

**A Study of Behaviour Change Communication
Messages on Gender Vulnerability to HIV/AIDS
in Rural Areas: Spouses in Focus**

By

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ABSTRACT

An Analysis of the Impact of Behaviour Change Communication Messages on Gender Vulnerability to HIV/AIDS in Rural Areas: Spouses in Focus

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Recent studies indicate that rural areas have not been researched well concerning HIV/AIDS and even if researched, emphasis has been given to numbers. This study was intended to study behaviour change communication on gender vulnerability to HIV/AIDS in rural areas by focusing on spousal behaviour. The research employed constructive paradigm as a lens through which the world is understood. Methodologically, the research followed qualitative methodology. Data were gathered from spouses, health workers, OSSA (organization for the social support of AIDS) representative, PLWHA (persons living with HIV/AIDS) chairperson and HAPCO (HIV/AIDS prevention and control office) representative through interview and focus group discussion as well as from documents. The data gathered were analysed using discourse analysis. Results obtained from the document analysis indicated that there is a gap in the design of the messages concerning representation of audiences in the messages and presentation of the messages. Findings from interview and focus group discussion also indicated that there are gaps in the delivery of the messages concerning the strategy used to make people accept the messages. It was also found that the use of inappropriate words is forcing HIV patients' to hide their serostatus and husbands to resist discussion of HIV/AIDS and related issues. Study of the delivery of the messages indicated that the interventionists used discourses of fear and blame in delivering the messages, which

triggered hidden resistance from the audiences in some cases. The findings also indicated that people use expressions which show hatred about condom, and health workers did not do enough to develop people's awareness about the issue. The study indicated that there are three factors that aggravate the spread of the virus in rural areas. One of these factors is that people stigmatise those living with the virus through their words and this is creating a feeling of fear and revenge in people living with the virus. The other factor is that there is still a practice of extramarital and premarital sexual relation among the people. The third factor is that rural people express their hatred towards condom and say that it has to be used by the unmarried youth, by the educated or by urban people. The overall implication of the study is that the messages have succeeded in developing people's awareness about the virus and even resulted in attitudinal change towards some practices that aggravate the transmission of the virus. There is, however, a gap in both the design and delivery of the messages in transforming this attitudinal change into behaviour change.

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Declaration

I, the undersigned, declare that this Thesis is my original work and has not been presented for a degree in any other University and that all the materials used in the Thesis have been duly acknowledged.

Name: _____

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CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

HIV/AIDS is one of the biggest public health and development challenges the world has ever seen. Ever since its emergence, it has claimed lives and caused devastating damage to economies. Recent documents, however, indicate that HIV/AIDS has stabilized and begun to decline in many countries of the world. Nevertheless, there are still many people being infected, getting sick and dying because of the virus (WHO, 2011). In the year 2011, for example, there were 34.2 million adults living with the virus worldwide. Of these, 30.7 million were adults out of which 16.7 million were women. In the same year, 2.5 million people were newly infected and 1.7 million people, out of whom 1.5 million people were adults, died due to HIV/AIDS. There were 7000 new infections in a day, out of which about 97 percent are in low and middle-income countries. Of the 7000 daily infections, about 6000 occurred in adults aged 15 years and older, of whom almost 47 percent were women, about 41 percent among young people aged 15-24 years (WHO,UNAIDS and UNICEF, 2012) .

Sub-Saharan Africa is a region most affected and carries disproportionate burden of the epidemic (Kartikayan, Bharmal, Tiwari and Bisen, 2007; UNAIDS, 2008). The 1.9 million people who were newly infected by the virus in this region in 2010 represented 70 percent of all the people infected by the virus globally. Of the 34 million people living with the virus globally in mid-2010, about 68 percent resided in sub-Saharan Africa, a region which hosted only 12 percent of the world population. Sub-Saharan Africa is also a region where men and women are disproportionately affected by HIV. In this region, in 2010, 1.4 times more women than men were living with HIV just as it was a decade ago. It was also found out that 59 percent of adults living with the virus in 2010 in this region were women (WHO, 2011). This is in spite of decrease in the number of people being infected by and dying of the virus. In sub-Saharan Africa, the number of people who were newly infected by the virus, for example, decreased in 2011 to 1.7 million from 1.9 in 2010. Again, about 16 percent fewer people were newly infected by the virus in 2011 than in 2010 when an estimated 2.2 million people were newly infected (WHO and UNAIDS, 2012; WHO, UNAIDS and UNICEF, 2011). Hence, although there is a decrease in HIV incidence

and the number of people dying of the virus, the disproportionate impact of the disease on women continued unabated.

This disproportionate impact of the disease was the result of gender inequality (Fuller, 2008; WHO, UNAIDS and UNICEF, 2011). Gender inequality makes women in the developing world economically dependent on men, deprives them of their educational opportunities and political power, and makes them victims of sexual violence and coercion because of unequal sexual power emanating from gendered attitudes (Bell, 2002; FHI/AIDSCAP, 1997; Wodi, 2005). Hence, whether these women know the impact of the disease and how to protect themselves from the disease make no difference because they lack the power to resist men's sexual needs and interests owing to their gendered position (Unterhalter, Boler and Aikman, 2008).

Some scholars even describe HIV/AIDS as 'a feminized epidemic', a term used to refer to the fact that in many countries the number of women infected by the virus is significantly higher than that of men (Gordon, 2008; Unterhalter, Boler and Aikman, 2008). The term is also used to indicate the association between gender relations and HIV infections.

Research findings indicate that HIV prevention efforts in sub-Saharan Africa so far have had limited impact on changing these gendered attitudes. This is because they focused on biomedical facts and changing the behaviour of sexually active people and failed to challenge socio-cultural factors that underlie the behaviour (Gordon, 2008; Fuller, 2008). The interventions capitalized on effecting sexual behaviour change to challenge heterosexual transmission, which is the major mode of transmission in this region (Adih, 1999; Fuller, 2008; Mishra et al., 2009; Oster, 2009; Wodi, 2005). However, Campbell and Gibbs (2009) suggest that to break the cycle of the virus it is important to understand and deal with gender inequality and its impact on women.

1.2 The Ethiopian Context

HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986. Following the detection of HIV in 1984, the Ethiopian government first established a National HIV/AIDS taskforce in 1985 and the National AIDS Control Program (NACP) at a department level at the MOH in 1987. The formulation by the Ministry of Health and adoption by the council of Ministers of the HIV/AIDS Policy in 1998 was also another move made by the government to contain the virus. The formulation of the policy created an enabling

environment for HIV/AIDS prevention and control. The policy supplemented several policies such as the Health Policy, Women's Policy, and the Education and Training Policy, facilitating conditions for a multisectoral response (MOH, 1998).

This policy stipulates that information, education and communication (IEC) would be used as a strategy for disseminating information. Promoting fidelity or safer sex emanating from societal cultural norm among couples was also another focus area of the policy (MOH, 1998). The formulation of this policy paved the way for development of other strategic plans, guidelines and frameworks.

Building on the national HIV/AIDS Policy statement, the Ministry of Health formulated in 1999 the National Multisectoral HIV/AIDS Strategic Plan for 2000–2004. Besides, taking into account the fact that HIV/AIDS is not only a health problem but also a developmental, political, economic, and social problem, the government chartered a new National AIDS Council, to be chaired by the President of Ethiopia and involving leaders from multiple sectors as members. In 2002, this council was restructured and set up as an office under the name HIV/AIDS Prevention and Control Office (HAPCO). The office undertook the activities of developing and implementing a five-year (2000-2004) national strategic framework as part of the national response to HIV/AIDS. The development of this strategic framework led to successful implementation of several priority interventions and targets. The office also developed strategic plan for the succeeding four years (2005-2008) which focused on the provision of preventive, care and support and treatment services (MOH/HAPCO, 2006).

The development of the National HIV/AIDS Communication Framework in 2002 was another attempt on the part of the government to intensify the fight against HIV/AIDS. The framework has the general objective to provide comprehensive contextual, societal as well as personal behaviour-related information that can assist to develop communication guideline in different scopes and levels.

This framework has five contextual domains that are identified as universal factors in communication for HIV/AIDS preventive health behaviour. These are the policy, culture, socio-economic, gender and spirituality domains. Some of the issues that have been highlighted under culture, socio-economic and gender domains are:

- a) Understandability of language for possible application in communication strategies,

- b) Exploration of relationship within the family and the community, particularly in terms of decision making about preventive health behaviour,
- c) Shift of focus from the individual to the family and community for intervention endeavours,
- d) Recognition of differences in cultural characteristics within the country and with other countries and making messages relevant to the context,
- e) Encouraging men and women/spouses to communicate openly on issues of sexual relations (HAPCO, Pact Ethiopia, & UNAIDS, 2002); MOH/HAPCO, 2006).

In December 2009, FHAPCO developed Behavioural Change Communication (BCC) Material Development Guideline with an overall objective of providing practical direction for the design, development, implementation, evaluation, monitoring, and support of behaviour change communication materials and programs. The development of this guideline has as its rationale to encourage the government, regions, NGOs and other stakeholders to design, produce, implement as well as monitor and evaluate appropriate BCC materials (FHAPCO, 2009).

As part of its continued effort to fight against HIV/AIDS, FHAPCO established BCC Framework in 2011 whose major objective was to provide the basis for programs that target MARPs (most at risk population groups) and for HIV prevention communication strategies that are intended to reach out to segmented high-risk groups (FHAPCO, 2011). The BCC Framework is not limited to describing individual behavior change. It is also concerned with varieties of social change which can be targeted and influenced by communication. Its basic assumption is that individual health behaviours, including sexual behavior, are not free from socio-cultural factors. It recommends, therefore, that BCC interventions have to take into account individual behaviours as well as social norms which can exert influence on the behaviours. It is not enough to address only social network to which an individual belongs. Other structural and environmental issues that can impact sexual behavior also have to be considered.

The framework outlined behaviour-related risk factors that should be targeted by intervention efforts some of which are:

- Having multiple and concurrent sexual partnerships,
- Lack of consistent and proper condom use, and

- The emerging pattern of the virus among couples of reproductive age (FHAPCO, 2011).

The formulation of the policy, designing of strategic plans, frameworks and guidelines and setting up different offices at various levels indicate the government's efforts to address issues related to the virus. Nevertheless, the work done to combat the epidemic, especially in rural areas, was not as fruitful as expected owing to many factors among which one is information gap (Bishop-Sambrook, 2004; FHAPCO, Pact Ethiopia and UNAIDS, 2002). Another factor affecting the success of HIV/AIDS interventions is lack of research-based evidence that guides the implementation and control of the intervention programs. On top of this, groups identified as vulnerable through the scanty research have not been targeted through the actual intervention activities. A report released on the success of the strategic activities of 2004-2008, for example, states that identified vulnerable and risk groups did not get attention as emphasized in the plan (Yemane Berhane et al., 2009).

In spite of these shortcomings, different reports on the epidemic in Ethiopia show that the epidemic is stabilizing in the country following the global trend. It was indicated that HIV prevalence was estimated to be 3.5 percent in 2005, 3 percent for males and 4 percent for females. In 2006, this decreased to 2.1 percent, 1.7 percent among men and 2.6 percent among women. In 2007 and 2008, HIV prevalence was 7.7 for urban and 0.9 for rural areas. (Yemane Berhane et al., 2009). In the same year, it was 1.5 for the national level, 1.0 and 1.9 for men and women respectively. FHAPCO (2012) also indicated that recent sentinel surveillance data show HIV prevalence among women 15-24 declined from 5.6 percent in 2005 to 3.5 percent in 2007, and to 2.6 percent in 2009; showing a decline of 3.0 percent between 2005 and 2009. The same document showed that the prevalence had halved declining from 11.5 percent in 2003 to 5.5 in 2009. As indicated in this data, there is a notable urban rural disparity in the prevalence of the epidemic. Nevertheless, the document indicated that the epidemic was stabilizing and declining in urban areas while the rate of new infections was increasing in smaller towns. FHAPCO also recommends in this document that the data on which these findings are based was collected from locations which are more urban and along trading routes and this calls for further study to generate more geographically representative data. At the same time, FHAPCO warns that the possibility of a sharp increase in the rate of new infections in small towns is worrisome since these small towns can bridge further spread of HIV to rural areas.

The risk of HIV infection in rural areas may also be increased by lack of access to information on preventive measures and related services such as IEC/BCC and VCT (FHAPCO, 2012).

Research results and activity reports also indicate that intervention efforts on HIV/AIDS in Ethiopia have been biased to urban centres and rural coverage is still patchy. Consequently, knowledge about actual prevalence rates of the disease in rural areas is very little. The few areas covered by study were also not representative of the rural area since they had been restricted to places where there were sentinel sites (Bishop-Sambrook, 2004; HAPCO and GAMET, 2008). A look at these findings may indicate that a lot remains to be done in rural areas to stop the spread of the disease and to know the true picture of the disease there. One possible way to materialize this is through conducting research in the rural areas that have been neglected so far.

1.3 Statement of the Problem

Though both men and women are affected indiscriminately by HIV/AIDS, the disease affects more women than men due to biological, social, political and economic factors. Women are at greater risk of HIV infection as a result of their low socio-cultural and economic status in society, which puts them in a position not to make decisions on matters affecting their health including their sexual relations (Belsey, 2005; Unterhalter, Boler, & Aikman, 2008). Women are also vulnerable to HIV due to gender based-violence and rape (FHAPCO, 2011).

As stated in MOH (2004) report, two large population groups, rural Ethiopians in general and women, carry the brunt of the disease. It has been recommended in the same report that, since 85 percent of the Ethiopian population lives in the rural setting, more resource and attention need to be invested to check the further spread of the epidemic in rural Ethiopia (Bishop-Sambrook, 2004). In spite of this statement, HAPCO, Pact Ethiopia and UNAIDS (2002) state that all published research results up to this time (2002) focused on urban areas and the rural area was not given due attention in the HIV interventions. MOH's 2004 report also shows that no improvement has been made to change the condition of the epidemic in rural areas in the two years' interval. HAPCO and GAMET (2008) also say that there were few studies describing the rural HIV epidemic in Ethiopia. Data are lacking concerning prevalence or incidence, and there has been little research to describe the rural spread of HIV/AIDS, to investigate rural sexual practices or attitudes, sexual networking, the existence or absence of rural sex work, and other factors intensifying or inhibiting the

spread of the disease. Miller and Rockwell (1988) also maintain that rural areas need to get attention because studies of the HIV epidemic and the expression of AIDS in Africa thus far have focused almost exclusively on urban populations.

