) as escort. 43(86%) participants work managed through the bar/hotel they were working in, 5 (10%) participants worked exclusively as an independent, 2 (4%) participants work was a combination of independent work and owning the bar/hotel they were working in. The longest time working as a sex worker was 15 years (n=1) and the shortest time as a sex worker was 5 months (n=2). The average length of years working as a sex worker was 4.25 years.

Table 1: Demographic characteristics of respondents

Characteristics	Number	Percentage (%)
Age group (in years) (n= 50)		
18 – 24	14	28
24 – 32	28	56
32 -40	7	14
40 -46	1	2
47 - 50	0	0
Ethnicity(n=50)		
Amhara	41	82
Oromo	2	4
Tigre	3	6
Mixed(Amhara & Oromo)	4	8
Type of Sex work(n= 50)		
Street worker	5	10
Bar lady	43	86
Escort	2	4
Do the sex work (n= 50)		
Independently	5	10
Managed via the bar/hotel	43	86
Both independently and Managed	2	4

4.2. HEALTH RELATED PROBLEMS EXPERIENCED BY CSWS

To determine the nature of health problems experienced by the participants in this study, the researcher reviewed notes and lists compiled during the interview visits. According to the CSWs interviewed the common illnesses that the women suffer are STIs (66%) with syphilis (38%) and gonorrhea (36%) cited as the most common. Chancroid (10%) and HIV / AIDS (6%) were also mentioned. The majority of the CSWs visit the nearby health centers for treatment for STIs and some of them visit the private hospitals / clinics. Some of them claim to visit a traditional healer, or take traditional medicine.

The women also voiced a considerable number of physical health concerns, respiratory problems (20%) including allergies, sinus infections, colds, pneumonia, and tuberculosis. Also mentioned was the need to be tested for tuberculosis (TB) or to have a TB test. A few other physical health conditions identified by the women were dental problems, lip burns, facial rashes and sores, herpes, frost bite, swollen legs, bleeding ulcers, abscesses on legs, and cellulites or osteomyelitis. One woman had a fractured arm, while another had sutures in her head that needed to be removed. A woman stated she had found a swelling in her breast.

Lack of information appeared to be a barrier to health care. Many of the women stated that they did not have enough money to get the health care. Some women did not know where they could get health care. Others knew they should seek medical care, but it seemed to be low on their list of priorities.

4.3. PSYCHOLOGICAL PROBLEMS EXPERIENCED BY CSWS

Commercial sex workers often have endured extreme trauma in their lives before, during, and after their work in the sex work and frequently show signs of depression, anxiety, and post traumatic stress disorder. The symptoms of these diagnoses may have specific implications to commercial sex workers.

According to the findings of this study, the following symptoms of depression had been observed, insomnia (60%), feelings of worthlessness or excessive inappropriate guilt (52%), diminished ability to think or concentrate (48%), and recurrent thoughts of death and suicidal ideation (22%). These symptoms could be dangerous for any individual; they may pose a significant threat to the welfare of a commercial sex worker who often has to make critical decisions to keep herself safe while they are working.

A person diagnosed with a generalized anxiety disorder has extreme anxiety that often gets generalized into several facets of their being and can make life in general seem frightening or overwhelming. The anxiety that commercial sex workers may experience due to the danger and stress in their profession may transfer into other important areas of their lives and prove hazards to their ability to function. Based on the findings of this study, (72 %) of the respondents have shown signs of anxiety disorder.

Post traumatic stress disorder (PTSD) occurs when the trauma of an event prevents a person from returning to their normal level or functioning after a catastrophe. Often nightmares, flashbacks, hypervigilance, fearfulness, numbness, and an inability to connect to others are symptoms experienced by people with PTSD. Many commercial sex workers are assaulted while working. Commercial sex workers may be less inclined to report assault and consequently there is an increased probability that they may not receive care or counseling after the trauma and, because of the dangers, could be re-traumatized by returning to work. These disorders, coupled with a lack of resources (real or perceived), and frequent substance abuse offer minimal opportunities for these women to receive psychiatric evaluations, counseling, or therapy. Based on the findings of this study, a great majority (74 %) of the CSWs interviewed expressed that they suffered from Post traumatic stress disorder.

Addiction to khat or alcohol was also prevalent among the sex workers observed. Depression, thoughts of suicide, and grief caused by the loss of a parent were also some of the psychological problems mentioned by the women.

Out of 50 participants 46 (92%) hadn't sought professional help as defined as a counselor, psychologist, peer counselor, therapist, or social worker for emotional issues and 4(8%) had sought professional help for emotional issues. Although most of the participants who reported never having sought professional help for emotional issues, 7 participants reported that when they have emotional issues or problems, they talk to someone and 2 participants reported that they do not talk to anyone when they have such emotional issues. 17 reported talking to a friend,

8 women talked to an intimate partner, 4 talked to a co-worker, and 2 women talked to their family when they have emotional issues or problems.

Table 2: Type of people whom CSWs talk to when they have emotional problems

Type of people	No. of Respondents	Percentage (%)
Friend	17	42.5
Co-worker	4	10
Family	2	5
Intimate Partner	8	20
Other*	9	22.5

*other – Refers to participants reported that when they have emotional problems, they talk to someone (n=7) or do not talk to anyone (n=2).

Those who did not report talking to someone when they have emotional issues, engaged in the following behaviors when experiencing emotional issues, spiritual practice (n=4), withdrawing from normal activities (n=2), drink alcohol and/or chew khat (n=3). One participant described being temporarily "disconnected" from her emotions until the problem in question is resolved, fades into the background or is ignored.

When asked why they have not sought professional help, 28 participants reported they did not know where to go for help, 12 participants stated that they lacked adequate money, 1 participant don't need help, and 5 participants specified other reasons. 3 of these 5 participants commented, "I didn't trust opening up fully to professionals, I was afraid of being judged, and I was never long enough in one spot to be able to communicate with the professionals". Another participant

explained, “I don’t know if they would understand” and another participant stated, “It is hard to find the right kind of help suitable to me”.

Participants reported talking to others about the following emotional and relationship issues (n=16), health related issues (n=12), work related issues (n=4), family issues (n=4), grief/loss (n=4), emotional support (n=2), and legal issues (n=2). 2 participants talked to someone about the possibility of a career outside of sex work.

Table 3: Type of issues being talked by CSWs for non-professionals

Type of issues being talked about	No. of Respondents	Percentage (%)
Grief/Loss	4	8.7
Health Related	12	26.07
Relationship	16	34.78
Family	4	8.7
Legal	2	4.35
Work Related	4	8.7
Emotional Support	2	4.35
Other*	2	4.35

*other – Refers to type of issue being talked about the possibility of career outside the sex work.

Participants who sought emotional supports from non-professionals were asked to rate the helpfulness of such a dialogue (Table 4). Participants were asked how helpful talking to someone

about their emotional issues was for various life issues including crisis, family relations, social situations, school, sex work, non-sex work, housing, participating in meaningful activities, taking care of their own needs, and handling difficult situations. 42 out of 46 participants agreed with the statement, "I am better able to handle things when they go wrong" as a result of talking to someone about their emotional issues. 41 of 46 respondents also agreed that as a direct result of talking to someone about their emotional issues, they were better able to deal with the crisis (n=41), do better in social situations (n=31), do thing that are more meaningful to them (n=41), and are better able to take care of their needs (n=39).

Table 4: Respondents who sought emotional supports from non-professionals

How helpful did you find talking about your emotional problems? As a direct result of talking to someone about my emotional issues:						
Answer Options	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	NA
I am better able to deal with the Crisis	7	34	5	0	0	0
I am getting along better with my family	3	24	19	0	0	0
I do better in social situations	6	25	15	0	0	0
I do better in school	4	11	11	0	0	20
I do better in my work as a sex worker	11	18	17	0	0	0
I do better in my work (non-sex work, if applicable)	4	6	16	0	0	20
My housing situation has improved	1	17	4	3	0	21
I do things that are more meaningful to me	4	37	4	0	0	1
I am better able to take care of my needs	4	35	7	0	0	0
I am better able to handle things when they go wrong	4	38	1	1	1	1
						Answered=46

4.4. SOCIAL PROBLEMS EXPERIENCED BY CSWS

Sex workers face stigma and discrimination in different forms. It is also very common for female commercial sex workers (FCSWs) to face violence from a range of sources including clients, employers, community members, partners and other sex workers.

Very few i.e. 8% of the commercial sex workers reported positive interactions with their families, while an equal number reported distant relationships and abusive relationships. The women reported receiving no respect because of their occupation. Almost half i.e. 48% of the respondents reported as they suffer from stigma and discrimination.

According to the CSWs interviewed in this study, harassment and abuse are almost universal and seen as an expected part of a CSW's life, particularly when they are new and inexperienced. The abuse and violence CSWs face routinely as part of their work lowers their self-esteem and diminishes their self worth.

CSWs are highly stigmatized because of their job and the CSWs in this study recognize this and speak of routinely being insulted and mistreated by non-CSWs; people in the street, neighbors and in particular married women, who fear the CSWs will steal their husbands.

The clandestine, violent and stigmatized nature of sex work, a CSW's perceived control over her life and her limited employment options all combine to reduce the ability of a CSW to implement effective preventative behaviors, that is to say to escape sex work or to hinder factors that lead her to social malfunctions.

There is almost a unanimous desire among these women to leave sex work but all feel that they are unable to, or are not yet ready to do so. Many CSWs argue that they would not be able to get used to having to wait to the end of the month to be paid, as is usual in many other jobs, as they are used to being paid instantly for their services. There is a general inability among these SWs to save the money they earn. Many speak of wanting to leave sex work and start their own businesses, but of being unable to save up enough cash to do so.

For many of the participants, sex work is tough work that involves insecurities and risks of all kind; however, it is also a kind of work that brings the women into contact with a wide range of people on a daily basis.

CHAPTER FIVE

5. DISCUSSION

The purpose of the study was to explore the health related psychological and social problems of female commercial sex workers which is yet to be recognized as an important social and public health problem in Ethiopia like other countries of Africa (Wendy Fisher, 2003). Stigma and disapproval of sex work from society at large may limit sex workers willingness to access health related services. Overall, the study findings reiterated the importance of fundamental principles of social work. For example, one of social work's key values is to respect the worth of a person, including that of self-determination. In addition social workers make a commitment to demonstrate competence in the provision of services that are sensitive to clients' cultures and social diversity.

According to the CSWs interviewed, the common illnesses that the women suffered were STIs (66%) with syphilis (38%) and gonorrhea (36%) cited as the most common. Chancroid (10%) and HIV / AIDS (6%) were also mentioned, which are similar to a study conducted in New York City (Baker et'al, 2003).

Like a similar study done in Switzerland the women in this study voiced a considerable number of physical health concerns. Respiratory problems included allergies, sinus infections, colds,

pneumonia, and tuberculosis. Other health conditions identified by the women were dental problems, lip burns, facial rashes and sores, herpes, frost bite, swollen legs, bleeding ulcers, abscesses on legs, and cellulites or osteomyelitis (Rossler et’al, 2010).

Commercial sex workers often have endured extreme trauma in their lives before, during, and after their work in the sex industry and frequently show signs of depression, anxiety, and post-traumatic stress disorder which are similar to symptoms shown in another study done by El-Bassel and his colleagues in 1997.

Another similar study done in different areas and culture also showed a similar psychological out comes as this study which stated as People in sex work suffer from posttraumatic stress disorder (PTSD). Symptoms are anxiety, depression, insomnia, irritability, flashbacks, emotional numbing, and hyper alertness. Farley and his colleagues in 1998 interviewed 475 prostituted people in 5 countries (South Africa, Thailand, Turkey, USA, and Zambia) and found that 67% met diagnostic criteria for PTSD, suggesting that the traumatic sequel of sex work were similar across different cultures.

As Herek, Capitanio and Widaman argued in 2002, although the level and form of stigma changed during the past two decades people are still showing negative attitude towards female commercial sex workers. Similarly, the findings of this study explained that commercial sex workers face stigma and discrimination in different forms. According to the CSWs interviewed

in this study, harassment and abuse are almost universal and seen as an expected part of a CSW’s life, particularly when they are new and inexperienced. CSWs are highly stigmatized because of their job and the CSWs in this study recognize this and speak of routinely being insulted and mistreated by non-CSWs; people in the street, neighbors and in particular married women, who fear the CSW will steal their husbands. To the contrary, very few i.e. 8% of the commercial sex workers reported positive interactions with their families. The later one is in agreement with a study conducted in Zambia by Wendy Fisher, 2003.

Sex work means high vulnerability due to FSWs’ low social status and self-esteem, lack of education and skills, poverty, family responsibility, poor health, negative societal attitudes, illegal nature and legal restrictions (Wong et al., 2003). This vulnerability may result in difficulties accessing health services and treatments, a lack of safe sex practices, increased abortion rates, and low negotiation power in condom use (UNAIDS Geneva, 2008). More specifically, in Ethiopia, one study has documented FSWs' low access to STI services (UNAIDS/WHO, 2006), and generally women with STIs are low users of health services (Tandukar, 2003). Based on the findings of this study, even though the commercial sex workers voiced a considerable number of physical health concerns, they didn’t get health care services. Lack of information appeared to be a barrier to health care. Many of the women stated that they did not have enough money to get the health care. Some women did not know where they could get health care. Others knew they should seek medical care, but it seemed to be low on their list of priorities.

Meanwhile, out of 50 participants 46 (92%) hadn't sought professional help as defined as a counselor, psychologist, peer counselor, therapist, or social worker for emotional issues and 4(8%) had sought professional help for emotional issues. When asked why they have not sought professional help, 28 participants reported they did not know where to go for help, 12 participants stated that they lacked adequate money, 1 participant don't need help, and 5 participants specified other reasons. 3 of these 5 participants commented, "I didn't trust opening up fully to professionals, I was afraid of being judged, and I was never long enough in one spot to be able to communicate with the professionals". Another participant explained, "I don't know if they would understand" and another participant stated, "It is hard to find the right kind of help suitable to me".

CHAPTER SIX

6. SUMMARY, CONCLUSION, RECOMMENDATION AND IMPLICATIONS FOR FURTHER RESEARCH

6.1. SUMMARY

Ethiopia is one of the developing countries. There are many marginalized people in both rural and urban areas and the country experiences considerable seasonal labor migration mostly from rural areas to urban. Female labor migrants seeking work in Ethiopia, in particular, mostly engage in commercial sex work, which expose them to different kinds of health and psycho-social problems. The objective of this study was to assess the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa.

The study was conducted in different bars, hotels and restaurants. This work employed both qualitative and quantitative methodology. It combined detailed one-to-one interviewing with personal observation to bring out the perspectives of the women themselves. The data collected by utilizing the designed questionnaire was checked for completeness and consistency by the researcher. Data entry and analysis was carried out using SPSS version 20. Descriptive statistical methods were used to explore the characteristics of the study participants and their health, social and psychosocial problems.

50 female sex workers participated in the survey for this study. Participants' ages range from 18-47. 41 (82%) participants identified as Amhara, 3(6%) as Tigre, 2(4%) identified themselves as Oromo and the rest 4(8%) as mixed, Oromo and Amhara.

According to the CSWs interviewed the common illnesses that the women suffer are STIs (66%) with syphilis (38%) and gonorrhea (36%) cited as the most common. Chancroid (10%) and HIV / AIDS (6%) were also mentioned. According to the findings of this study, the following symptoms of depression had been observed, insomnia (60%), feelings of worthlessness or excessive inappropriate guilt (52%), diminished ability to think or concentrate (48%), and recurrent thoughts of death and suicidal ideation (22%). Very few i.e. 8% of the commercial sex workers reported positive interactions with their families, while an equal number reported distant relationships and abusive relationships. The women reported receiving no respect because of their occupation. Almost half i.e. 48% of the respondents reported as they suffer from stigma and discrimination.