HAPCO and GAMET (2008) also comment that producing prevalence estimate for the whole country on the basis of national level data, as practised by HIV/AIDS intervention programs so far, cannot show the magnitude and heterogeneity of the epidemic. They say that HIV/AIDS programs should be focused geographically as well as the prevalence rate of regions, districts and communities. This calls for a new type of research based on data gathered from district level so as to identify areas severely affected by the epidemic and communities that are at higher risk. This in turn necessitates the consideration of not only urban-rural disparities but also differences among rural regions since there are variations not only between rural and urban areas but also between districts and villages within the same area (Becker et al., 2007; Chandrasekaran et al., 2006).

Research findings indicated that, let alone urban rural differences, rural areas in many African countries show marked difference depending on their closeness to trading points. A research conducted in a district in Zimbabwe, for example, showed that HIV prevalence increased from 25 percent in traditional areas to 50 percent in areas nearer to highways in shopping centres (Carael and Glynn, 2007).

According to a study conducted in Senegal, circulation of migrants between rural and urban or market settings is a cause for exposure to the highest levels of HIV prevalence that exists in towns (Coffee, Garnett and Mlilo, 2005). In Ethiopia too, HAPCO (2009), based on the analysis of the 2005 Demographic Health Survey (DHS) data indicated that HIV prevalence rate is higher in small market towns that have recently become commercial and administrative centres than in bigger towns. The fact that these small towns are serving as commercial and administrative centres, and are often visited by people from rural areas, increases their chances of serving as a bridge to carry the disease from urban to rural areas. FHAPCO (2011:23-24) expresses the contribution of small towns to the spread of HIV/AIDS in rural areas as follows:

There is also concern about the spread of HIV from urban to rural settings as small towns become sites of infrastructure development and centre of commercial activities including more bars and sex work to attract daily labourers, which leads to an increase in HIV infection rates.

Thus, small towns are becoming not only commercial and administrative centres but also spots for the transmission of HIV from urban to rural areas.

Taking into consideration that the major mode of transmission of the epidemic in Africa is through heterosexual relations and women are more vulnerable to the epidemic than men whether they live in urban or rural areas, most interventions in Africa so far have focused on empowering women socially, politically and economically (Fuller, 2008; Garbus, 2003; Panos Ethiopia, 2004). These interventions, however, failed to take into consideration the realities associated with marital life. They consistently focused on promoting chastity before marriage, fidelity while married or using condoms where fidelity fails. Chastity, fidelity or the use of condom may be appropriate for extramarital contexts but not within marriage, where the condom is considered as a sign of promiscuity and a hindrance to sexual pleasure and spouses become exposed to AIDS due to the unfaithfulness of one's marriage partner (Cohen and Reid, 1999; FHI, 2002b). Though HIV/AIDS intervention programs need to take into consideration both marital and extramarital relations, efforts to improve partners' communication to discuss issues related to sexuality have been made in limited settings and have not been thoroughly evaluated (FHI, 2009b).

Since it is the men who hold sway on deciding on the when and how of sexual contact (Foreman, 2000), attempts to empower women and check the spread of the disease have to include men too if the efforts are to bear the desired fruit. Peacock and Weston (2008) suggest that organizations working to reduce gender inequality in AIDS should approach men differently. Men should be approached as potential partners and not just probable perpetrators of violence or inevitable obstacles to women's health and wellbeing. Intervention programs should take into consideration that the reason why men do not accept women as their equals may be their ignorance concerning the impact of gender on their own and women's lives (Greig, 2003). The current global situation also demands two key challenges concerning men. One of the challenges is that men should be considered as individuals with differing views, attitudes and beliefs in the design and implementation of campaigns. Some may accept the reality of gender inequality and show readiness to avert it while others may resist the existence of gender inequality altogether (Bell, 2002).

The other challenge is accepting that what the campaigns attempt to change is not individual men and women but the relation that exists between the two. Nowadays, accepting this fact, HIV/AIDS campaigns have begun to target men though the campaigns are restricted in focus to promoting condoms and raising personal risk awareness. Whereas they should also focus on men in general, they focus on specific risk groups such as long-distance truck drivers or the army only. These campaigns also fail to challenge the existing power imbalance between men and women and appeal to men to act from their self-interest (Bell, 2002).

The reality of AIDS in Sub-Saharan Africa also indicates that marriage is increasingly becoming a risk factor. Research findings indicate that married, monogamous women are highly vulnerable to HIV infection due to their lack of rights within marriage, difficulties negotiating safer sex, absence of partner for long time, and domestic violence (Galavotti, Pappas-DeLuca and Lansky, 2001). Gorna (1996), cited in Campbell (1999), remarks that mutual monogamy also is not a reliable HIV-prevention alternative for many women are vulnerable to HIV owing to gender power differentials as a result of which their male partners may not be monogamous. Hence, in addition to improving women's status and negotiating skills, including men as partners should thus be the key area for any prevention strategy if spread of the disease and infection of both men and women are to be avoided. Women are increasingly vulnerable to HIV infection, and conditions that increase their vulnerability increase men's vulnerability too (Galavotti, Pappas-DeLuca and Lansky, 2001).

Iiffe (2006) noted that interventions made so far with the aim of empowering women targeted only women by totally ignoring men. These interventions, says Iiffe, helped most researchers to understand only half of the picture. Dion (2011) also observed that discourse on gender that has emerged within the behavioural paradigm has in fact significant changes. The gender discourse, however, focused only on either men or women, and failed to consider both of them, a practice which limited the attention to half of the picture. Researches also capitalised on individuals, moving away from the concept of men and women co-existing within the context of relationship. These researches also tried to understand sexual behaviour from the point of view of sex leaving out the social factors that influence the behaviour.

Interventions aiming at bringing gender equality and minimizing the risk of HIV/AIDS are more likely to succeed if they focus on couples than target only men or women alone (Boesten and Poku, 2009). These interventions should also be based on researches focusing on exploration of complex behaviours of the actual people than those which simply enumerate the number of at-risk or vulnerable groups (Dion, 2011; Lafort et al., 2010).

Among studies conducted on discourse of behaviour change communication and HIV/AIDS, one is that conducted by Oloo (2012) in Nyanza province of Kenya. In this study, the researcher was interested in analyzing the dominant discourse on HIV and AIDS in Nyanza Province, Kenya, with a view to identifying the representations of HIV and AIDS in the region and the resulting perceptions and attitudes towards HIV and AIDS. The researcher conducted the research using discourse analysis and systemic functional linguistics. The research findings indicated that HIV/AIDS has been represented differently in the language used to communicate information. It also indicated that inhabitants of the province lack specific knowledge concerning HIV/AIDS.

Strebel and Lindegger (1998) have also researched HIV/AIDS in South Africa using discourse analytic approach. Their research was concerned with capturing the range and interplay of repertoires; mapping the range and interplay accounts in relation to existing depictions of the problem; and to explore how discursive positioning mediated possible HIV prevention action. The research also tried to identify areas where possible spaces and shifts could be expected within the changing socio-political context of South Africa. Through their study, they found that the women studied had awareness concerning HIV/AIDS and drew on medicalising and stigmatising depictions of HIV/AIDS, which shows their [the women's] difficulty to respond effectively to HIV infection. It was also found out that gender issues centred around representations of power and responsibility among couples.

Another study conducted using discourse analytic approach was that of Kamanzi (2008), in Tanzania. This study was conducted with the aim to know the state of HIV/AIDS in the landing sites of Lake Victoria. The results of the finding indicated that the people studied were giving up their effort to stop HIV/AIDS considering the virus as 'occupational hazard.' That means, they accepted that contracting HIV/AIDS is related to their livelihood, and hence cannot be avoided. (Kamanzi, 2008)

Kamanzi, also studied the discourse of HIV/AIDS based on data collected from the Tanzanian islands of Lake Victoria. Based on the findings from the data, the researcher tried to propagate an “alternative open discourse based on the acknowledgment of both economic and anthropological factors leading to the spread of the disease”.(Kamanzi, 2011: 52). The findings indicated that, in the first place, it has not been possible through African HIV discourse to deal with HIV/AIDS, decrease and eventually eliminate it. This calls for an alternative HIV/AIDS discourse with transformational educational paradigm. This paradigm, according to Kamanzi, involves belief systems that help pool together efforts of members of different cultural groups to work towards increasing social justice.

Kamanzi also suggests the necessity of going beyond the African HIV/AIDS discourse that considers the epidemic just as a public health hazard to be prevented and controlled as an epidemic. The current HIV discourse, says Kamanzi, is based on early experiences and policies of the developed countries where the effect of the epidemic was restricted to specific groups. In Africa today, however, HIV/AIDS has already become a generalised epidemic affecting different sections of the society and can only be controlled through the coordinated efforts of those who faced the reality of HIV/AIDS. In order to bring such change in the discourse, it is necessary to develop an intervention model on the basis of ‘transformative paradigm’ which includes pillars of the tenet, reflection and action.

The first pillar in the paradigm, tenet, includes axiological, ontological, epistemological and methodological elements. The axiological element demands ethics of listening (Lombard, 1999). The second element, ontology, refers to acceptance of multiple opinions about reality, in this case, about issues relating to HIV/AIDS. The third element is epistemological and is concerned with issues of recognition (Fassin & Schneider, 2003). In addition to these, there is also the methodological approach that has to do with issues of participation in the inquiry. The second pillar of the paradigm, reflection, demands consideration of the subjective as well as the objective causes of HIV/AIDS. The third pillar, action, relies on the pillar of reflection and requires taking into account promotion of case detections, testing, treatment, public education, research and impact mitigation in dealing with HIV/AIDS (Parran, 1937).

Thus, we conclude from the discussion in this section that HIV/AIDS research is making a shift of paradigm-a shift from focusing on mere numbers and sex

to including social factors that contribute to the rise or fall in the numbers. This new paradigm calls for the use of discourse analysis- a study of language as it is used to express lived experiences of the people. It can generally be concluded from this section that:

- a) Rural areas so far have not been researched well and given proper attention in HIV/AIDS interventions,
- b) There is a concern that HIV/AIDS is spreading into rural areas through small towns,
- c) Women continue to carry disproportionate burden of HIV/AIDS as a result of gender inequality, and men themselves are vulnerable to the virus though the degree varies,
- d) Intervention programs intending to empower women have not focused on couples and have not targeted men,
- e) HIV/AIDS interventions so far have focused on enumeration and consideration of individual cases and ignored social factors, and
- f) Discourse analysis is getting recognition in researching HIV/AIDS and finding solution to social factors that fuel the spread of the virus.

Hence, this study was an attempt to conduct research about HIV/AIDS in rural areas based on data gathered from rural areas in order to fill the gap that previous studies on the epidemic neglected rural areas. It tried to investigate representation of audiences in behaviour change communication on gender vulnerability to HIV/AIDS messages, presentation of the messages, assumptions behind the representation and the presentation, changes observed in discourse following the interventions and factors contributing to the impacts.

This study differs from other studies conducted on HIV/AIDS in Ethiopia hitherto because these studies focused mostly on measuring overall achievement of the interventions. They tried to measure success of interventions by studying the increase or decrease in HIV incidence or prevalence, investigating people's knowledge and awareness about the virus, and measuring people's attitudes towards a new concept or object like abstention or the use of condom. When doing this, they mostly focused on urban areas or on both urban and rural areas. They rarely focused exclusively on rural area. This means that they were not focused in their scope concerning population groups and the contents of messages they targeted. The current study, however, is focused in its scope. It is focused from demographic point of view

in that it targeted rural areas. It is also focused concerning message content in that it is concerned only with BCC messages relative to gender vulnerability to HIV/AIDS. Again, it is focused concerning target audience because it focused on couples only. Above all, it is different in that it tried to study HIV/AIDS from the point of view of change in discourse.

1.4 Objectives of the Study

1.4.1 General Objective

The general objective of this study is to explore behaviour change communication messages on gender vulnerability to HIV/AIDS in rural settings by analyzing the content of the messages and the change brought about in spousal behaviour.

1.4.2 Specific Objectives

The specific objectives of the study are to:

- find out whether there are behaviour change communication messages on gender vulnerability to HIV/AIDS in rural areas, and if there are, to
- analyze the content of the behaviour change communication messages in relation to:
 - representation of the target audience in the messages,
 - presentation of the messages,
 - the assumptions behind the representation of the audiences and presentation of the messages,
 - the focus given to spouses,
- find out the impacts the messages have had on the discourse of HIV/AIDS and gender vulnerability,
- find out factors associated with the power and influences of the messages in effecting change.

1.4.3 Research Questions

More specifically, the research will try to answer the following questions.

1. Are there behaviour change communication messages on gendered vulnerability to HIV/AIDS in rural areas?
2. What is the content of the messages in relation to:
 - a) representation of the audiences in the messages?

- b) presentation of the messages?
 - c) assumptions behind the representation of the audiences and presentation of the messages?
 - d) the focus given to spouses?
3. What are the factors associated with the power and influences of the messages in effecting change?
 4. What impact did the messages have on the discourse of HIV/AIDS and gender vulnerability?
 5. What are the factors associated with the power and influence of the messages in affecting change?

1.5 Scope of the Study

The focus of the study was to analyse the content of HIV/AIDS gender vulnerability messages in rural areas and the changes brought about in spousal behaviour as reflected in the discourse. Out of the behaviour change communication messages, the study focused on those messages that were related to gender vulnerability to HIV/AIDS and the changes these messages brought on spousal behaviour as reflected in the discourse. Questions that delve into the target audience's understandings of behaviour change communication messages and changes brought, representation of the audiences, presentation of the messages and how the messages impacted spousal behaviour were used to access the behavioural structures. Geographically, the study was limited to one rural kebele found in Waayyuu Tuqaa district of East Wollega Zone.