As conclusion the findings of this study showed that most of CSW suffers from different types of health and psychosocial problems stated as followed, according to the CSWs interviewed the common illnesses that the women suffer are STIs with syphilis and gonorrhea cited as the most common. Chancroid and HIV / AIDS were also mentioned. The following symptoms of depression had been observed, insomnia, feelings of worthlessness or excessive inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death and suicidal ideation. Moreover, the majority of the CSWs interviewed expressed that they suffered from Post

traumatic stress disorder and have shown signs of anxiety disorder. Stigma and discrimination were stated as the commonest social problems of the CSWs.

6.2. CONCLUSION

This study was focused on the health, related psychological and social problems of female commercial sex workers in Arada Sub-city, Addis Ababa. A total of 50 female sex workers were participated in the survey for this study. Participants' ages range from 18-47. 56% of the participants' age ranged from 24 to 32. Most respondents described their work as bar lady and work managed through the bar/hotel they were working in. The longest time working as a sex worker was 15 years and the shortest time as a sex worker was 5 months. The study showed that there is a considerable health concerns stated by female commercial sex workers of Arada sub-city. According to the CSWs interviewed the common illnesses that the women suffer are STIs with syphilis and gonorrhea cited as the most common. Chancroid and HIV / AIDS were also mentioned. The majority of the CSWs visit the nearby health centers for treatment for STIs and some of them visit the private hospitals / clinics. Some of them claim to visit a traditional healer, or take traditional medicine. The women also voiced a considerable number of physical health concerns, respiratory problems including allergies, sinus infections, colds, pneumonia, and tuberculosis. Lack of information appeared to be a barrier to health care. Even though some of the respondents got information about health care services, many of the women stated that they did not have enough money to get the health care. According to the findings of this study, the following symptoms of depression had been observed, insomnia, feelings of worthlessness or excessive inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts

of death and suicidal ideation. Moreover, the majority of the CSWs interviewed expressed that they suffered from Post traumatic stress disorder and have shown signs of anxiety disorder. Stigma and discrimination were stated as the commonest social problems of the CSWs. Out of the fifty participants most of the sex workers hadn't sought professional help as defined as a counselor, psychologist, peer counselor, therapist, or social worker for emotional issues.

6.3. RECOMMENDATIONS

The findings made it clear that problems related to health, related psychological and social problems and their predisposing factors are numerous and complex.

- It is therefore, worthwhile to design comprehensive and holistic approaches by integrating the prevention, protection and rehabilitation strategies at micro and macro levels of interventions.
- Establishing an integrated medical and psycho-social support services within the health institutions (hospitals and health centers) in order to address the medical, psycho- social and emotional needs of commercial sex workers is needed.
- It is important to recognize the health related problems of sex work. Health care professionals are among the most respected professionals in our society. They can play a major role in improving the way society deals with sex workers.
- Target oriented, audience specific, appropriate and consistent IEC (Information Education Communication) campaign should be designed to address the diverse information needed for those who are working in the sex work and joining to this life.

- Educational curricula should include subject about sex work while taking in to consideration the importance of informal education given through print and mass media.
- A club or an association of females CSWs with a vision of transforming in the developmental activities and an intermediate goal of capacity building should be organized.
- Establish local advocacy coalition team which composed of the government and non government organization, and the female CSWs' representatives which undergo advocacy campaign on the harmful effect of commercial sex so that the sex workers' reach voluntary decision and to enforce policy maker to formulate relevant laws and regulations.

6.4. IMPLICATIONS FOR FURTHER RESEARCH

Most sex workers live and work under poor environmental conditions. Establishment owners exploit sex workers; the sex workers receive low salaries or are unpaid and in some cases share their income with establishment owners. A study of the magnitude of this exploitation and the economic needs of sex workers is required urgently.

It may be helpful to further examine sex workers' health, related psychological and social problems of female commercial sex workers, with a larger sample size or a more in-depth analysis, such as through individual case studies. Further research is required to establish the extent to which CSWs' experiences observed in Arada sub-city of Addis Ababa could reflect a national pattern.

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12. ANNEX – SEX WORKERS QUESTIONNIRES

RECRUITMENT QUESTIONS

Survey Questions

Pre-Screen Questions (*Required for Participation)

***Are you between the ages of 18-50?**

1. Yes

2. No (SURVEY END. THANK YOU, BUT YOU ARE NOT ELIGIBLE FOR THIS SURVEY)

***Have you exchanged sexual services for money or another reward in the past year?**

1. Yes

2. No (SURVEY END. THANK YOU, BUT YOU ARE NOT ELIGIBLE FOR THIS SURVEY))

Survey Start

Q1. How old are you?

1. 18-24

2. 25-32

3. 33-40

4. 41-50

Q3. How long have you been working as a sex worker?

1. Years: _____

2. Months: _____

3. Days: __________

Q4. What describes your work? CHECK ALL THAT APPLY

1. Street Worker

2. Bar lady

3. Escort

4. Other (Please Specify): _________________________

Q5. Do you work?

1. Exclusively as an independent

2. Exclusively managed or with an agency

3. Combination of independent and managed/agency

Q6. Have you ever sought professional help (i.e. counselor, psychologist, peer counselor, therapist, social worker, etc) for emotional issues?

1. Yes (IF YOU ANSWERED YES, PLEASE SKIP TO THE NEXT QUESTION)

2. No

Q7. Why haven't you sought professional help (i.e. counselor, psychologist, peer counselor, therapist, social worker, etc) for emotional issues?

1. Don't know where to go for help

2. Not enough money

3. Services were unavailable

4. Don't need help

5. Other (Please specify): ________________________________

Q8. When you have emotional issues or problems, do you talk to someone?

1. Yes (IF YOU ANSWERED YES, PLEASE SKIP TO NEXT QUESTION)

2. No

Q9. What do you do when you have emotional problems or issues?

1. Spiritual Practice

2. Withdraw from Normal Activities

3. Exercise/Physical Activity

4. Drink Alcohol and/or Use Drugs

5. Nothing

6. Other (Please specify): ______________________

SURVEY END; THANK YOU FOR COMPLETING THIS SURVEY, PLEASE GO TO END OF SURVEY.

Q10. Who do you talk to about emotional issues?

1. Friend

2. Co-Worker

3. Family

4. Intimate Partner

5. Other (please specify) __________________

Q11. What types of things have you talked to them about? CHECK ALL THAT APPLY

1. Grief/Loss
2. Health Related Issue
3. Relationship Issue(s)
4. Family Issue(s)
5. Legal Issues
6. Work Related Issues
7. Emotional Support
8. Other (Please specify): ______________________________

Q12. How helpful did you find talking about your emotional problems?

As a direct result of talking to someone about my emotional issues:

Answer Options	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	NA
I am better able to deal with the Crisis						
I am getting along better with my family						
I do better in social situations						
I do better in school						
I do better in my work as a sex worker						
I do better in my work (non-sex work, if applicable)						
My housing situation has improved						
I do things that are more meaningful to me						
I am better able to take care of my needs						
I am better able to handle things when they go wrong						

SURVEY END, THANK YOU FOR TAKING THIS SURVEY, PLEASE SKIP TO END OF SURVEY.

Q13. How were you referred to help for your emotional issues? CHECK ALL THAT APPLY

1. On my own
2. Friend outside of sex work
3. Another sex worker
4. Health Extension worker
5. Community Based Organization
6. Other (Please specify): _________________

Q14. What part of your income would you usually get from doing sex work?

1. None
2. Some
3. About half
4. Most
5. All

Q15. Before you became a sex worker – how were you employed?

1. Not employed
2. House maid servant
3. Full-time work
4. Daily Laborer

5. Student

Q16. Who, outside of the people you know in the sex industry, knows that you are a sex worker?

1. Family members
2. Close friends
3. Neighbors
4. Acquaintances

Q17. Have you ever been diagnosed with an STI/HIV?

1. Yes
2. No

Q18. How often do you check your clients for signs of Sexually Transmitted Infections (STIs)/HIV?

1. Never
2. Some times
3. Always

Q19. What do you do about a client you suspect of having an STI/HIV?

1. Refuse to see the client
2. Refer client to another worker
3. Do as usual
4. Other, please specify

Q20. If a client offers you more money for sex without condom, what would you usually do?

1. Not applicable
2. Refuse to see the client
3. Accept the money and do the job
4. Talk the client in to using the condom
5. Refer client to another worker
6. Other, please specify

Q21.What kinds of illnesses have you ever suffered from? **CHECK ALL THAT APPLY**

1. STIs (syphilis , gonorrhea , Chancroid)
2. Respiratory problems including allergies, sinus infections, colds, pneumonia, and tuberculosis
3. Dental problems
4. Lip burns
5. Facial rashes and sores, herpes
6. Others (Specify) ....

Q22. Which of the following psychological problems have you ever faced from? **CHECK ALL THAT APPLY**

1. Depression
2. Anxiety
3. PTSD(post traumatic stress disorder)
4. Others (Specify) ....

Q23.What kinds of social problems did you faced being as a sex worker? **CHECK ALL THAT APPLY**

1. Violence
2. Stigma
3. Discrimination
4. Interaction
5. Others (Specify) ....

Q24. Compared to one year ago, how would you rate your health in general now? Would you say it is?

1. Much better than one year ago
2. Somewhat better now than one year ago
3. About the same as one year ago
4. Somewhat worse now than one year ago

5. Much worse now than one year ago

Q25. To what extent has your physical health or emotional problems interfered with your social activities like visiting family, friends, neighbors or groups.

1. Not at all
2. Slightly
3. Moderately
4. Quite a bit
5. Extremely

Q26. Right now, would you like to leave the sex industry?

1. Yes, definitely
2. Yes, mostly
3. Don't know
4. No, mostly
5. No, definitely

Q27. Thinking of the sex industry as a whole, how safe do you feel on average?

1. Not safe at all
2. A little safe
3. Moderately safe
4. Quite safe
5. Extremely safe

Q28. Since starting work as a sex worker how do you think the industry has changed?

1. Much worse
2. Somewhat worse
3. No change
4. Somewhat better
5. Much better

Q29. In general, would you say your health is?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Q30. Is there anything that you would suggest to health care providers to improve their work with sex workers?

UNIVERSITY OF IGNOU

SCHOOL OF GRADUATE STUDIES

HEALTH AND RELATED PSYCHOLOGICAL AND SOCIAL PROBLEMS OF FEMALE COMMERCIAL SEX WORKERS IN ARADA SUB-CITY, ADDIS ABABA

BY: WONGELAWIT ANDUALEM

A PROPOSAL SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF UNIVERSITY OF IGNOU IN PARTIAL FULLFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN SOCIAL WORK.

ADDIS ABABA, ETHIOPIA

ACKNOWLEDGMENTS

My cordial appreciation forwarded to my advisor, Dr. Assaye, for his excellent scientific guidance and tireless efforts to make this work a reality. His comments and suggestions throughout my research time are of a highly prized value.

I gratefully acknowledge University of IGNOU for creating such a conducive learning environment.

I wish to thank Arada Sub-City Governors who gave me permission and support in conducting the research and also data collectors who participate in pre testing and data collection in this locality.

Finally, my heartfelt thank goes to my family, especially to my dad for giving all rounded support in the academic career.

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ABBREVIATIONS AND ACRONYMS

a.s.l - above sea level

AIDS - Acquired immunodeficiency syndrome

BCC - Behavioral change communication

BSS - Behavioral surveillance survey

CSW - Commercial sex worker

ETB - Ethiopian birr

FHI - Family Health International

FMOH - Federal Ministry of Health

FSW - Female sex worker

HIV- Human Immunodeficiency Virus

IDs - Identification Numbers

NGO - Non-governmental organization

PI - Principal Investigator

PTSD - post-traumatic stress disorder

SPSS - Statistical Package for Social Science

STD - Sexually Transmitted Disease

STI - Sexually transmitted infection

VD - Venereal Disease

WHO -World Health Organization

Summary

Ethiopia is one of the developing countries. There are many marginalized people in both rural and urban areas and the country experiences considerable seasonal labor migration mostly from rural areas to urban. Female labor migrants seeking work in Ethiopia, in particular, mostly engage in commercial sex work, which expose them to different kinds of health and psychological-social problems.The objective of this study will be to assess the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa.The study will be conducted in different bars, hotels and restaurants. This work will employ both qualitative and quantitative methodology. It will combine detailed one-to-one interviewing with personal observation to bring out the perspectives of the women themselves.The data will be collected by utilizing the designed questionnaire, checked for completeness and consistency by the researcher.Data entry and analysis will be carried out using SPSS version 20. Descriptive statistical methods will be used to explore the characteristics of the study participants and their health, social and psychosocial problems.The total budget that will be needed for conducting the study including the contingency is 7038 Ethiopian birr.

CHAPTER ONE

1. INTRODUCTION

1.1. BACKGROUND

Ethiopia is one of the developing countries. There are many marginalized people in both rural and urban areas and the country experiences considerable seasonal labor migration mostly from rural areas to urban. Female labor migrants seeking work in Ethiopia, in particular, mostly engage in commercial sex work, which expose them to different kinds of health and psychological-social problems.

In the 1950s and 1960s, the number of hotels, bars/restaurants, ‘[2]tella’, ‘[3]araki’, ‘[2]tej’, and other eating and drinking establishments and the number of sex workers increased markedly. These establishments were the primary sites where clients met sex workers. During the 1960s and 1970s, sex workers and waitresses working in hotels, bars, restaurants etc. were examined monthly for sexually transmitted infections (STI) and other communicable diseases at government health centers and clinics, as part of the ‘weekly Venereal Diseases(VD) Control

[1]**Tej** – a local alcohol made of a mixture of honey and sugar

[2]**Tella** - local beer made of barely,

[3]**Araki** – local alcohol made of a mixture of grains,

Program. Nevertheless, this service was discontinued in the 1980s when the program was integrated into the general health services (FHI-ETHIOPIA, 2002).

Commercial sex workers are exposed to numerous adverse conditions such as poor living conditions/housing, social stigma and sexually transmitted infections, including HIV. Studies conducted between 1988 and 1991 by the Ministry of Health in 23 Ethiopian towns indicated the seriousness of both HIV and STI among female sex workers (Mehret1992; Workineh, 1994). In most urban areas, HIV prevalence among sex workers was over 20% and in some towns prevalence was as high as 50%. Nevertheless, efforts to address the problem amongst this target population have been limited. Moreover, the problem has been compounded by Ethiopia's poor socioeconomic conditions.

Women experience higher rates of depression and anxiety in the general population (Angst , Gamma , Neuenschwander et al, 2005). Some researchers linked increased anxiety or depression rates of women to health damaging psychosocial factors like high job demands and low decision latitude in work (Lennon, 1995). As a marginalized group, female commercial sex workers are normally expected to experience poorer health than comparable age groups of the general population. But because of the quasi-legal or illegal and stigmatizing character of sex work, sex workers do not fit into the public health framework of occupational health (Jones , 2007), although there is a growing demand for both legal and illegal sex work.

For example in the United Kingdom, where sex work is illegal, the proportion of men who reported paying for sex doubled in the decade from 1990 to 2000 (Ward , 2005). Given that public health is more concerned with the health of customers of sex workers, public health actions almost exclusively focus on risks associated with transmittable infectious diseases like human immunodeficiency virus / acquired immune deficiency syndrome rather than on health questions in general or in particular on the mental health consequences of sex work. But across all topics, articles expressing opinions or stereotypes about sex work seem to outweigh research articles (Day, 2007).Most women do not choose sex work; rather, they are forced into this type of work because of drug addiction, poverty, or lack of education (Romero-Daza, 1998–99 and Williamson, 2001; cited Sep 2002). These factors, in addition to their lives on the streets, expose sex workers to a number of health problems other than HIV/AIDS and sexually transmitted diseases (STDs). No studies have determined the general health problems of women whose occupation is sex work. In addition, little attention has been paid to the health information needs of sex workers, although sources of information about STDs and HIV/AIDS have been identified (Mak, 1991&Wolitski, 1996).