1.6 Significance of the Study

The researcher believes that the research result, in addition to indicating the presence or absence of behaviour change communication messages to gender vulnerability in rural areas, has attempted to point out the gap in the design and delivery of BCC messages on gender vulnerability to HIV/AIDS. It also attempted to show the change the messages have brought in spousal behaviour and factors contributing to the changes. This will help to fill the gap that existed in the design and delivery of the messages. Above all, it tried to study the change brought in spousal behaviour by analysing discourse on HIV/AIDS and indicate the gap between expected behavioural outcomes and the actual behavioural change observed. The results will contribute to improving the design and delivery of behaviour change

communication messages on gender vulnerability to rural areas, especially to spouses, and supplement the efforts made to combat HIV/AIDS so far.

Thus, the results of this study will benefit, in the first place, those working on HIV/AIDS policy. This is because, as the study is concerned with issues of design of the messages, it will enable them to see what shortcomings there are in the design of the messages and to make the necessary improvements for the future.

Governmental and non-governmental organisations working on designing HIV intervention programs also will benefit from the findings. This is because the study attempted to identify gaps observed in the design of the messages and this will help them to focus on the gaps in the design of future interventions. And as the cumulative impact of the benefit to policy makers and intervention programmers is to improve the quality of the messages, targets of the messages, rural people, will also benefit from the study as it will contribute to minimizing gender vulnerability.

Finally, the study will serve as a benchmark those researchers who will be interested to conduct study on similar issues.

1.7 Operational Definition of Terms

Vulnerability= Degree to which people are susceptible to harm due to being exposed to infection by HIV/AIDS.

(Behaviour Change) Intervention: A combination of activities tailored to the needs of rural people and developed with them to help reduce risk behaviours and vulnerability to HIV by creating an enabling environment for individual and collective change. (FHI, 2002a.)

Communication= is a planned process whose effectiveness comes to fruition when the audience has achieved, acted on or responded to a message.

Couple= A male and a female united by marriage.

Spouse= A marriage partner; a husband or wife.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

This section presents issues related to gender vulnerability, behaviour change communication, and discourse. In other words, the section will present conceptual, theoretical and analytic frameworks of the study.

Research findings on discourses of HIV/AIDS show that the epidemic affects more women than men due to biological and social factors. This awareness of women's vulnerability resulted in maximising prevention efforts with women and emphasising HIV and gender. This is especially true in Africa where discourses of women's sexual behaviour are still dominated by patriarchal relation that is prevalent in the continent. Scholars particularly mention factors like economic dependency, unequal distribution of sexual power between men and women, limited educational opportunities for women, and lack of political will on part of leaders as contributing to the unequal prevalence of the virus between men and women in Africa, all of which can be attributed to gender inequality (Boesten and Poku, 2009; Wodi, 2005).

Salazar, Figueroa, Giron and Caceres (2009) also remark that the major factor for women's vulnerability to HIV/ AIDS is the context of socially unequal structures. They say that vulnerability indicates the existence of social and gender disparity and should be one of the focus areas that need to be given attention. They associate vulnerability to the virus to lower income and educational attainment.

The following section deals with the contribution of gender to the spread of HIV/AIDS and some factors that exacerbate gender vulnerability to the virus.

2.1 The Role of Gender Discourse in the Spread of HIV/AIDS

Scholars differ in their view concerning sex-gender dichotomy. Some argue that sex and gender are different in their origins while others maintain that the two have the same origin. According to the view that supports sex-gender dichotomy, sex is an attribute that is biologically determined. Naturally people are born male or female and belong to either one of these two categories. Sex does not vary across cultures. Gender, however, is a social construct confirming inequality between the sexes and is culture specific. Cultures create and sustain gender relations in order to generate and maintain social inequality (Grown, Gupta, and Kes, 2005). Geeta (2000:1), in support of the above view expounds that:

Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. It is a social and cultural

construct that differentiates women from men and defines the ways in which women and men interact with each other.

Gender differences, thus, have their root in sexual differences. But unlike sexual differences, which are based on biological factors, gender differences are socially constructed and reflect attitudes of a given society towards the two sexes. They are socially accepted ways of how men and women have to behave and they put a limit on social, political and economic rights of individual members of a society. It is due to such gendered attitudes that women are deprived of their rights and are made to carry disproportionately the burden of HIV/AIDS. The natural biological differences between females and males serve as foundation upon which appropriate social norms and behaviours for women and men are defined and the differential social, economic, and political power between the sexes are determined (Grown, Gupta, and Kes, 2005).

Those scholars who oppose to sex-gender dichotomy argue that consideration of sex as biological and gender as social or cultural is a camouflage. These scholars argue that sex is as socially constructed just as gender is. Proponents of sex gender binary use the natural-cultural distinction between sex and gender to support the idea that it is nature itself and not culture that made the distinction and it is acceptable to make distinction for cultures too. But according to feminist scholars, nature offers shades of difference and similarity much more often than clear opposites. So the argument that gendered attitudes, which are culturally constructed, are based on sexual differences, which are naturally determined, is intended to make the segregation a naturally occurring given (Speer 2005). Eckert and McConnell-Ginet (2003:13) in agreement with this view write that:

Gender is the very process of creating a dichotomy by effacing similarity and elaborating on difference, and even where there are biological differences, these differences are exaggerated and extended in the service of constructing gender. Actual differences are always paired with enormous similarities...

According to these scholars, those who argue for sex-gender dichotomy do this by intentionally erasing similarity and substituting it by difference. This is because nature, upon which people base their dichotomous views, does not offer oppressive clues like the ones reflected in gendered attitudes. Though there is difference in nature between males and females, there is no ground to assign superiority or inferiority to anyone of the two sexes.

These gendered attitudes are created and maintained by discourse because discourse is a totality of practices used to systematically form the objects of which they speak (Butler, 1990a quoted in Speer, 2005). Thus, discourse creates inequality and at the same time provides means of speaking about the same inequality. Speer (2005) says that discourse is political by its nature and people, when they use discourse to communicate, make oppressive understandings of gender and gender role appear natural, acceptable and timeless. If we take the presumed inequality between men and women, this inequality is created by discourse. Again, it is through discourse that members of the society are made to accept that this inequality is god-given and natural, forcing even women themselves to accept that they are naturally inferior to men. We can also take discourse concerning the origin of HIV/AIDS. Though it has not been possible to prove empirically the origin of the virus, there is a belief held by religious communities that HIV/AIDS is the result of the wrath of God. This view is still perpetuated by the same discourse that created it in spite of the interventions made to remove it. The same discourse that is used to form, naturalize and perpetuate gendered attitudes, maintains Speer, can be used as a tool to expose and denaturalize oppressive views of gender and inform social change for the better.

Whether gender and sex have the same origin or not, one undeniable fact is that there are gender discourses that created bias against women and women are victims of this bias. As a result of this bias, women are made to suffer economic, social and political domination and their vulnerability to HIV/AIDS is also in part the result of this domination. Some scholars researching on HIV/AIDS even argue that the disease is a pandemic of gender inequality because more women are affected than men due to gender bias that is encouraged by the existing discourse. This partial impact is more pronounced in Africa, especially sub-Saharan Africa, where more women are suffering the burden of the disease due to their low economic, socio-cultural and political position or sexuality and gender discourses (Strebel and Lindegger, 1998). The impact the disease is having on women shows absence of the formulation and implementation of human and legal rights on an equal basis for all members of the society irrespective of their gender (Arrehag, De Valder, Dureval, and Sloblom, 2006; Boesten and Poku, 2009; Fuller, 2008).

Strebel and Lindegger (1998), quoting different sources (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1990; Juhasz, 1990; Hollis, 1992), argue that gender relations have significant role to play in helping us understand the impact

of HIV/AIDS on women. This view posits that women’s ability to respond effectively to HIV is affected by their relative position in society. The current intervention discourse demands women to practice ABC’s-abstention, being faithful to one’s partner or negotiating the use of condom with their partners. According to this discourse, women are accountable to ensure safer sex. Nevertheless, either to abstain, to be faithful or to use condom are options over which women have no control. This is paradoxical in that women are required to exert influence and make decisions in areas where they have little power and few options themselves.

FHI/AIDSCAP (1997) remarks that women are made to suffer disproportionately from HIV/AIDS because of their gendered position. It says that:

Gender roles are ascribed to the social and cultural context through the socialization process. Universally, females are assigned by society to a subordinate position to males. This becomes a disadvantage to women with respect to the distribution of power and with implications for increased vulnerability of women to HIV/AIDS (p. 13).

Thus women, especially those in Africa, lack economic and political power to defend their right and to minimize their vulnerability to the virus owing to the sexuality and gender as well as socio-economic discourses.

In Ethiopia also women are disproportionately affected by HIV/AIDS as a result of the prevailing socio-economic, sexuality and gender discourses. This disproportionate impact of the disease between males and females is illustrated in the following table.

Table1. Trends of HIV prevalence in Ethiopia (2004-2011) in percent: National male and female.

	2004	2005	2006	2007	2008	2010	2011
National	2.2	2.1	2.1	2.1	2.2	2.4	1.5
Male	1.7	1.7	1.7	1.7	1.8	1.9	1.0
Female	2.6	2.5	2.5	2.6	2.6	2.9	1.9

Sources: HAPCO/MOH, single point prevalence estimate, June 2007, FHAPCO 2011 and Central Statistical Agency & ICF International 2012

As can be seen from this table, HIV prevalence for females fluctuates between 2.5 and 2.6 throughout the five years (2004-2008) but rose to 2.9 in 2010 and declined to 1.9 in 2011. For males, however, it was 1.7 for the first four years (2004-

2007) and 1.8 in the fifth year (2008). It rose again to 1.9 in 2010 but fell to 1.0 in 2011. It can be concluded from this table that there is a fluctuation in HIV prevalence from year to year.

When we look at the figures under 2011, we can say that there is a decrease in prevalence. Though this decrease is true for both females and males, the gap between the two sexes continued unaffected. If we look at the first and the last years in the table, the gap in prevalence between the two sexes remained 0.9. Thus, we can say that there are achievements in minimising HIV prevalence over all, nevertheless, the gap that existed between females and males has not been affected and females continue to carry disproportionate burden of HIV/AIDS. This shows that the interventions that have been underway during this period did not do enough to narrow the gap that existed between males and females in HIV prevalence, which in turn indicates that a lot has to be done to narrow this gap.

This imbalance between men and women in prevalence has its roots in the prevailing gender relations. These gender relations have not only made men relegate women to low social status but also made women themselves accept their low social status in society relative to that of men (Wodi, 2005). It is these limiting attitudes that play important role in determining women's reaction in the face of risky behaviours (Travers and Bennett, 1996). In relation to this, Campbell (1999) quoting Amaro (1995) identified four essential components of any theory about women's HIV risk behaviour. These components are:

- 1) women's social status is a major factor in their risk;
- 2) connection and the relational self in women's development and the fear of disconnection because of conflict are critical features in women's risk;
- 3) male partners play important role in women's risk; and
- 4) some women are deterred from reducing sexual risk due to fear of physical and sexual abuse.

Thus, as discussed above, women have been victims of the existing gender discourse and this condition also contributed to their vulnerability to HIV/AIDS. Scholars researching HIV/AIDS also agree that different prevailing conditions on gender and HIV/AIDS show that the central discourse influencing writings on the virus and gender depict the impact of socio-economic discourses on women in relation to sexual relations, economic status and HIV risk minimization (Strebel and Lidegger, 1998; Ankrah, 1991)

Fuller (2008) remarks that African women are vulnerable to HIV/AIDS because of their lack of access to health care and treatment information, lack of education, their roles as caretakers of the family, unemployment and the ensuing economic dependence on men. Travers and Bennett (1996) also say that women become socially vulnerable to HIV/AIDS owing to their low social status which places them at risk for the disease. Scholars also mention a number of factors as contributing to vulnerability of women to HIV/AIDS some of which are presented below.

2.1.1 Harmful Traditional Practices

Traditional Practices are among factors increasing vulnerability of women. Bujra (2009) says that it is not forbidden forms of traditional practices but approved forms of sexual behaviour which expose people to infection by the deadly virus. She mentions polygyny, widow inheritance, circumcision, dry sex and abduction among others as contributing to the spread of the virus. Other scholars also agree with Bujra but add other contributing factors too as discussed below.

Widow inheritance

When a woman becomes a widow in several sub-Saharan African countries, the husband's family obliges her to choose a member of the husband's family, usually his brother, as a husband or to marry a person chosen by the family. Protection and security to the widow and orphans were offered as partial explanations to justify this practice. This practice increases the vulnerability of both the woman and the man she is forced to marry since they do not take any HIV test before starting sexual intercourse. So, if the woman's first husband died from HIV infection, the new husband is also exposed. There is also a possibility that the new husband has the virus in his blood in which case he infects the widow. The woman is forced to enter such a relation because, if she refuses to be inherited, she does not have any right to inherit or claim the possession of her dead husband (Villareal, 2000).

Early marriage or early sexual practice

In some developing countries, girls are expected to marry before they are 18. Studies indicate that, in Ethiopia, girls are forced to marry at the age of 13 or 14 (Central Statistical Agency [Ethiopia] and ICF International, 2012). In these marriages and other non-marital relations, the ideal gap between spouses or partners is 10 years which shows that girls have sexual relations with older people, who have

already had sexual experience and may have been infected by the virus (Kalipeni, Craddock, Oponng and Ghosh, 2004).

Another factor that exposes girls to marriage or early sexual intercourse is men's belief that sex with younger girls is safe from sexually transmitted diseases including HIV/AIDS, and older men hunting for the girls. The fact that these men are older, more mature and economically well off gives them upper hand to dominate their female partners on issues including decision on the form of sexual relation such as the use of condoms and thereby fosters compliance and passivity in the girls (Foreman, 2000; Meel, 2003).