1.2. STATEMENT OF THE PROBLEM

A certain female becomes sex worker due to several problems. For instance, poverty and loss of parent or guardian can be taken as a major cause for becoming a sex worker. As Ethiopia is one of developing countries there are different kinds of social and economic problems that undermine the health status of sex workers. There are several factors that heighten sex workers' vulnerability to STD (FHI-ETHIOPIA, 2002). As many sex workers are migrants from different

rural areas to the city of Addis Ababa it is very difficult to reach through standard health service, and also their mobility highly spreads diseases. As a marginalized group, sex workers are normally expected to experience poorer health than comparable age groups of the general population. Moreover, because of the quasi-legal or illegal and stigmatizing character of sex work, sex workers do not fit into the public health framework of occupational health (Jones, 2007). Since commercial sex workers are part of the society, their problems specifically with regard to health, social and psychological aspects must be studied with great scrutiny. The researcher conducted the study in Arada sub city, one of the ten sub-cities of Addis Ababa. It is located at the center of the city. There are many Bars, Restaurants and Hotels which accommodate them. In countries and States where the government sanctions female commercial sex workers selling their services, sex workers are required to attend clinics on a regular basis to check for evidence of sexually transmitted disease. When diseases are found, treatment will be given so that transmission will be prevented. This all helps to minimize the infection in unwanted disease, some of which are more easily treated than others (Roxburgh , 2006). Due to several societal problems like poverty, illiteracy, family death, and other societal malignancies, young females are susceptible to sex work; in order to earn some sort of income. And this situation is highly hazardous to their health.

In Ethiopia the most repeatedly discussed issues have been “causes of Commercial sex worker”, “types of Commercial sex worker” and “consequences of Commercial sex worker” (Alemayehu., 1996; Alemayehu., 1973; Banchiyeleku, 1984; Habtamu, 1991; Seble, 1998, Tamene, 1993). The same themes have been tested over and over again with an ever increasing number of samples. It

appears that this happened partly for lack of research integration, poor archival research, and/or inaccessibility of earlier research reports.

This study will focus on the health, related psychological and social issues of female commercial sex workers. Since socially and psychologically healthy society members are fit enough to be productive; this sub-topic is will be dedicated in raising the main problems in relation with the health, social and psychological issues of female commercial sex workers in Arada Sub-city, Addis Ababa.

Research Questions

The study will be guided by the following questions:

6. What are the health related problems that commercial sex workers in Arada sub city face?
7. What are the social related problems that commercial sex workers in Arada sub city face?
8. What are the health, social and psychological problems commercial sex workers in Arada sub city face?
9. What are the perceived barriers to commercial sex workers' access to health care services?
10. What information do commercial sex workers in the study area need to tackle their health, social and psychological problems?

1.3. OBJECTIVES

1.3.1. GENERAL OBJECTIVE

To assess the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa.

1.3.2. SPECIFIC OBJECTIVE

The specific objectives of this study are to:

- assess the health problems of female commercial sex workers, in Arada sub-city, Addis Ababa.
- examine the health related psychologicalproblems in female commercial sex workers, in Arada sub-city, Addis Ababa.
- assess the social problems of female commercial sex workers in Arada sub-city, Addis Ababa.
- explain factors that influence health among female commercial sex workers in Arada sub-city, Addis Ababa.
- assess the barriers to health care services among female commercial sex workers in Arada sub-city, Addis Ababa.

1.4. SIGNIFICANCE OF THE STUDY

The health, social, and economic consequences of HIV/AIDS have prompted numerous studies about the risk factors, transmission and knowledge about this disease among female commercial sex workers. Although scanty reports are available about sex workers and the social context of sex work in Addis Ababa, little is known about thehealth, related psychological and social problems of female commercial sex workers in the city.

- The findings of this study will beworthwhile to women and children affair office of Arada sub-city to design comprehensive and holistic approaches by integrating the prevention, protection and rehabilitation strategies at micro and macro levels of interventions.
- In addition to this, the results of this study can be helpful in establishing an integrated medical and psycho-social support services within the health institutions (hospitals and health centers) in order to address the medical, psycho-social and emotional needs of commercial sex workers.

Therefore, this study is aimed to assess the aforementioned issues and provide relevant information to policy makers and other stake holders that are interested on the intervention of this kind of scope.

1.5. DELIMITATION OF THE STUDY

This study will be delimited to assessment of the health, related psychological and social problems of female commercial sex workers in Arada sub-city, Addis Ababa.

1.6. LIMITATIONS OF THE STUDY

- There could be a possibility of social desirability biases in responding their cultural sensitive sexual issues and information obtained on the socio-cultural and demographic characteristic can be changed over a time, not reflecting the true pictures.
- There could be a possibility of recall biases during determination of event related to psychological problems occurring in the past and there will be potential biased conclusions.
- High non-response rate will be expected as results of commercial sex workers fatigue, since there will be no incentive in this study and the information in the study variables required are culturally sensitive and time consuming.

1.7. OPERATIONAL DEFINITIONS

Araki bet/house - A house where local alcohol (araki) is sold. Many araki sellers also sell sex.

Bar/ restaurant- An establishment where drinks and/or food are served. This definition limits bar/restaurants to those establishments that do not provide accommodation. Nightclubs, pubs, kebele recreation centers and groceries that primarily serve drinks are included in this category.

Bar/restaurant-based sex workers - Women, sometimes employed as barmaids by the bar/restaurant, who use the establishment to make contact with sex clients.

Brothel - An establishment with a number of rooms that acts as a base for sex workers. Sex clients visit the brothel to make contact with the sex workers. The sex client may use a room at the brothel or may take the sex worker to another place. The brothel owner takes a good share of the money paid to each sex worker in the house.

Café house - An establishment where coffee, cakes and cold drinks are served. It is similar to a pastry house.

Establishment- A house, building (big or small), recreation center or other place where food and drinks are served for clients or customers. Rooms for accommodation may also be available.

Grocery - A kind of liquor store that also serves drinks to its customers. Usually, it has long bench seats and employs male waiting staff to serve drinks to customers.

Home based sex workers - Women who sell sex from the building or house where they live. This includes sex workers in brothels, red-light houses, tella, araki and tej bets, zigchilots, shiro bets and others. This category excludes sex workers based in hotels, bars and restaurants.

Hotel - An establishment where food and drinks are served for clients; rooms for accommodation are also available. To meet the needs of differing clientele, hotels range from small low-cost establishments to large five-star buildings.

Hotel-based sex workers - Sex workers, sometimes also employed by the hotel toserve food and drinks, who sell sex to the hotel clients, with or without the hotel's permission.

Pastry shop - An establishment where cold drinks, coffee, tea and cakes are served to clients.

Red-light house- Usually, a single room for residence and for commercial sex. Sometimes two sex workers share a room.

Sex work - Sex work is defined as work completed by any person who exchanges sexual services for economic compensation, such as money, drugs or alcohol. Bernstein (2007).

Sex worker - A commercial sex worker; an individual who is paid money in exchange for sex.

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

Tella bet/house - A house where local beer (tella) is served. Some but not all tella sellers are sex workers.

Woreda - The second level administrative unit of the government structure. A woreda is composed of two or more kebeles.

Zigchilot - The living quarters of sex workers who retain some anonymity within the community. Since these are hidden houses, they are usually identified through pimps or friends.

CHAPTER TWO

2. LITERATURE REVIEW

The health, social, and economic consequences of HIV/AIDS have prompted numerous studies about the risk factors, transmission and knowledge about this disease among female commercial sex workers. In some of the studies about this disease, other health problems have been identified.

In their study of risk behaviors for HIV, Faugier, Cranfield, and Sargeant, 1997 interviewed 100 drug-using and 50 non-drug-using female commercial sex workers in Manchester, England. The authors noted that while many women were aware of the risks of HIV, 33% of drug users and 12% of non-drug users were willing to dispense with condoms if they could get more money from their clients. General health problems identified by these authors were poor antenatal care, hepatitis, malnutrition, and many different types of infections that were resistant to treatment.

Identifying the need for more research on the general health-related concerns of commercial sex workers, Valera, Sawyer, and Schiraldi interviewed 100 individuals (42 females, 32 males, and 26 male trans-genders) who worked as street prostitutes in Washington DC (Valera, Sawyer, and Schiraldi, 2001). Data were collected through the use of two established instruments: the post-traumatic stress disorder (PTSD) checklist and a thirty-two-item instrument that "examined demographic information, life experiences as a commercial sex worker, and perceived health needs

and health status"(Valera, Sawyer, and Schiraldi, 2001). The authors listed sixteen different physical health problems and reported the percentages of respondents in each of the three groups who acknowledged having a particular health condition. Thirty women reported being raped since entering commercial sex work. Of the forty-two females interviewed, twelve (28.6%) were listed as having physical health needs, four women (9.5%) as having general body pains, and three women (7.1%) as having anemia. Very small percentages (2.4%) of the forty-two women were listed for each of the following diseases: sickle cell anemia, asthma, high blood pressure, diabetes, syphilis, hepatitis B, dizzy spells, or positive HIV status. From the description of the results, it was difficult to determine whether a woman had more than one ailment or what was included in the category "physical health needs."

Weiner studied the social and medical needs of 1,963 streetwalking sex workers in New York. Using an ex-post facto design, she analyzed sex workers' responses on a two-page questionnaire that gathered information about demographics, sex and drug practices, risk reduction, and health history. Gonorrhea, syphilis, tuberculosis, and hepatitis were the diseases mentioned by the women (Weiner, 1996). Implication from this study suggests that there are barriers to treatment due to a woman's status as a sex worker. Certain drug treatment facilities exclude sex workers from entering into programs, believing that the women will continue to trade sex for money or drugs and undermine the program. Weiner (1996) also identifies the vulnerability of sex workers loss of social services due to disclosing their status as sex workers. Women who disclose their sex work status risk the removal of their children from their homes, loss of parental rights, and expulsion from social support systems, such as their families or church. Weiner (1996) advises social workers to be sensitive to the

difficulty sex workers have in trusting workers and revealing information related to their sex work status.

In a study conducted by Seugio Aral and his colleagues in 2002 in Moscow, in response to ever increasing economic deprivation, informal economies associated with crime, sex work, and drugs emerged and rapidly expanded. The economic situation of women deteriorated and domestic and international trafficking of women in the sex trade increased. In addition, sex work became less covert and more visible in public venues. Age at first sex has dropped and a more permissive attitude to multiple sex more common (Seugio Aral et al., 2002). In the same study, interviews and observations suggest that the behavior of many health care providers towards sex workers reflect negative social attitudes toward marginalized populations and affects both the quality of care that is provided and sex workers willingness to approach public health care facilities, female sex workers consistently described differences in their interaction with the physicians according to whether the providers were aware of the type of work that preformed. One informant described observing a physician who was examining another sex worker by using a pen to avoid touching her (Seugio Aral et al., 2002).

In a study conducted in New Zealand examined the mental and physical health of female sex workers, findings described mental health seeking behaviors of female sex workers. This study points to the difficult issues sex workers face in disclosing their status as sex workers to health professionals, arising as a result of the marginalized position of sex work in society (Romans, Potter, Martin, & Herbison, 2001). The study looked at the participants' professional mental health

help seeking behaviors as well as their social support seeking behaviors. Of the 29 participants interviewed, in relation to their lifetime experiences in therapy, almost half of participants (n=14) had seen a counselor, one third had seen a psychologist (n=9), and one fifth (n=6) had seen a psychiatrist at least once (Romans, Potter, Martin, & Herbison, 2001). In regards to non-professional emotional support, over 90% (n=27) of participants said that they had someone to talk to if something was troubling them. Participants named a partner or a female friend (28%), a fellow sex worker (17%) another person (17%), and parent (n=1) as people they talked to when something was troubling them (Romans, Potter, Martin, & Herbison, 2001).

Given that public health is more concerned with the health of customers of sex workers, public health actions almost exclusively focus on risks associated with transmittable infectious diseases like human immunodeficiency virus ⁄acquired immune deficiency syndrome rather than on health questions in general or in particular on the mental health consequences of sex work. But across all topics, articles expressing opinions or stereotypes about sex work seem to outweigh research articles (Day & Ward, 2007). Rigorous research is therefore needed to understand the precise context of sex work (Brooks-Gordon, 2008).

In another study, El-Bassel et al. assessed levels of psychological distress in a sample of poor, inner city women from Harlem. Of the 346 women interviewed, 176 were classified as sex traders (those who had traded sex for money or drugs within the 30 days prior to the interview) and 170 as non-sex traders (women who had never traded sex for money or drugs or who had not done so in the 30 days

prior to the interview). The authors found that more sex traders than non-sex traders were homeless and had been raped within the past year. The former group also had significantly higher mean scores of psychological distress (e.g. anxiety, depression, hostility) as measured by the Brief Symptom Inventory subscales and the General Severity Index (El-Bassel et al., 1997).

The vast majority of research related to sex workers addresses the physical health and safety of sex workers, but does not discuss their psychosocial needs. Research has shown that such workers maintain high rates of HIV risk behaviors, substance abuse, and are often victims of violence. (Nemoto et al, 2005). Much of the research has been derived from a public health perspective with less of an emphasis on psychological factors. Literature pertaining to the psychological impact of sex work has centered on the notion that sex work is seen as a form of emotional labor (Giner-Sorolla, 2006) with the use of such techniques as identity boundaries and disassociation (Chapkis, 1997) to cope with work related stress and prevent burnout (Vanwesenbeeck, 2005).

In most studies of sub-Saharan Africa the burden of STIs other than HIV among FSW is high, with half to two-thirds typically having a curable STI at any one time. In some settings, 10% or more have an active genital ulcer and over 30% have reactive syphilis serology (Dunkle, 2005 & Feldblum, 2005). Gonorrhea and Chlamydia infection may be found in a third or more of sex workers, trichomoniasis is common, and many women have multiple infections (Alary, 2002 &Laurent, 2003). Where testing has been done, as reported by a study in Tanzania, about two-thirds of FSW have evidence of herpes infection (Riedner, 2003). Significantly, FSW with ulcerative STIs,

such as herpes simplex virus type 2 and chancroid are more likely to transmit HIV, particularly in settings where men are uncircumcised, although an STI in either partner facilitates HIV transmission. Sex workers commonly report that economic necessity or fear of violence makes it difficult for them to avoid or refuse male clients with an obvious STI, such as a genital ulcer (Elmore-Meegan, 2004).

Many young African women who trade sex for food, money or shelter come from disadvantaged backgrounds, are poorly educated, divorced, and lack the skills required for other types of formal or informal employment. A startling proportion of FSW in West and East Africa have received no formal education; well more than 10% in most of these studies and above a third in several. Economic and food insecurity may make sex work the sole survival option for women, particularly those with dependents or whose parents have died (Campbell, 2000). Food insecurity, in particular, may predict unsafe sexual behavior among sex workers, as found in Nigeria (Oyefara, 2007 & Gysels et al., 2002).

In Ethiopia, interest in Commercial sex workers, goes back to the 1960s (Mayor, 1962, 1963, Andargachew, 1967; Lema, 1968), has increased in leaps and bounds since the end of the 1970s and the beginning of the 1980s (Laketch, 1991; Bethlehem, 2002). However, with a few outstanding exceptions, notably that of Laketch (1991), Andargatchew (1988), and Bethlehem, 2002,), these studies displayed common characteristics in terms of themes, approaches, and conclusions (Bethlehem, 2005).