Female genital mutilation

Female genital mutilation (FGM) is practiced in different places with an intention to control female sexuality (Henrion, 2003). The practice, besides exposing the girl to psychological and physical pain, has a lasting health consequence on the girl. Jackson (2002:126) described the cruelty involved in the practice of FGM and its psychological impact on the girl's health as follows.

The worst violation of women's rights is the practice of female genital mutilation (FGM), which denies the women the right even to sexual pleasure. FGM exposes girls to severe psychological trauma, serious risk of infection and even death, and excruciating pain at the time of the operation, traditionally done with no anaesthetic. The agony is repeated when her husband later has to break open the scar tissue to have sex with her, and again during childbirth.

Thus, women suffer both psychological and physical prolonged pain as a result of FGM. The wound that is caused around the genital organ as the husband tries to have sex with the lady, besides causing severe pain at the time of intercourse, can result in loss of life.

The 2005 EDHS preliminary report indicated that FGM is widely practised in Ethiopia. It was found out that 74 percent of the women had been circumcised in 2005. The survey also indicated that there was a decline in the practice among younger generation as only 62 percent of women aged 15-19 were circumcised compared to 80 percent of women aged 35 and above. It was also found out that there was higher prevalence in rural areas, 75.5 percent, than in urban areas, 68.5 percent and women with little or no education practiced it more compared with those with at least secondary education (Central Statistical Agency, 2005.)

Abduction

Abduction is a violent act on women against which they cannot defend themselves and encourages forced sexual intercourse that puts the women in high risk of contracting the disease (Panos Ethiopia, 2004). In abduction, the woman is under complete control of the abductor and does not have the right to choose or resist. Under such circumstances, whatever the health status of the man, the girl has no opportunity to check his moves. The only choice left to her is submit to his needs and suffer the consequence.

2.1.2 Economic Factors

Women are vulnerable to infection by HIV due to their lack of access to education, low social and economic status, and lack of economic opportunities. Low economic status in turn fosters in women lower self-reliance, lower knowledge levels and sexual activities which increase their degree of vulnerability (FHAPCO, 2011).

The prevailing gender roles also have serious consequences on women's access to economic resources and relegate them to subordinate status which in turn increases their vulnerability to HIV infection. These gender roles, especially in Africa, resulted in husbands' monopolization of the economy, enhanced women's dependence on their husbands and forced them to be submissive in all matters including when, how and under what circumstances sexual relation has to take place irrespective of the risks that may be involved (Kalipeni et al., 2004).

Though poverty has impact on vulnerability of both men and women, it affects women more because of their lack of access and control over financial resources. Some scholars even use the term 'feminization of poverty' to show the fact that women are more impoverished than men. Among factors which influence the notion of an increase in female poverty are absence of enough opportunities for women on labour market, assigning women to caring responsibilities and reducing their time for paid work. Failure to focus on women in global restructuring programs also facilitated the marginalization process (Doyal, 1995). In situations where women economically depend on their husbands, women may be forced to stay in a relation even if this puts their life at risk. This is because resistance to participate in a risky sexual relation may result in men denying the women and their children access to material support which in turn may affect their survival. These women, to avoid the economic consequences of refusing risky relations, are forced to take high sexual risk which increases their vulnerability to HIV/AIDS (Gysels, Pool and Nnalusiba, 2002).

There are also conditions where women are forced to offer sex in exchange for personal favours. Concerning this, Baylies and Bujra, (2000: 7) refer to sex as “a currency by which women and girls are expected to pay for life’s opportunities from a passing grade in school to a trading license or permission to cross a border” and associate sex not only with personal relations but also with economic strategies. The problem here is, even if these women know the negative consequences of risky sexual behaviour, the unequal relation between them and the ones they are seeking favour from does not allow them to insist on safer sex lest this spoil the situation and stand in the way of attaining their goal.

But still there are writers who object to the view that economic benefit is the driving reason behind women’s engaging in unprotected sex. Among such scholars, Sobo (1995) argues that impoverished women do not engage in unprotected sex because of their lack of power or for economic benefit. In Sobo’s view the main reason why women engage in sex with men, whether protected or unprotected, is not economic purpose but status and emotional fulfilment. These women, says Sobo, even do not accept financial resources from their partners because this may foster gender-related disparity that these women want to avoid.

2.1.3 Restricted Access to Information

According to current cultural norms in the developing world, especially Africa, women are inhibited from discussing sex-related matters let alone openly seeking information on such issues. They are often told to be passive concerning sex issues. This situation is stated in Commonwealth Secretariat (2002:41) as follows.

Young women who show knowledge about sex and reproduction may be seen as promiscuous and risk getting a “tarnished sexual reputation”....For many young women, discussion around the subject of sex is limited to warnings about its dangers and about the importance of preserving their honour.

These limiting attitudes deprived women of their right to access general information, and the resources, and knowledge and skills to use the information to protect themselves from infection and to minimize the risk if already infected (Buescher and Michuru, 2001).

Ethiopian women are also less educated and, have lower level of literacy and have less exposure to mass media. They are economically dependent on men because they lack manual skills, predominantly engaged in agricultural occupation and less likely to engage in professional, technical or managerial skills than men. Women’s

low educational attainment, low literacy level, less exposure to information and employment greatly hamper the development of their personality and affect their assertiveness at home and in the society (Central Statistical Agency [Ethiopia] and ICF International, 2012).

We have seen that socio-cultural, political and economic reasons increase the degree of vulnerability of women to HIV. But this does not mean that men are not vulnerable to the disease. This is because the prevailing gendered cultural attitudes make men develop behaviours that expose them to the disease. This is because, as a result of their dominant position, men develop unchecked sexual behaviour that increases theirs and their partner's vulnerability to the disease (Brent, 2010). To prevent or control the spread of this disease, therefore, it is mandatory to do away with gendered attitudes that fuel the spread of the virus and change the behaviour that increases people's chances of contracting the disease, and one of the strategies often used to change people's behaviour is 'behaviour change communication' (HAPCO, 2009).

Though the majority of HIV/AIDS research findings indicate that women are vulnerable to the virus due to gender and socio-economic discourses, there are also findings which indicate that capitalizing on one gender leaving out the other is not advantageous. Among these, Cleaver (2002) and Kaler (2009) state that HIV/AIDS discourses nowadays create rift between males and females. These discourses condemn men of risky sexual behaviours, subverting women, promiscuity, refusal to use condom, putting their own desires for drink and cigarettes before the family's needs, while representing women as resourceful and caring mothers thereby promoting discourse of difference between the two sexes.

Morrell (2001) also decries the tendency in current HIV/AIDS research to overlook the role of African men as fathers and caring and placing them all under an umbrella of 'single masculine identity'. This scholar posits that such condemnations and divisive attitudes limit the degree of understanding the success of prevention endeavours and, hence, negatively affect both men and women.

Other researches even have gone to the extent of stating that the vast amounts of aid and empowerment measures directed only at women resulted in disempowerment of men and 'crisis of masculinity' (Cleaver, 2002; Sweetman 1997). Thus, these scholars state that what they call 'discourse of the marginalization of men' affects both men and women. They also state that though men's unchecked power

should be challenged and the fact that women are oppressed should be taken into account, they also advocate that the corresponding reality that men are not always the oppressors should be considered.

African gender discourse relating to HIV/AIDS always capitalized on finger pointing. First, it focused on blaming women as vectors of the virus and men for sleeping with these vectors and passing over the disease to their innocent partners. Again, gender norms were blamed for rendering women powerless concerning issues of sexuality. Recently, the empowerment of women has been blamed for marginalizing men and causing 'crisis of masculinity'. This finger pointing gave rise to discourse of division between who were more at risk, spreading the disease and needed to change on one hand, and who were powerless, oppressed and victims on the other, and distracted attention from the bigger picture, that is the socio-cultural discourses which cause the differences (Cleaver, 2002; Sweetman, 1997).

The issue of male-female vulnerability or male risky behaviour is acceptable in contexts where the spread of HIV/AIDS is fuelled through heterosexual relations. But it has to be noted that there are scholars who reject the discourse of 'African sexuality' and that the spread of the disease is attributed to this discourse, labelling such discourse as 'western discourse' (Booth, 2004; Fuller, 2003). According to this view, HIV discourses in Africa place much emphasis on African sexuality as a cause for the spread of the virus, leaving out other possible routes. Consequently, the questions, answers and conclusions drawn concerning issues of HIV transmission revolve around African sexuality, which resulted in creating concepts of African backwardness and abnormal sexuality.

To some scholars (Aggleton, 1992; Stillwaggon, 2003; Kamanzi, 2008), the notion of attributing the spread of HIV/AIDS in Africa to the continent's hypersexuality and backwardness are based on colonial literature, which was ethnocentric and evolutionist. These scholars use as reference Caldwell, Caldwell and Quiggin (1989) "African permissive sexuality thesis" which attempted to connect Africa's high HIV prevalence rate to the continent's sexuality that is characterized by high rates of partner change and sexual networking.

2.2 Behaviour Change Communication in HIV/AIDS Interventions

Behaviour change communication (BCC) is a strategy that is used currently by different HIV intervention programs. Before its emergence, intervention programs

used information, education and communication (IEC), which did not go beyond developing people's awareness about HIV/AIDS and failed to change behaviour. This strategy, IEC, focused on development of communication strategies and support materials, and targeted influencing behaviours among specific groups (FHI, 2002a). It focused on working with individuals and communities with the aim of developing communication strategies to promote positive behaviours appropriate to their settings. But behaviour change communication (BCC), in addition to working with individuals, communities and societies to develop communication strategies to promote positive behaviour, includes providing supportive environment that will enable to initiate and sustain positive behaviours.

The main difference between the two strategies is, thus, IEC focuses on providing people with information and telling them how to behave whereas BCC, on top of providing information on how to change unhealthy behaviour, helps people to make a personal decision concerning the behaviour to be changed. It includes the recognition of other supportive environment factors such as the community and the society that may have a negative or positive influence on the process of an individual's behaviour change. BCC treats cultural difference and audience reception and makes use of a variety of communication channels in the delivery of messages (Wood, 2008). It maintains that a medium that people can understand and relate to should be used in giving basic facts about HIV and AIDS. BCC includes provision of medical, social, psychological and spiritual services and commodities in addition to information about the epidemic. It is based on the assumption that before individuals and communities can reduce their level of risk or change their behaviours, they must first understand basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services (Eldis, 2009).

Behaviour change communication as defined by Family Health International (2002a:5) is:

an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours.

Thus, behaviour change communication has the following characteristic features as can be observed from this definition.

- a) It is an interactive process or governed by interaction among individuals.
- b) It is interested in communities and not just individual persons.
- c) It works through developing tailored messages and approaches- messages that are appropriate to a specific society or situation. This also shows that BCC is a strategy to be used in conjunction with other strategies such as STD (sexually transmitted diseases) treatment, condoms and creation of enabling environment.
- d) It makes use of variety of communication channels to get the messages across.
- e) Its purpose is developing positive behaviour- behaviour that is of importance to the group the communication is intended for.
- f) It intends to promote and then sustain individual, community and societal behaviour change. Though the change focuses on communities, it has as its goal to influence individual behaviour as a member of a given community and sustain positive change. BCC programs attempt to guide individuals, groups, or a whole population to voluntarily adopt, maintain or change an attitude and behaviour with the aim of changing life for the better. BCC interventions comprise interpersonal communication, counselling, mass media, and community participation approaches that take into account popular values, the context and the relationships of the target community. BCC programs usually employ elements of advocacy, social mobilization and community participation methodologies (FHAPCO, 2011).

Advocacy programs are used to influence the political commitment of those in influential roles to maintain positive influence. Advocacy helps to get organizational, community and individual support to mobilize resources and services and create conducive environment to implement intervention programs. Community mobilization, on the other hand, is a process whose goal is to rally community members for action to attain social goal with minimum cost through the efforts and contribution of the community. Community participation is usually a sequel to community mobilization and consists of leading a given community through a communication convincing it that it has the necessary resources for the development

of a program and for taking part in the planning, implementation and evaluation of the program (FHAPCO, 2011).

HAPCO (2009) specifies five different steps behavioural change materials should go through. These steps are analysis, strategic design, development and pretesting, implementation and monitoring, and finally evaluation and re-planning.

Analysis encompasses two different stages which are understanding the dynamics of the health problem and understanding the audience and potential participants. The first stage, understanding the dynamics of the health problem, is concerned with issues of identifying health problems, health-related behaviours, reviewing existing materials and resources and developing problem statement. The second stage, the stage of understanding the audience and potential participants, comprises identification of primary audience- individuals whose behaviour is primarily targeted by the intervention- and a secondary audience- those people who can exert either positive or negative influence on the primary audience in its efforts to develop new behaviour. These include people such as family, peer educators, allies, or other decision makers such as teachers, community leaders, and health authorities.

HAPCO (2009) also states topics to be considered for audience analysis along with information needed under each topic. The first topic concerns demographic factors which require information on age range, level of schooling, marital status, income and occupation of the audience. The second topic under audience analysis is area assessment which includes location, cost and accessibility of health related services and whether the poor or the rich; males or females, children or adolescents use the services. The third topic that is to be considered is healthcare seeking behaviour which includes, among other things, services people use for general health, services they chose for STI (sexually transmitted infections) diagnosis and treatment, services they chose for sexual and reproductive health, when people seek different kinds of care and perception about the services and diseases. The other topic that needs to be considered under audience analysis is existing knowledge, attitude and behaviours. This topic needs information in relation to how STIs including HIV are transmitted, knowledge as to how STIs including HIV are prevented, frequency of protected or unprotected sexual contact, number or type of partners, issues related to condom use, social norms including gender norms, values, beliefs etc. The last topic to consider under audience analysis is media habit that needs information regarding

possible sources of information about health, access to media, listening and viewing habits and frequency of media use.

The other important issue under audience analysis according HAPCO (2009) is audience segmentation. Audience segmentation here means dividing and organizing an audience into smaller manageable groups based on their communication-related needs, preferences and characteristics.