One study found that 63% of sex workers in Addis Ababa cited poverty as the major factor that influenced them to become sex workers (Bethlehem, 2005). As Bethlehem argues, this seems like an underestimate, perhaps because mutually exclusive choices of answer were offered. Sex workers all said that it is difficult to attract enough customers to make sustained changes to their economic status and this is presumably a direct consequence of oversupply and subsequent low prices and other unfavorable conditions for the seller.Sex is cheap even by local standards. This distinguishes the situation of sex workers in Ethiopia who tend to stay poor, from their counterparts in middle income countries where poverty is relative and sex work is in fact a route to a more prosperous life for many women (Bethlehem, 2005).

Another study in Ethiopia indicate that, amongst those FSWs who Knew/remembered the age at which they first had sex, 90.8% reported that they were less than or equals to 19 year old. Worryingly, 49.9% reported that they were less than or equals to 15 years old. Age when respondents first received money for sex ranged from 10 to 40 years old. A small group of FSWS (8.2%) started to sell sex when they were less than or equals to 15 years old. The most commonly mentioned reasons for becoming a sex worker were financial problems (36%), divorce /separation (18.4%) and disagreement with people they lived with (18.4%)(Getnet et al., 2002).

The same study indicates that, 4.9% of the FSWS reported having had STIs (genital discharge or ulcer/sore). FSWs that had experienced an STI during the previous 12 months were asked what treatment they had received. In general, 83.5% of the FSWs had sought medical care from health

service institutions. Actions mentioned other than treatment included: stopping sexual activities at the time when symptoms were present (20.8%); seeking advice from peers/friends about the symptoms (19.2%); and seeking advice/medicine from a private pharmacy (14.9%). About one in ten (9.2%) of the FSWs with a history of STI sought advice/medicine from a traditional healer or took traditional medicine they had at home (Getnet et al., 2002).

CHAPTER THREE

3. METHODOLOGY

3.1. STUDY DESIGN

This study will be carried out in different bars, hotels and restaurants of Arada sub-city, Addis Ababa, the capital city of Ethiopia. It will employ both qualitative and quantitative methodology. The study will combine detailed one-to-one interviewing with personal observation to bring out the perspectives of the women themselves. Quantitative and qualitative data will be collected from different bars, hotels and restaurants from the selected sub-city. The study will focus on Female Sex Workers (FSWs) aged 18-50 years who have involved in the sex trade in exchanging sex for money or equivalent at least for the past one year prior to the survey and willing to participate in the study.

3.2. STUDY SETTING

This study will be carried out in different bars, hotels and restaurants of Arada sub-city, Addis Ababa, the capital city of Ethiopia. Addis Ababa has a surface area of 540 Square kilometer of which 11.56 Km^2 areas is defined by Arada sub city (AAAMPSC, 2004). In the year 2007 the population of the city was about 2.74 million, 5046 people live per Square kilometer, and 52.4% of the residents were females (CSA, 2007). Administratively, the city is divided into 10 sub-

cities and 116 *Woreda* which are the lowest administrative units. The Addis Ababa city administrations had potential health service coverage of 21% in 2009 G.C. (FMOH, 2009).

The altitude of Arada sub city ranges between 2300 m and 2,500 m a.s.l (EMA, 1982). The lowest and the highest annual average temperature of Addis Ababa, Arada Sub city, are about 10 ^{0}c and 25 ^{0}c (Tilaye Nugussie and Mesfin Tilaye, 1998). The climate is divided in to three distinct seasons. The period of heavy rains (*Kiremt*) occurs between June and September, The dry period (*Bega*) is between October and January, and the small rains (*Belg*) occurs between March and May (MAA, 2002).

According to CSA (2007), Arada Sub City, one of the 10 Sub Cities of Addis Ababa, has about 37,897 housing unit. Based on the information extracted from Addis Ababa Trade and Industry Bureau data base in May (2007), there are around 13,396 commercial establishments or centers in Arada Sub City and among which 48.78 % of them are retailers shops, 20.58 % of them are business centers, 20.24 % of them are Bar and Restaurants, 5.87 % of them are wholesalers shops and 4.53 % of them are Repair service providers.

3.3. STUDY UNIVERSE AND SAMPLES

All female commercial sex workers working sex as a means of living at Arada sub-city will be sample universe of the study. The exact number of female commercial sex workers working sex

as a means of living at the sub-city is not known. The study will focus on female sex workers(FSWs) aged 18-50 years who have involved in the sex trade in exchanging sex for money or equivalent, at least for the past one year prior to the survey. A 'quota' approach will be utilized to sample the respondents. This approach specifies that a proportional number of interviews will be conducted in each bar/hotel or site. The quota will be determined based on the total number of FSWs selected, as well as the minimum number of FSWs estimated to be found in a particular bar/hotel or site. However, in bars where it will anticipate that only a few sex workers will be present, all of the sex workers will be contacted. In contrast, when large numbers of sex workers will be expected, a fixed number of sex workers will be selected randomly.

3.4. INCLUSION AND EXCLUSION CRITERIA

All participants between the ages of 18 years and 50 years old having all the necessary information will be included in the study.

3.5. DATA COLLECTION INSTRUMENT

An instrument will be developed through the modification of questionnaires used by the World Health Organization. The questionnaire will firstly be developed in English and then translated into Amharic language.

Interviewing will be appropriate in situations where sensitive issues can be addressed. Conducting semi-structured interviews will allow the researcher to hold some elements of

control over the line of questioning, whilst still leaving scope for respondents to cover issues not directly addressed in the interview schedule.

3.6. PILOT STUDY

The questionnaires will be first developed in English and then translated in to Amharic, which is the common language of the study subjects. A standard questionnaire that addresses all important variables will be prepared and pre-tested in areas similar to the study area in other parts of Addis Ababa to avoid contamination; and feedback will be used to make modifications to the questionnaires.

3.7. DATA COLLECTION PROCEDURE

Data will be collected from different bars, hotels and restaurants where the female commercial sex workers can be found. Data of all female commercial sex workers will be collected by health professionals recruited for this study with possible experience in data collection in previous similar studies

Ten interviewers (five female and five male) will be trained to conduct the interviews. All will be expected to have at least diploma. Thus, interviewers will be instructed to make the highest possible care during interview session to record response correctly and completely.

Interviews will be conducted at a convenient location chosen by the respondent, usually in a public area due to fear of disclosure of their occupation. Questionnaire completion will take 45 minute to two hours. The in-depth interviews will be completed by the first interviewer that will last between two to five hours and several visits will be made to complete one case history as needed.

To ensure standard (uniform) transformation of information, the principal investigator will be around to respond to questions that may arise from misunderstanding or doubts. The investigator will try her best to avoid incompletely filled questionnaires and/or implausible answer that may cause misunderstanding. Supervision will be conducted by the principal investigator during data collection for timely edition of the data and feedback.

3.8. DATA QUALITY ASSURANCE

To ensure quality of the data, the following measures will be taken. A one day training will be provided for data collectors before the start of data collection. The overall activities of data collection will be monitored by the principal investigator, and there will be strict supervision during data collection. This will be done by cross checking about 10 % of the collected data with the actual source. All completed questionnaire will be examined for completeness and double data entry systems will be used. Besides, consistency of the collected data will be checked during analysis.

3.9. DATA PROCESSING AND ANALYSIS

The data collected by utilizing the designed questionnaire will be checked for completeness and consistency by the researcher. Data entry and analysis will be carried out using SPSS version 20. Descriptive statistical methods will be used to explore the characteristics of the study participants and their health, social and psychosocial problems. The computer program, SPSS, will summarize the data and calculate the percentages and responses for each question.

3.10. ETHICAL CONSIDERATION

Ethically, informed consent of the respondent will be obtained first. To this end, the rights of the respondents to refuse to answer for few or all questions will be respected. The interview will be conducted in a way that it will not violate their privacy and confidentiality of information. In order to ensure confidentiality of the information, names or other identifications of study participants will not included in the data sheet.