Factors which are worth considering when segmenting audiences are:

- Demographic characteristics

These include age, gender, place of residence (or work), income, religion and ethnicity. Rural residents, for example, can be divided according to their sex and then according to their age within the same sex (Becker et al., 2007).

- Psychosocial characteristics

Psychosocial characteristics refer to the knowledge, attitudes and practices demonstrated by a specific group or audience. These include the role each specific group has in the society, formal and informal responsibilities and level of authority. We can, for instance, divide rural population on the bases of their level of education, marital status and knowledge about HIV/AIDS.

- Structural factors and settings

Structural factors and settings are factors related to places of work or residence and risk behaviour. People can thus be divided according to their residence into rural and urban areas, and then into smaller groups within each urban or rural area based on their specific behaviours such as degree of vulnerability and the degree of their contact with people of other areas.

In general, BCC messages have to be audience specific but if they are not so, even if they provide some information, they would turn out to be vague and fail to affect people's action (HAPCO, 2009).

This does not mean that audience segmentation is the only factor interventions have to consider for their success. There are three important factors that interventions have to take into account in order to succeed. These are the personal factors, social factors and environmental factors (COI/GCN, 2009; Jackson, 2005). Personal factors include factors inherent to an individual person such as their level of knowledge and their confidence in their capacity to change an undesirable behaviour. Social factors are those factors related to an individual's relation with those living

around him/her and those who can exert influence on an individual's changing his/her behaviour. These include people such as peer groups, family members, co-workers, etc. Finally, environmental factors are factors which are outside the individuals control. They include factors such as availability of facilities, technology, economic status and access to services. Interventions which capitalise on any one or two of these three factors and ignore the other are defective and are not likely to bring the desired behavioural change (COI/GCN, 2009; Darnton, 2008; Jackson, 2005).

2.3 Discourse Analysis as a Research Approach

The word 'discourse' originated from Latin 'discursus' which means 'conversation, speech' (Wisniewski 2006). Since its introduction, however, it has been defined in different ways. Traditional linguists defined discourse as anything beyond the sentence. That means they considered it as a structural unit that can be studied by comparing it with the sentence. This view puts discourse on equal scale as a grammar, and makes it a collection of descriptive statements that is not related in any way to the human mind.

There is also a second view on discourse—that of functionalists. According to this view, discourse should not focus on structural study only, because this does not take into consideration the function of language. Therefore, function, and not structure, should be the major focus of discourse. This view of discourse posits that the study of discourse is the study of language in use. Language use focuses on meaning, and study of discourse, according to functional view, can be taken as how users view the meaningfulness and unity of language in context (Cook, 2003). According to this view, discourse analysis is an analysis of linguistic behaviour, written and spoken, longer than a sentence, focusing primarily on the meaning created and interpreted as language is used in particular social contexts. This definition focuses on two major points: the fact that language can be analyzed beyond the limits of individual sentences and on the level of text, and the fact that language ought to be analyzed not as an abstract set or rules existing independently of human action, but as a tool for social action. In short, language should be analyzed from the point of view of its function (Bhatia, 2004).

The third view of discourse is that of critical theorists. They proposed that language function should include nonlinguistic social practices and ideological assumptions that construct power relations in the society. According to this view, discourse becomes a count noun and the term 'discourses' includes linguistic and non-

linguistic social practices and ideologies that together form power relations, in which case we can talk of discourse of power and of racism. Critical theorists, hence, view discourse as a particular way of talking about and understanding reality or an aspect of reality (Jorgensen and Phillips, 2002). Potter and Edwards (2001), cited in Hibberd (2005: 4) define discourse as "...talk and texts, studied as social practices".

The many definitions of discourse we saw above fall into the following three main categories: (1) anything beyond the sentence, (2) language use, and (3) a broader range of social practice that includes nonlinguistic and nonspecific instances of language (Schiffrin, Tannen and Hamilton, 2001).

Thiesmeyer (2003) defines discourse as consisting of language accessible to the public and other forms of expression circulating widely and consistently throughout a society. These include language forms such as the ones used for exchange of information as well as for commenting on, analysis, entertainment, or criticism. Such a language is learned and used publicly and has social frameworks and functions. It is these frameworks and functions that are the subject of discourse analysis. Discourse analysis in this sense is not confined to analyzing specific language structures and usages. It is also concerned with conceptual evaluation of the language relations, social norms, and political actions and ideologies.

Gee (2005) referred to the use of language to enact activities and identities as discourse with "small d" and the one that melds language use plus other stuff to enact identities and activities as discourse with "big D". The substances that change a discourse from "little d" into "big D" are the employment of practices and activities such as body, clothes, actions, interactions, tools, technologies, values, attitudes, beliefs, emotions and so forth used rightly at the right time and place. Thus Gee's "little d" discourse corresponds with the functionalists' view whereas his "big D" discourse corresponds with that of critical theorists.

As a result of these differing views on discourse, nowadays there are two groups of links in discourse studies. The first one is formal links, which refer to linguistic facts or facts found in the analyzed text. The other is contextual links- links that refer to the knowledge that is not part of the communicative product or to extra linguistic facts which may be related to the place and time of interaction or conditions related to the interactants (Cook, 2003; Widdowson, 2004). Gee's 'Discourse' above can be categorised under contextual links since it gives emphasis to factors outside language use that have something to do with the social actors' actions or identities.

The analysis of discourse, therefore, is basically the analysis of language in use since limiting the analysis to only linguistic forms leaving out the functions which the forms are intended to serve does not give us the full picture. Linguists may still study language to discover rules that produce acceptable texts. In discourse as communicative behaviour, however, the analysis focuses on finding out what constrains the occurrence of utterances and how sentences combine to form texts (Blakemore, 2001).

To conduct discourse analysis, generally, means to investigate language beyond the boundaries of syntactic or semantic form. The analyst, beyond the lexico-grammatical resources of the language system, is expected to pay attention to the functions of this system in the utterances and the functions of the utterance within its context. Thus, discourse analysis is interested not only in the formal aspects of language but also in the social actions performed by language users communicating within social and cultural contexts. It should take into account the formal as well as the social and cultural aspects of language (Barker and Galasinski, 2001).

Blakemore (2001), quoting Fasold (1990), defines the study of discourse, as the study of any aspect of language use. This definition broadens the territory to any aspect as far as the study is concerned with language use. Trappes-Lomaz (2004:134), concerning the multi-throged function of discourse analysis, defines it as: “[T]he study of language viewed communicatively and/or communication viewed linguistically,” and goes on to say that it “...involves reference to concepts of language in use, language above or beyond the sentence, language as meaning in interaction, and language in situational or cultural context.”

Thus, according to Blakemore’s definition here, discourse analysis covers wider area of language use since it encompasses the communication aspect of language. It includes language as meaning in interaction which may possibly indicate that, not only language beyond the sentence but also below the sentence, since meaning can be conveyed in interactions with the help of phrases or even words (Widdowson, 2004).

2.3.1 Models of Discourse Analysis

Different scholars have dealt with the issue of language-in-use and approaches to be employed in analyzing discourse. Though they have language function as their common point of departure, they differ in important ways in the discourse analytic approaches they propose. The next section will entertain a

discourse analytic model, proposed by Gee (2005), out of many existing under the topic.

2.3.1.1 Language as a tool for building tasks

Emphasizing the role of language in expressing daily social practices, Barker and Galasinsky (2001) quoting Shotter (1993) say that we can think of language as a resource that gives expression to ourselves as social beings and the world around us in an event of talk or practice that is otherwise difficult to explain. Thus, language plays a significant role by expressing human feelings, thoughts and practices. In agreement with this view, Gee (2005) asserts that language in use can serve for designing things or representations of reality. We use language to express emotions, moods, opinions and so forth. We also use language to build identities, relations, activities, importance etc. in a given situation, to share what we have with others and share from them. According to Gee (2005) we all the time build and rebuild our worlds through language used in conjunction with actions, interactions, non-linguistic symbol systems, objects, tools, technologies, and distinctive ways of thinking, valuing, feeling, and believing. Through spoken or written language, we always and simultaneously construct seven things or areas of reality what Gee calls “seven building tasks” of language. These tasks are presented as follows as discussed in Gee, (2005).

A) Significance

This task refers to the task of language as it is used to give meaning, importance or value to things, actions, people (speakers themselves or others). Whenever we do things, we accompany our language with actions that give significance to what we say. When a person chairs a meeting, for example, s/he speaks like someone who is a chairperson. To give significance to the words uttered s/he sits in front of the other people attending the meeting. The language used also, such as opening or calling the meeting to adjourn, gives significance to the person as a chair.

In their utterances too, people refer to certain things as significant and to others as insignificant. The significance attached to things gives us a clue as to what discourses utterances belong to, or support and help us in analyzing what is uttered.

In this study, the data were gathered through interview, focus group discussion and documents. Since it is difficult to know how respondents enact significance through their actions all the time, the focus was to analyse how they

express significance through their words. Respondents often said, for example, 'It is important to be faithful to one's partner'. In this case, they are expressing significance of being faithful and such expressions were the focus analysis in this study.

B) Activities

Language also has the task of building activities. This is the use of language to enact social activities. We engage, for example, in an activity of teaching and the language we use also shows that we are teaching. Or we may engage in preaching and the language we use also shows that we are preaching. Language here is used to make clear to others the sort of activity a person is engaged in. In the current study, however, the respondents engaged in verbal interaction with the researcher and it was not possible to see them actually engaging in other discursive activities. It was, therefore, mandatory to focus on what activities they express verbally than what they do to enact activities.

C) Identities

One of the functions of language is to enable us to establish identities recognized by others and to maintain these identities over time or to depart from them. According to historical and cross-cultural work, the material for personhood has as its resources in the language and cultural practices of specific times and places. The language that we use for expressing our identity has long been there as an element of culturally shared material before we were born. It is through the use of language that we came to realize our identity as persons and the very concept of personhood (Agha, 2007; Barker and Galasinski, 2001).

When used to build identity, language helps others to recognize who we are at a given time. The same individual can assume different roles at different times. One time he may be a school principal and at another time, he may be a head of family. So as to be recognized which role a person is playing, she/he enacts the activity at the right time and at the right place which helps others to identify which role the person is assuming (Gee, 2005). The focus in this study was to find out how they used language to express what the respondents believed or thought they were and how they expressed the identities of others through their use of language.

D) Relationships

Language can be used to indicate what sort of relationship we have, want to have with those with whom we are communicating. The language we use when communicating with our boss and the one we use when chatting with our friends is

not the same. With the former one we use formal language while with the latter we use informal one. Thus, the identity of the person we are communicating with constrains the degree of formality of language we use, and language in turn reflects the type of relation we have with the other person. By examining the language individuals use when communicating, we can tell the type of relationship that exists between them. For example, the way the wife addresses her husband and the way the husband addresses his wife are not the same. Husbands usually address their wives with less formality whereas the wives use formality and, in some cultures, even avoid calling him by his name.

E) Politics (the distribution of social goods)

Politics according to Gee refers to how members of a given society think about, argue over and distribute social goods. Social goods are what a group of people considers to be a source of power, status, value, and so forth. These social goods can be expressed in a form of money, wisdom, intelligence, etc. We often use language to express what the world is like from our own perspective; we distribute social goods from the point of view of what is normal or not normal, acceptable or not acceptable, right or wrong, appropriate or inappropriate. We have our own perspectives as to what is real, right or true and this perspective gets expression through the language we use. Whatever political perspective we are conveying is built through our language. People may see the same event, but still may have different reactions towards the event because these reactions are influenced by their perspectives- what they consider to be normal, correct or true. When we analyze politics as an element of discourse, we are analyzing what perspective the speaker or writer is taking concerning what is crime, guilt, innocence, etc. Respondents in this study, for example, expressed their perspective concerning who is promiscuous and who is faithful, which was analysed under politics

F) Connections

This task refers to when language is used to show whether things are connected or relevant or whether they are disconnected or irrelevant. We can talk of the relevance of a person's question or suggestion to an issue that is under discussion or whether there is a relation between a person's mental capacity and his/her family status. Thus, we can use language to indicate how relevant or connected things are. Analyzing connections in a discourse means, therefore, analyzing how language is used to connect or disconnect things. In this study, for instance, respondents

connected condom use to adultery. They also connect discussion to educational status and area of residence. Such issues where respondents connect a behaviour or an action to something else was analysed under connection.

G) Sign systems and knowledge

People's reactions to different languages, language varieties, forms of knowledge and beliefs as sign systems are not the same. They may favour their own language or the language they know and disfavour the ones they do not know. They may speak in favour of one form of knowledge while ignoring the other. They approve of one belief and disapprove others. In general, they use language, in Gee's (2005) words, to build privilege or prestige for one sign system or knowledge claim over the other. In analyzing sign systems and knowledge in discourse, the analyst examines how language is used to express preference for one sign system over another.

In a discourse analysis, therefore, some or all of the above language tasks can be analyzed against a written or spoken text. What the analyst has to do is take each or select relevant task and analyze how the task is reflected in that particular text. In addition to these tasks, however, Gee (2005) mentions other language elements worthy of consideration in relation to how different people assign meaning to texts in analyzing discourse, of which one is discourse models.

2.3.1.2 Theoretical tools

Gee (2011) presents five theoretical tools which are used to show how language is connected to the world and to the culture. These tools are: the situated meaning tool, 'social languages', intertextuality, "figured worlds/discourse models" and "Discourses" with a capital "D". In this section, these tools will be presented in turns as discussed in Gee (2011).

A. The Situated Meaning Tool

Any word has two types of meaning: "utterance-type meaning", which is the general meaning of the word or utterance, and "utterance token meaning" which is specific meaning of a word or an utterance as it is used in a specific context of use.

Words or structures in a language have 'meaning potential'-possible meanings a word or a structure may have when used in different contexts. Definitions of words found in dictionaries, for example, are meaning potentials of words. This is general meaning or utterance-type meaning of the word. The general meaning of a word or structure, however, may change as the word is used in different contexts or as

users intentionally change its meaning through the use of extralinguistic features such as the rise or fall of intonation. In everyday communication, words and structures give much more specific meanings within the limited scope of their meaning potentials. Gee calls this type of meaning ‘‘situated meaning.’ If we take the word ‘snake’, for example, it can take on at least two different meanings depending on its context of use. It may mean ‘legless, sometimes venomous reptile’, or ‘an unreliable person.’