CHAPTER FOUR

4. WORK SCHEDULE

S.N	Activities to be done	Responsible person	Time when activities will be performed (Jun. to Dec, 2013)						
			June	July	Aug.	Sept.	Oct.	Nov.	Dec.
1	Proposal development	Principal investigator							
2	First draft submission	PI/Advisor							
3	Second draft submission	PI/Advisor							
4	Final submission	UI							
5	Proposal approval	UI							
6	Data collection	PI/data collectors							
7	Data entry and clean up	Data clerk/PI							
8	Data analysis	PI							
9	First draft thesis	PI/Advisor							
10	Second draft thesis	PI/Advisor							
11	Defense	PI							
12	Final thesis submission	PI/UI							

CHAPTER FIVE

5. BUDGET PLAN

Personal costs

No	Title		Qualification	Quantity	Cost/Per diem	Duration of work	Total	Remark
1	Training of data collectors	Trainee	Diploma nurse	10	100 birr/d	1 day	1000	
		Trainer	Degree	1	200 birr /d	1 day	200	
2	Data collection		Diploma nurse	12	15 Birr/Questionnaire	10	1500	15 Birr will be paid per Questionnaire for 10 data collectors within 10 days.
5	Principal investigator		Degree	1	200 birr /d	10 days	2000	
6	Total						4700	

Stationary

No	Title	Quantity	Cost	Total	Remark
1	Paper	6 pack	125 birr	750birr	
2	Pen	25 pieces	3 birr	75 birr	
3	Pencil	25 pieces	1.0 birr	25 birr	
4	Note book	10 pieces	12 birr	120 birr	
5	Marker	1 pack	80 birr	80 birr	
6	Mobile card	5pieces	100 birr	500 birr	
	Total			1550 birr	

Transport

No	Title	Cost	Trips	Total	Remark
1	PI	37.80birr/trip	12 trips	453.6 birr	

Sub-total		6703.6
Contingency (5 %)		335.18
Grand Total		7038.78

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ANNEX – SEX WORKERS QUESTIONNIRES

RECRUITMENT QUESTIONS

Survey Questions

Pre-Screen Questions (*Required for Participation)

***Are you between the ages of 18-50?**

1. Yes

2. No (SURVEY END. THANK YOU, BUT YOU ARE NOT ELIGIBLE FOR THIS SURVEY)

***Have you exchanged sexual services for money or another reward in the past year?**

1. Yes

2. No (SURVEY END. THANK YOU, BUT YOU ARE NOT ELIGIBLE FOR THIS SURVEY))

Survey Start

Q1. How old are you?

1. 18-24

2. 25-32

3. 33-40

4. 41-50

Q3. How long have you been working as a sex worker?

1. Years: _____

2. Months: _____

3. Days: __________

Q4. What describes your work? CHECK ALL THAT APPLY

1. Street Worker

2. Bar lady

3. Escort

4. Other (Please Specify): _________________________

Q5. Do you work?

1. Exclusively as an independent

2. Exclusively managed or with an agency

3. Combination of independent and managed/agency

Q6. Have you ever sought professional help (i.e. counselor, psychologist, peer counselor, therapist, social worker, etc) for emotional issues?

1. Yes (IF YOU ANSWERED YES, PLEASE SKIP TO THE NEXT QUESTION)

2. No

Q7. Why haven't you sought professional help (i.e. counselor, psychologist, peer counselor, therapist, social worker, etc) for emotional issues?

1. Don't know where to go for help

2. Not enough money

3. Services were unavailable

4. Don't need help

5. Other (Please specify): ________________________________

Q8. When you have emotional issues or problems, do you talk to someone?

1. Yes (IF YOU ANSWERED YES, PLEASE SKIP TO NEXT QUESTION)

2. No

Q9. What do you do when you have emotional problems or issues?

1. Spiritual Practice

2. Withdraw from Normal Activities

3. Exercise/Physical Activity

4. Drink Alcohol and/or Use Drugs

5. Nothing

6. Other (Please specify): ______________________

SURVEY END; THANK YOU FOR COMPLETING THIS SURVEY, PLEASE GO TO END OF SURVEY.

Q10. Who do you talk to about emotional issues?

1. Friend

2. Co-Worker

3. Family

4. Intimate Partner

5. Other (please specify) __________________

Q11. What types of things have you talked to them about? CHECK ALL THAT APPLY

9. Grief/Loss
10. Health Related Issue
11. Relationship Issue(s)
12. Family Issue(s)
13. Legal Issues
14. Work Related Issues
15. Emotional Support
16. Other (Please specify): ______________________________

Q12. How helpful did you find talking about your emotional problems?

As a direct result of talking to someone about my emotional issues:

Answer Options	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	NA
I am better able to deal with the Crisis						
I am getting along better with my family						
I do better in social situations						
I do better in school						
I do better in my work as a sex worker						
I do better in my work (non-sex work, if applicable)						
My housing situation has improved						
I do things that are more meaningful to me						
I am better able to take care of my needs						
I am better able to handle things when they go wrong						

SURVEY END, THANK YOU FOR TAKING THIS SURVEY, PLEASE SKIP TO END OF SURVEY.

Q13. How were you referred to help for your emotional issues? CHECK ALL THAT APPLY

7. On my own
8. Friend outside of sex work
9. Another sex worker
10. Health Extension worker
11. Community Based Organization
12. Other (Please specify): _________________

Q14. What part of your income would you usually get from doing sex work?

6. None
7. Some
8. About half
9. Most
10. All

Q15. Before you became a sex worker – how were you employed?

6. Not employed
7. House maid servant
8. Full-time work
9. Daily Laborer
10. Student

Q16. Who, outside of the people you know in the sex industry, knows that you are a sex worker?

5. Family members
6. Close friends
7. Neighbors
8. Acquaintances

Q17. Have you ever been diagnosed with an STI/HIV?

3. Yes
4. No

Q18. How often do you check your clients for signs of Sexually Transmitted Infections (STIs)/HIV?

4. Never
5. Some times
6. Always

Q19. What do you do about a client you suspect of having an STI/HIV?

5. Refuse to see the client
6. Refer client to another worker
7. Do as usual
8. Other, please specify

Q20. If a client offers you more money for sex without condom, what would you usually do?

7. Not applicable

8. Refuse to see the client
9. Accept the money and do the job
10. Talk the client in to using the condom
11. Refer client to another worker
12. Other, please specify

Q21.What kinds of illnesses have you ever suffered from? **CHECK ALL THAT APPLY**

7. STIs (syphilis , gonorrhea , Chancroid)
8. Respiratory problems including allergies, sinus infections, colds, pneumonia, and tuberculosis
9. Dental problems
10. Lip burns
11. Facial rashes and sores, herpes
12. Others (Specify) ………………………………………………….

Q22. Which of the following psychological problems have you ever faced from? **CHECK ALL THAT APPLY**

5. Depression

6. Anxiety

7. PTSD(post traumatic stress disorder)

8. Others (Specify) ………………………………………………………….

Q23. What kinds of social problems did you faced being as a sex worker? **CHECK ALL THAT APPLY**

6. Violence

7. Stigma

8. Discrimination

9. Interaction

10. Others (Specify) ………………………………………………………….

Q24. Compared to one year ago, how would you rate your health in general now? Would you say it is?

6. Much better than one year ago
7. Somewhat better now than one year ago
8. About the same as one year ago
9. Somewhat worse now than one year ago
10. Much worse now than one year ago

Q25. To what extent has your physical health or emotional problems interfered with your social activities like visiting family, friends, neighbors or groups.

6. Not at all
7. Slightly
8. Moderately
9. Quite a bit
10. Extremely

Q26. Right now, would you like to leave the sex industry?

6. Yes, definitely
7. Yes, mostly
8. Don’t know
9. No, mostly
10. No, definitely

Q27. Thinking of the sex industry as a whole, how safe do you feel on average?

6. Not safe at all
7. A little safe
8. Moderately safe
9. Quite safe
10. Extremely safe

Q28. Since starting work as a sex worker how do you think the industry has changed?

6. Much worse
7. Somewhat worse
8. No change

9. Somewhat better

10. Much better

Q29. In general, would you say your health is?

6. Excellent
7. Very good
8. Good
9. Fair
10. Poor

Q30. Is there anything that you would suggest to health care providers to improve their work with sex workers?