Though words have their own general meanings, they have also specific meanings depending on the context in which they are used. If we take the word ‘club’, for example, it has different meanings in the sentences that read ‘The police used clubs to disperse the crowd’ and ‘Members of the club contributed a huge amount of money’. In the first sentence, it means type of stick used for hitting something or somebody, whereas in the second, it means ‘an institution organized for specific purposes’. Here, our previous experiences or knowledge of the words or phrases has a bearing influence on how we situate the meanings of words or phrases.

Meanings of words are not always similar or the same to their dictionary meanings. Listeners fill in their own meanings as they hear the words and based on other words uttered or other context. This is what discourse analysts do when working out the meanings of words in order to unmask what has been unsaid on the basis of what has been said.

A. The Intertextuality Tool

Intertextuality refers to the condition where one text refers to, quotes or alludes to another text. Speakers or writers often make reference to what other people have said or written or to other texts. Intertextuality can be realized either through directly quoting like in ‘He said, “I will pass the exam,” or indirectly as in ‘He said that he would pass the exam.’ In both cases the speaker or the writer is making reference to what somebody else has said. People, for example, are making reference to Biblical story when they admire the leadership qualities of a person saying, ‘He is the Moses of our time’. People also make allusion to the Bible when they imitate the way the Decalogue was written saying, “Thou shalt not do this or that”. People also use intertextuality by mimicking the grammatical or phrasing mistakes speakers commit when speaking a second or foreign language.

When we analyze discourse, we pay attention to intertextuality to find out how words and grammatical structures are used to refer to other texts or what others

have said or written. This helps to make comparisons between different texts and widens the researcher's general understanding.

B. The Big "D" Discourse Tool

Gee (2011) says that discourse with small "d" is changed to Discourse with capital "D" when other "stuff" is added to language in use to enact identity and activity. That is, when we enact an identity or an activity, we do not use language alone. Gee (2011) says that our language is accompanied by ways of "acting, interacting with others, believing, valuing, dressing, and using various sorts of objects and tools in various sorts of distinctive environments." (p. 177) Thus, if I want to identify myself as a policeman, it is not enough to use language that expresses that I am a policeman. My language has to be accompanied by other "stuff" such as wearing a uniform, carrying club or gun, among other things.

To analyse "Discourse" in discourse analysis, the analyst needs to ask how the person uses language as well as how he/she acts, interacts, believes, values, dresses, and uses other objects in addition to language to "enact a specific socially recognizable identity and engage in one or more socially recognizable activities." (Gee, 2011:181) In other words, the analyst has to ask how language is used to express who is doing what in a particular social context.

C. Discourse models

Discourse models are what scholars like Quinn and Holland (1987) call "cultural models" and are, largely, unconscious theories that we hold that help us understand texts and the world we live in. These theories are well established in the practices of social or cultural groups of people. In D'Andrade's (1987) words, Discourse/Cultural models shape the way we understand the workings of the world around us and our decisions concerning future actions and events. Most of our goals and plans are subsumed under cultural understandings and learned as part of this heritage.

Discourse models are like mental simulations that preserve main episodes that help us to act spontaneously or (Gee, 2005). These simulations are based on our experiences, which are raw materials our mind works on. Cultural/Discourse models, according to Quinn and Holland (1987), can serve for setting goals for action, planning the attainment of goals, guiding the accomplishment of the goals, understanding the actions and the goals of others, and enabling us to verbally express about these activities and give our own meanings to what has happened. Since our

experiences are shared with other social and cultural group members to which we belong, our simulations overlap with that of other members of our group. This results in our sharing ways of looking at things with other members of our social and cultural groups.

These Discourse models are not entities that reside in people's mind. They are gained from books and the media, from what other people say, and inferred from social practices. What a social or cultural group member can know is only parts of Discourse model from what is available in his/her group (Quinn and Holland, 1987). According to Gee (2005), Discourse models may be related to "appropriate" attitudes, view points, beliefs and values. They can also be acceptable ways of acting and interacting, participating and participant structures; "appropriate ways of talking, listening, writing, reading, and communicating or acceptable ways of feeling and displaying emotions. What a group considers to be "acceptable", "appropriate", "correct" or "normal" is part of the group's Discourse model.

Discourse models are important tools in discourse analysis because they play an intermediary role between what people do when communicating using the seven building tasks discussed above and Discourses as they function "to create the complex patterns of institutions and cultures across societies and history" (Gee, 2005: 71). By implication, whatever people speak or write, spoken or written texts, are based on people's Discourse models and when we analyze discourse, we are analyzing a product of these Discourse models.

In this research, Gee's (2005) model has been used for the purpose of categorising and analysing the data. This is because the functions language is used to build in this model- significance, activities, identities, relationships, politics, connections and sign systems and knowledge- are appropriate to study behaviour and gender relations. This is because behaviour is exhibited and can be studied through people's activities, expressions of their activities, the type of connections and relations they have, and the perspective from which they understand and explain these social practices.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter provides information about the overall design of the study, research population and sample selection, instruments used for collecting data, and the methods used to analyze the data.

3.1 Research Design

The research paradigm which influenced the researcher's view about the world in this study was constructivism. This is because this paradigm, ontologically posits that reality can be understood as a mental construction, is based on social and experiential factors and highly influenced by individuals or groups of people holding the constructions. The construction people hold also change along the changes in corresponding 'realities' (Guba & Lincoln, 1994). It accepts that the researcher and the researched are linked through their interactions as a result of which meanings are created in the research process. This means that meanings are either individually or socially constructed and it is the meaning the researched give to their experiences and interactions that is the basis of the findings. As this research is concerned with studying the ways in which behaviour change communication affected informants' representations of themselves, their activities, actions, etc., reliable source of information for the study is the informants themselves. Therefore, the researcher used constructive paradigm as a view from which reality is understood.

Methodologically, this research employed qualitative methodology. This is because, in the first place, answers to the research questions were based on "subjective opinions, experiences and feelings of individuals" Dornyei (2007:38). Dawson (2002) also agrees with Dornyei and says that qualitative research is suitable for exploring attitudes, behaviour and experiences through interviews or focus groups and getting in-depth opinion from the respondents.

This study attempted to study behaviour change communication messages and how these messages affected respondents' representation of identity, activity, relations, etc. To answer questions to each of these constructs, the researcher had to focus on what the respondents themselves say about the issues. In short, the data were based on what respondents said about their own behaviours, actions and interactions in their environment. Thus, the meaning the respondents give to their own and others' behaviours, actions and interactions were the basis of the interpretations and the findings. The goal of research, from qualitative methodology point of view, is to learn about the respondents' perception of the situation under

study. Dornyei (2007), citing Punch (2005), also says that from qualitative researchers' stand point, human behaviour is based on meanings people assign to and bring to situations and through understanding how participants construe their experiences and actions.

Barron (2006) and Vanderstoep and Johnston (2009) also say that qualitative methodology is suited to researches that aim to describe life experiences of respondents from the respondents' own perspective and to comprehend the interpretations they give to their experiences. Sarantakos (1998:125) citing Flick and colleagues (1991) agrees to what scholars have said above and suggests that researchers resort to using qualitative methodology under the following situations, among others.

- When there is a need to study reality from the inside rather than from the outside, that is, to understand it from the point of view of the subject.
- When the researcher intends to present the information gathered not in number or formulae but, rather, verbally in a detailed and complete form.

Hence, in the current study, the findings have been based on data gathered from respondents. Besides, the data gathered were also analysed using discourse analysis, which is entirely based on the use of words, which indicates that the methodology used was a qualitative one.

Under the umbrella of qualitative methodology, Ethnographic-based discourse analysis has been used for gathering and analyzing data. This is because, in the first place, ethnographic method is suited to address issues of perspective or how people make sense of the world in which they live, their relationships, their social actions and identities (Marvasti, 2004; Smart, 2008). One of the features of ethnography as remarked by Dornyei is its focusing on how participants construe their own behaviours and customs. This helps the researcher to look at events the way insiders do (Dornyei, 2007). The fact that fieldwork, interviews and document review have been used as instruments of data collection also makes this research ethnographic as stated by Berg (2001). Hence, ethnographic approach has been used for gathering research data.

Discourse analytic approach has been used for analyzing data gathered through ethnographic approach. This was done with the assumption that analyzing discourse of the data gathered would enable the researcher to look into the

behavioural changes brought about by the behaviour change communication messages and unmask the reality about the behaviour change or the interventions made.

Sapsford (2006: 262) says that discourses “create elements or objects which are to be described and set acceptable or unacceptable rules that govern the elements or objects. Thus, discourses create, for example, gender and also set rules as to which way of talking about gender is appropriate and which is not. Since the study attempts to investigate BCC messages in relation to their impact on gendered vulnerability, and this impact is influenced by people’s views and attitudes towards gender itself, discourse analysis is an important tool to find out the outcome of these messages. Potter and Edwards (2001) cited in Hibberd (2005) also defined discourse as spoken and written texts, studied as social practices. Since how people express their gender relations and HIV/AIDS are expressions of social practice, they are worth analysis as part of discourse.

DuBois (1997) also says that discourse analysis is a way of understanding daily processes of expressive behaviour and interaction. Since the study attempts to find out whether there is a behaviour change, and behaviour is studied in relation to social actions and interactions (Griffiths and Elwyn, 2004), and these actions and interactions can be understood through studying discourse, analyzing the discourse has been found an effective way of attaining this objective. Besides, according to Widdowson (2004), it is through discourse analysis that one can understand how members of a given social group use language to represent the world around them or their lived experiences. This means that people encode their experiences in talk and texts as social actions and analyzing these talk and texts, analyzing the discourse, is an effective means of getting at how people understand and express the world in which they live.

Hence, using discourse analytic approach makes it possible to relate spoken and written data to the social actions that the texts reflect. Thus, the approach used for data gathering was ethnography, whereas the analysis was conducted using discourse analysis concerning interviews and focus group discussion and hence, the research approach is ethnographic-based discourse analysis.

3.2 Sampling Techniques

Different techniques have been used to sample study area and respondents. This part of the paper presents the techniques used for sampling. It includes the sampling technique used to select the research site and the respondents.

3.2.1 Sampling of Research Site

The study was conducted in East Wollega zone. This was because, the researcher, as he was born and brought up in rural area, often visited his relatives who are still living there. During his visit, he observed that rural people still engaged in risky sexual relations irrespective of rumours about HIV/AIDS. Hence, the researcher was interested to find out whether there were interventions to help rural people change their behaviour and whether the interventions have brought any change concerning their sexual practices. Out of the zone, one target district was selected using criterion based or purposive sampling technique as proposed by Ritchie Lewis and Elam (2003). The selection of the district, in the first place, was based on the relatively short distance of the district from Nekemte town. It was also influenced by the presence of strong association of persons living with HIV/AIDS (PLWHA). This selection was made with the assumption that the presence of the association would shed light on the effect of behaviour change interventions conducted in the district and the extent of behaviour change they brought so far. Out of this district, one rural kebele that is within a walking distance from the district town was selected for the research again in consultation with the district authorities.

3.2.2 Sampling of Study Population

The source population of the study was spouses in the age group of 15-49 years, kebele health extension workers, heads of district health office and HIV/AIDS Prevention and Control Office, OSSA (organisation for social support of AIDS) and PLWHA (persons living with HIV/AIDS). HIV/AIDS-related BCC documents available in district health and HIV/AIDS Prevention and Control Offices were also used as sources of data.

Selection of wives in the target kebele was conducted using proportionate stratified sampling. First, spouses in the total age group, 15-49 years, were divided into three sub-groups, 15-24, 25-35, and 36-49, using the kebele's electoral registration book and in consultation with kebele officials. This division was made with the assumption that members of each age group differed in their sexual behaviour and the information they provide also differed likewise. Thus, those in the age group 15-24 years are sexually more active than the remaining two groups and are more likely to be affected by the virus (FHAPCO, 2010; MOH, 2004; Panos Ethiopia, 2004;). People in the age group 25-35 years are more active than the ones in the 36-49 age group and also suffer more from the epidemic. The third group, 36-49 years, is

sexually less active than the other two groups and suffers less from the epidemic (Ethiopian Public Health Professionals Association, 2004). The selection of documents was based, in the first place, on their availability in the district and, in the second place, on their functioning as sources of BCC messages for teaching.

Thus, the number of women in the kebele, according to documents available in the kebele office, was 312. Of this, 138 women belonged to the age group 26-35, 123 belonged to the age group 15-24 and 51 belonged to the age group 36-49. Taking this proportion into consideration, 5 women from the 26-35 age group, 4 from the 14-25 age group, and 2 from the 36-49 age group, totally 11 women, were selected as respondents for the study. The sampling technique used to select wives was proportionate stratified sampling.

There was a mismatch between what the age of respondents indicated in the kebele documents and what the respondents reported their age was, just like that of the preliminary study. Out of the 11 female respondents, four reported younger age than the documents indicated while one respondent reported older age than what was indicated in the documents. Irrespective of the mismatch, it was found that sticking to what the documents indicate was obligatory. This was because, although it was not exactly what was found in the documents, it was still in the same age range as divided by the researcher.

Husbands were also selected through the same selection technique that was used for selecting wives- proportionate stratified sampling. The documents indicated that there were 389 male members in the farmers association. Of this, 79 belonged to the age group 15-25, 180 belonged to the age group 26-35 and 130 belonged to the age group 36-49. Hence, two respondents from the 15-25 age group, five informants from the 26-35 age group and four respondents from the 36-49 age group, totally 11 respondents were selected by considering their proportion in the total population. This way, 11 husbands and 11 wives were selected as respondents for the study, sized according to the known proportion of each age-group in the whole population, using purposive stratified sampling proposed by Walliman (2006).

Selection of heads of offices and health extension workers was made based on their knowledge and experience in the field and their expert contribution to the data. Thus, the sampling technique used for selecting health workers, both at district and kebele levels, was critical case sampling.

Association of PLWHA (Persons Living with HIV/AIDS) was also selected through critical case sampling. This was because this association was included in the study assuming that the information gained from members or leaders of the association would enrich the data because of their experience working with those people living with the virus.

Documents have been sampled through availability sampling. The reason for including documents in the data was that they are the basis for what the health workers teach about HIV/AIDS and other health-related issues. The other reason was their non-reactivity, that is, they are not prone to distortion as a result of interaction between the researcher and the respondents (Corbetta, 2003).

Health extension worker working in the target kebele was selected using critical case sampling. This respondent was selected for her experience working on health issues including HIV/AIDS and her expert knowledge.

Again, the researcher used critical case sampling for selecting respondents from the district HAPCO. This is assuming that, data from head of the office, just like those from the head of health office, would have great contribution owing to the knowledge and experiences of the people.

OSSA representative was selected through opportunistic sampling. Opportunistic sampling, says Dornyei (2007), is an unplanned technique which researchers are forced to use when they come across respondents they should not miss. That was what happened in selecting OSSA representative. The representative was giving training to people living with the virus in the district one day when the researcher was gathering data. Informed by the district health office that there was such training, the researcher approached and asked the representative if he would volunteer for an interview to which the latter responded positively. The interview was conducted on the same day.

3.3 Background Information of the Study Area and the Respondents

This section focuses on providing information on the study area and respondents used in the study. Information on the study area presents issues related to the population, climatic condition, economic activities and development endeavours of the zone and the district where the study was conducted. This information is based on data obtained from East Wollega Zone and WayuTuqa District offices. Information concerning the respondents focuses on age, educational and occupational backgrounds of the respondents.

3.3.1 Background of the Study Area

East Wollega Zone is one of the zones found in Oromia Regional State and is located in eastern part of the region. It has an area of 14,252 square kilometres. The zone has an elevation of 750-3000 metres above sea level. It is estimated that of the total area of the zone, 63.35 percent of land has been used for agriculture, 11.5 percent for grazing, 4.02 percent for different public services, 10.9 covered by forest, and the rest, 10.49 percent not utilised. The zone is divided into three climatic zones with temperate zone covering 53.17 percent, hot climatic zone 41.92 percent and cold climatic zone 4.91 percent. East Wollega zone, according to the 2007 Statistical Agency data, has a population of 1,348,875 people out of which 661,215 are males and 687,660 females. Of this number, 96,599 are dwellers of Nekemte town, which is the administrative centre of the zone. Accordingly, rural areas account for 85.33 percent while urban areas account for 14.67 percent of the total population. The document also shows that 49 percent of the population are males and 51 percent are females. The zone has 17 districts, 24 towns excluding Nekemte, 287 rural kebeles and urban kebeles, totally 315 rural and urban kebeles. Nekemte has six sub-administrations and is a level 2A town.

Wayu Tuqa District, one of the 17 districts under the zone, is the target district of the current study. Wayu Tuqa District is located in East Wollega Zone. Its administrative centre, Gute, is located 318 kilometres away from Addis on the way to Nekemte. The district has a general population of 74,020 people of which 36,270 are males and 37,750 are females. The district is sub divided into 10 rural and two urban kebeles. The district is situated along the highway from Addis to Nekemte, and the Addis-Nekemte main road passes through its administrative centre, Gute. Owing to this, almost 80 percent of the kebeles have been interconnected with roads that can serve throughout the year. The two urban kebeles and one rural kebele have got electric services while pole extension has already been completed to extend the service to two additional rural kebeles. All rural kebeles of the district have telephone services and clean water service coverage has reached 59.34 percent. District educational coverage has reached 81.85 percent.

Concerning health services, all kebeles have their own health posts and there are three health centres located at different distance in the district. The health coverage of the district has now reached 85 percent.

Wayu Tuqa district has different big rivers, falls and mountains that can serve as a source of tourist attraction. A historical place called 'Dirree Injifannoo Banayyaa', a battle field where patriots fought the Italian fascist invading force, is also located in this district and is one of the potential tourist attractions.

Gute Badiya rural kebele, which is the target kebele for the current study, is one of the ten rural kebeles found in the district. This kebele is located six kilometres away from the district administration.

3.3.2 Background Information of the Respondents

The total number of respondents was 27 people, 11 males (husbands), 11 females (wives), 3 health workers, 1 NGO (non-governmental organization) representative and a chairperson of the District PLWHA. Data were gathered from these respondents through in-depth interviews, key informant interviews and focus group discussions. In-depth interviews and focus group discussions were used to gather data from husbands and wives. Key informant interview was used to gather data from kebele health extension workers, district health office, district HAPCO, OSSA and association for PLWHA.

Concerning background information of respondents who were included in key informant interview, they ranged from 22 to 60 years concerning their age, and from 10+1 to BA/BSc educationally. The individual in-depth interview included five husbands and five wives, totally 10 people. Sexwise, the age of respondents included in interview ranged from 25 to 40 years for wives and 26 to 40 years for husbands. Educationally, wives ranged from unable to read and write to grade nine and husbands from unable to read and write to grade eight.

Twelve respondents took part in two focus group discussion sessions. Though the ideal number proposed by scholars for participants in focus group discussion is between 6 and 11 (Dornyei, 2007; Dowsan, 2002), the researcher decided to have six people in each session due to manageability of size. The two focus group discussions were held for husbands and wives separately. Six wives between the ages of 24 and 40, and six husbands between the ages of 26 and 42 took part in the discussions. As far as the education level of respondents to focus group discussion is concerned, wives ranged from unable to read and write to grade four and husbands ranged from unable to read and write to grade 11. Totally 27 people, 15 men and 12 women were used as respondents in the study. Background information of respondents in the study has been presented in Table 2 below.

Table 2: Background information of the respondents

Instrument	Respondent category	Sex		Level of Education				Age Group				Total	
		M	F	Cannot read & write	1-4	5-8	9-10	Over 10	14-25	26-35	36-49		Over 49
Interview	Husbands	5	-	2	-	3	-	-	-	2	3	-	5
	Wives	-	5	1	1	2	1	-	2	2	1	-	5
	Kebele health extension	-	1	-	-	-	-	1	1	-	-	-	1
	District office	1	-	-	-	-	-	1	-	1	-	-	1
	District HAPCO	1	-	-	-	-	-	1	-	-	1	-	1
	OSSA	1	-	-	-	-	-	1	-	-	-	1	1
	Hawi chairperson	1	-	-	-	-	-	1	-	-	1	-	1
	FG D	Husbands	6	-	2	-	2	1	1	1	3	2	-
Wives	-	6	3	3	-	-	-	-	4	2	-	6	
Total		15	12	8	4	7	2	6	4	12	10	1	27

3.4 Instruments of Data Collection

Data were collected from these sources through focus group discussions, individual in-depth interviews and key informant interview.

The data gathering techniques used in this study rely on self-report data and the researcher was aware of the impact of such techniques on the reliability of the research. Nevertheless, the researcher tried to minimize this impact by using different data gathering techniques: interview, focus group discussion and document review and supporting the data gathered through these techniques by the researcher's field notes. Triangulation of this sort, says Berg (2001), increases validity in qualitative research.

There is also likelihood that the nature of the questions in the interviews and focus group discussions put respondents under psychological pressure, especially since some of the questions in this study are concerned with personal information such as one's sexual relations. The researcher had observed from the preliminary study conducted that respondents find themselves in a difficult situation to answer

questions honestly due to various reasons. One of the reasons is fear of being socially rejected if they admitted doing something that is culturally proscribed. In agreement to this, Zulu and Chepngeno (2003), for example, found out that both husbands and wives are not willing to admit the promiscuity of a partner and expose sexual secret to an interviewer. For this reason, the researcher tried to minimize questioning respondents directly about their personal experiences and rather asked them about the behaviours of other people they knew. In agreement with Foddy's suggestion (1993), the researcher also made the responses focus on past rather than current behaviour so as to lessen the psychological immediacy of the question and reduce the degree of threat.

Respondents may prefer to speak what seems socially and politically acceptable than what is actually practiced, due to fear (Foddy, 1993). The researcher also found out through the preliminary study that respondents associated him with the gatekeepers such as the district or kebele authorities and tried to answer in a way that pleased these gate keepers rather than what is their lived experience. To lessen the psychological immediacy and maximize trust on the part of the respondents, the researcher, in agreement with Bradburn, Sudman, Blair and Stocking (1978), guaranteed anonymity and confidentiality and assured the respondents that their answers would not lead to any political or economic measures. To abide by the agreement, the researcher, immediately after transcribing and translating the data, removed from the research records respondents' names and any other elements that might indicate identities of the subjects.

The researcher realized from the preliminary study that gathering data through data collectors has negative impact on reliability of the data and also affects the schedule from financial and time perspective. This is because, during the preliminary study, kebele authorities not only proposed health extension workers for data collection but also tried to impose this upon the researcher. Since rejecting this proposal altogether may have a negative impact on subsequent relations, the researcher decided to accept partially the kebele leaders' proposal. So, health workers were let to gather data from three wives and two husbands through interview. But interview with other three wives and two husbands and focus group discussion was conducted by the researcher himself. The researcher kept separate the data gathered by health extension workers and by himself and compared the two at the end. It was later discovered through listening to the audio tape that responses to the questions

were corrected before they were submitted to the researcher. The health extension workers corrected the respondents when they gave responses that did not match what the health workers taught. Hence, the researcher was forced to discard the responses of the six respondents because they were all reframed by health extension workers and interviewed additional two husbands and two wives to fill the gap. The researcher also realised that the respondents were genuine in their responses to the researcher once they were promised anonymity and confidentiality.

An effective way of doing away with this problem was to hire data collectors from other areas outside the kebele, which had its own problems. One of the problems to this solution was financial problem. The data gathering process, as the study was a qualitative one and as observed from the preliminary and the main study, could not be scheduled for a month or two. It had to follow the respondents' schedule and might be extended, and hence, keeping the data gatherers for such long time could have financial problems. The other problem was data gatherers being strangers to the respondents and this affecting the type of data the respondents could provide to the collectors. If the data collectors were strangers to the area, there would be no point in hiring data collectors for the study.

Based on this experience, all the interviews and focus group discussions for the main study were conducted by the researcher himself. The experience indicated that all respondents spoke freely and shared their views on the questions without reservation. This may be due to the researcher's explanation that the research finding would contribute to curbing HIV/AIDS and gender-related problems and his solemn promise that identity of the respondents would be kept secret.

Afan Oromo was used as a medium of communication for all the discussions and all the discussions were audio taped. After the discussion, the data were carefully transcribed and translated into English.

3.4.1 Focus Group Discussion (FGD)

Focus groups are important tools for gathering data concerning social norms and opinions or views of the informants. They create the opportunity for informants to influence one another through their presence and reaction and contribute to the discussion. Especially in situations where informants differ in their age, education and access to information and other factors, focus groups express various viewpoints and enrich the data to be collected (Mack et al., 2005). Berg (2001) agrees with the above idea and writes in support of using FGDs especially for women respondents.

Berg says that FGDs enable women to listen to each other's experience and to interact with each other which in turn enhance their participation and the flow of ideas. FGDs, Berg says, would create conducive environment where women would be able to build on each other's ideas and helps the researcher to identify social patterns through the women's shared experience.

Wooffitt and Widdicombe (2006) say that FGD is an efficient method of data collection because it enables the researcher to record reports of opinions and experiences of as many as ten or more people in a session. Bloor et al. (2001) also say that focus group discussions are means of getting access to in-group conversations that contain indigenous terms and categories in the situations of their use. Neuman (2007) also mentions advantages of FGD among which one is the natural setting in which the discussion takes place allowing people to express their ideas freely.

Getnet (2009) says that FGDs are better suited to capture sensitive information such as respondents' sexual experience. He says that respondents do not expose their personal information in FGDs but still speak about group norms and behaviours of other people they know. The questioning strategy to be followed by the researcher of this study includes asking informants to speak on behaviours of others and, hence, focus groups are suited as a data collection technique for the study.

FGDs were used to supplement data gathered through interviews. The researcher decided to use FGDs in order to compare the data gathered through interviews. Through FGDs, the researcher was able to get insight about the group norms and what conflicting views are there concerning stigma, rape, condoms, FGM. This was because, when the informants were discussing issues raised by the researcher, they bring different issues out either by supplementing or objecting to ideas raised by other members.

There were two separate focus group sessions in the kebele for couples (one for husbands and one for wives). The reason for having discussion for husbands and wives separately was mainly to get rid of the consequences of power differentials between the two groups of respondents that may cause some views to be silenced (Bloor et al., 2001; Momsen, 2006). Both focus group discussion sessions lasted from 1 hour to one and half hours. The groups comprised six members each as recommended by Walliman (2006) and Morgan (2006). Selection of respondents for focus group discussion, concerning couples, was made taking into consideration the proportion of the three age groups as discussed above. In addition to consideration of

the informants' age, the researcher, assisted by the key informant, selected informants who could contribute well to the data. That is, to make the discussion lively and interactive, informants who could share their views clearly were selected based on their skills and ability to express themselves. Thus, maximum variation sampling technique has been used to select respondents for focus group discussion (Patton, 1990)

Open-ended guide questions focusing on informants' access to BCC gender vulnerability information, understanding of the messages and changes observed on spousal behaviour concerning HIV prevention and gender vulnerability were prepared for focus group discussion.

Prior to contacting these respondents, the researcher first met with a key informant from the kebele leadership as suggested by Mack et al. (2005). This was because, it was difficult to contact these respondents, especially women, myself and make necessary arrangements concerning the time and venue of discussion. Among the qualities this informant has to have, as suggested by Davies (1999), were knowledge in cultural practices and ability to relate these, and willingness to spend time with the researcher. Before contacting this informant, who was a woman, the researcher has to discuss in detail with the kebele manager and chairperson the type of support needed from the kebele leadership, the nature of the research and the type of questions to be asked. Upon this discussion, the kebele leadership assigned a woman who was a member of the kebele cabinet, and who was better off educationally than the other cabinet members to be the researcher's informant. Thus, the sampling technique used to select the key informant was criterion sampling (Patton, 1990).

The first thing the researcher did after this assignment was to create acquaintance with the woman's husband and other family members. This informant, though was willing to spend her time helping the researcher to contact the respondents and giving invaluable information on respondent background, was trying to be present on all interviews and group discussion sessions. Therefore, it was mandatory to convince her that the research did not have any political motive and was purely academic. The researcher had to tell her that the questions were sensitive and her presence during the interview would make the respondents respond in a way that they would not if they were alone, and that this would have a drastic effect on the findings of the study. The researcher also told her that she would be providing him with genuine data in addition to what was to be gathered from other respondents based on

her experience in the kebele. Thereafter, though she stopped imposing her presence on every interview or discussion, was checking on what was raised on the interviews or discussions after every session by asking the respondents as to what the questions focused on. This lady played an important role in assisting the researcher to recruit spouses for the research and facilitating conditions on especially how female respondents could be contacted.

There was also a difficulty to convince some respondents to be tape-recorded. They said that they had never been tape-recorded before and did not want to be recorded either. It was after promising them that the tapes would be destroyed immediately following transcription and no one else would have access to them except the researcher that they showed agreement. It was also obligatory to convince them that the reason behind tape-recording the interview or the discussion was that it was impossible to write down everything spoken during the discussion and that it was necessary to listen to the tape and transcribe the text later.

3.4.2 Interview

Kinsey, Pomeroy, and Martin (1948) and Aronson, Fried and Stone (1991) have found out through their research that interviews are appropriate for studies focusing on behaviour that is of highly personal, secretive or illegal nature. Though people with such behaviour are not willing to be observed, they are willing to discuss their experiences on conditions that they are assured of anonymity and confidentiality. This makes interview appropriate for this study as it is concerned with sexual experience, which is people's personal affair.

Interviewing was the primary data collection technique for this study for three different reasons mentioned by Scott (1997). First, interviewing allows the researcher to access information about past events. The interviewer can elicit information from respondents by asking them about past events or experiences. Thus, it is an effective means of bridging time barrier. Interviewing also creates a possibility for the researcher to know about situations at which he cannot be present. The researcher can observe only one thing at a time but cannot be present at all places and see everything for himself. He can, however, obtain information through interviewing from different individuals and can know about different places and activities. Thirdly, interviewing gives access to the researcher to situations where he is not permitted to be present. For example, the researcher cannot have access to observing people's

sexual behaviours. But through interview he can get information from the couples on issues of sexual relations.

3.4.2.1 In-depth Interview (IDI)

In this research, in-depth one-to-one interviews were used to solicit individual experiences, opinions and feelings and also address sensitive topics which informants might be reluctant to discuss in group. Especially, since the interview and discussion guides focus on personal issues such as sexual practices and sexual partners of the respondents or of other people they know, guarantying privacy is of great importance.

The use of in-depth interviews makes it possible for the researcher to understand the experiences of the respondents and the meaning they attach to their experiences. The assumption behind this is that the meaning people attach to their experience has an impact on how they execute the experiences and searching the informant's deeper self produces more authentic data. Moreover, by letting respondents express their responses without restriction, in-depth interviewing has the potential to reveal multiple, and sometimes conflicting, attitudes about a given topic (Marvasti, 2004; Seidman, 2006).

In these interviews 12 respondents, six husbands and six wives, took part from the kebele. Respondents to in-depth interview were selected sequentially using purposive sampling. This was because the interview continued only until saturation was attained. So the researcher, as he was selecting respondents sequentially, was making sure that the respondents were within the age range selected for the study, 15-49 years. The researcher was also checking whether the respondents were proportionately represented in the interview according to their number of each age group in the total population. Thus, data were repeated after the fifth respondent and the researcher decided to stop gathering data after the sixth person.

The process of gathering data took over four months. This was because the data gathering was iterative by its nature. That is, the data were gathered, checked for clarity, respondents were recontacted and ambiguities were removed, and this took long time to accomplish. The data gathering approach used was also sequential (Kothari, 2004). The data gathered were coded and categorized before proceeding to the next respondent so as to make sure whether saturation was attained or to stop data gathering after new categories emerge no more.

Besides, there was difficulty to contact and arrange time with the respondents. One of the reasons for this was women being busy around the home and having little time for the interview. The other reason was the fact that the researcher had to contact these respondents only through his key informant. The researcher had to make arrangements not only with the respondents to conduct the interviews but also with the key informant as she is also a housewife and had her own problems to attend to. The process was more complicated in that it was mandatory to recontact some of the respondents due to errors or inaccuracies committed during the first contact. In some cases, the tapes were inaudible due to noise and need recording again. In some other cases, the answers needed more probing, which was known only after recording and during transcription. To do all these it was necessary to get the consent of the key informant and then that of the interviewee.

These interviews lasted from 25 to 55 minutes. Afan Oromo was medium of communication for the interviews. Like the focus group discussions, interviews were tape-recorded. In-depth interview guide questions also focused on informants' access to BCC gender vulnerability information, understanding of the messages and changes observed on spousal behaviour concerning HIV prevention and gendered vulnerability.

3.4.2.2 Key Informant Interview

Key informant interviews (KIIs) are a means of gathering data from people who have the knowledge of the issues and situations in which the researcher is interested (Sarantakos, 1998). Kalof, Dan and Dietz (2008) recommend researchers' using leaders as key informants for gathering data because these informants provide invaluable information. Corbetta (2003) also says that key informants can be used as sources of data even under circumstances where they are not part of the phenomenon under investigation.

Through these interviews, the researcher attempted to gain a picture of how BCC messages were delivered to the area under study and the results they yielded. Key informants for this study, therefore, were selected based on their experience and special professional knowledge. Thus, of the two health extension workers serving in the target kebele, one was selected for the interview through criterion sampling. Her selection was influenced by the fact that she was serving as a leader and that she is more experienced.

Data were also gathered from heads of district health office and HIV/AIDS prevention and control office (HAPCO). The researcher used criterion sampling to select these heads of offices (Patton, 1990). The reason for their selection was the researcher's assumption that they would provide wide range of information concerning the study.

OSSA representative was included because he was a member of an NGO working with those people living with the virus and this would give him an opportunity to learn a lot about the virus and the patients. When he was contacted for the interview, he was giving training to people living with the virus in the district and was selected through opportunistic sampling (Dornyei, 2007). Association for PLWHA was represented by the chairperson, who was selected through criterion sampling (Patton, 1990). Generally, data were gathered from five people through key informant interview.

Questions for these interviews focused on sources of the messages, who the target audiences of the messages were, efforts made to make the messages match audience background and behaviour changes observed following the interventions. These interviews lasted from 40 minutes to one and half hours.

3.4.3 Document Review

The researcher decided to include documents as source of data because, as suggested by Hammersley and Atkinson (2007), they provide important additional data that may support or challenge information received from respondents. The documents the researcher was interested in were those that were being used as a source of information for HIV/AIDS gender vulnerability messages. Hence, there was one document that was used for teaching the public and for reporting HIV/AIDS-related activities in the district. This document is 'Social Mobilization for Prevention and Control of HIV/AIDS: Community Conversation Training Manual' (HAPCO/MOH, 2007b). Since this material was the only one used for both teaching from and reporting HIV/AIDS-related activity, the same was selected for analysis through availability sampling.

Before the main study, the instruments, especially interview and focus group discussions, were tested following the same methods mentioned above and on similar population as the one in the main study. This preliminary study was intended to help to check, as stated in Colton and Covert (2007), the time it would take to complete the instrument, the influence of environmental conditions, and any problems respondents

might have with clarity of words, phrases or concepts in the instruments and make corrections for the main study.

3.5 Preliminary Study

Out of the instruments discussed above, interview and focus group discussion were tested on audience that was similar in characteristics to the one in the main study. The selected research site for the preliminary study was Nejo District of West Wollega Zone. Out of the 49 kebeles found in the district, Eba Waqayo Farmers Association was selected as a target for the study.

The preliminary study was intended to find out whether the questions could be used to elicit the expected information and what difficulties might be faced during the main study and make the necessary amendments on the questions and preparation for the problems. Specifically the preliminary study was intended to accomplish the following tasks as stated in Berg (2001).

First, they were intended to check whether the researcher had included all questions to answer the research questions. They were also prepared to find out whether the questions could elicit anticipated responses. Thirdly, they were intended to check whether the language used in the instruments was meaningful to the respondents. The fourth reason behind administering the pretest was to find out whether the questions were free from problems of double meaning or multiple issues embedded in a single question. Finally, it was intended to help the researcher to know if interview or FGD guide could motivate respondents to participate in the study.

Thus, it has been possible through the preliminary study to:

- a) change the wordings in two questions which were misunderstood by the respondents and, hence, produced unexpected responses;
- b) reconstruct three questions that were double barreled and confused the respondents;
- c) make preparations for the main study as to how to approach the gate-keepers and the respondents;
- d) plan in advance the time it would take to gather data;
- e) compare the findings of the preliminary study with that of the main study and increase reliability where the two produced the same result.

CHAPTER FOUR: ANALYSIS AND INTERPRETATION OF DATA

The major focus of this chapter is to present the analysis and interpretation of data gathered through interview and focus group discussion and document review. In both types of data, the analysis and interpretation are supported by excerpts taken out of the data. In case readers are interested to read the entire data, these have been presented in the appendices section.

4.1 Analysis of Data Gathered through Interview and Focus Group Discussion

The data gathered through focus group discussion and in-depth interviews were first screened immediately following the gathering process as suggested by Ulin, Robinson and Tolley (2005) so as to be able to re-contact study informants in cases of omissions, errors and inaccuracies. It was found out during the screening that the audio data needed recontacting the respondents because in some two cases the sound was inaudible due to recording errors and external noise. In two other cases, the data contained ambiguous responses that could be made clear through probing. This screening was done for all the data immediately following the data gathering process. Screening was also done after the second interviewee to check whether there were new data emerging. This was done to check whether saturation was attained.

After screening the audio data, the data that which were recorded on tape in Afan Oromo were translated into English and transcribed at the same time taking care that the translated version means the same as the original one. During the translation, names respondents were changed into fictitious names to keep the promise they were given that respondents would be anonymous.

In transcribing the data, the researcher used clean-read or closed transcript (Jenks, 2011), by at the same time keeping the flavour of the speech and taking maximum care that any important details were not changed. The researcher's preference to use clean-read transcript was that the focus of the study was to analyse the meanings the respondents give to their own lives and experiences but not the turn takings or other issues related to voice quality, etc.

The translated version was then edited against the original data in order to get rid of any ambiguities committed during the translation and transcription and then recorded onto computer. Following this, the data were first coded according to the themes they developed and categorized using the seven building tasks of language proposed by Gee (2005) as major categories. These tasks were significance, activity, identity, connection, relations, politics and sign systems and knowledge.

Categorizing the data gathered through FGDs, interviews and the field notes under some themes was a complicated and time-consuming process. Some texts did not totally belong to any one of the seven categories while some belonged to more than two or three categories. As a solution to this, the researcher closely examined the texts to find out which task was more prominent in the data. Following this, the researcher proceeded to categorizing the data taking maximum care that the same snippet did not appear in two or more categories as it was the case during the preliminary study. At the end, it was found out that the whole data belonged to six categories or language tasks. These tasks were significance, activity, identity, connection, relations and politics. Thereafter, how the informants used language in building the six tasks was analyzed. In the analysis, focus was given to the whole text extracted as a snippet than to individual words, clauses or sentences. This was because, meaning is derived by considering the message of the whole text as words, clauses or sentences combine to make up this whole message. Words, clauses or sentences were analyzed as they function within the text relative to the context in which they are used. This analysis was supported by extracts taken out of the texts. In the analysis theoretical tools (Gee, 2011), which have contributed to the production of the responses, have been considered depending on their presence in the data analysed. Some of the responses, for example, were constructed through the use of intertextuality- by quoting directly or indirectly what others said. Others still are constructed using different discourses such as gender discourse or discourse of blame. After thus analyzing the discourse of the text, what the analyses indicate have been presented as a conclusion.

To check the validity and reliability of the data, the first step was to use instrument triangulation or different data gathering techniques: Interview, focus group discussion, document review and to support these with the researcher's field notes. The researcher also tried to check validity and reliability through respondent triangulation. Respondents in the study included local people (spouses), health extension worker working in the target kebele, district health officials, an expert from an NGO working on HIV/AIDS and a chairperson of association for persons living with HIV/AIDS.

The other measure taken to check the validity and reliability of the data was to peer-review the data with other researchers who were pursuing their PhD from the same university, Wollega University, as the researcher and discuss any problems that

would affect the validity and reliability of the data. This review included issues like accuracy of the translation, whether the transcribed data corresponded to the original one, development of themes and categories and clarity in the use of language.

Recontacting the informants and checking with them to avoid any errors that would affect the reliability of the data was another attempt made to check validity and reliability. Through this recontact, it was possible to correct vague ideas that would be interpreted incorrectly and affect the validity and reliability of the data.

In this chapter, analyses of the discourse of data gathered through the techniques of interview and focus group discussion have been presented. The data gathered were categorised and analysed against six of the seven building tasks of language forwarded by Gee (2005). The reason behind restricting the analysis to these six tasks was prevalence of the tasks in the data gathered. Gee's (2011) theoretical tools were also used to analyse the data categorised with the help of the building tasks of language. How the respondents represented each of the tasks has been discussed in turns supported by excerpts from the data.

4.1.1 Significance

The respondents have expressed significance of things, activities or events using language in both the interviews and focus group discussions. One of the things they give significance to is efforts in relation to the results they yielded. We can see from the following excerpt taken from Tura's interview text that attempts made to help persons living with HIV/AIDS overcome the existing fear and become members of PLWHA did not bear the desired fruit. When responding to the question that says "What type of language do people use to refer to those living with the virus?" Tura says,

They use such terms as 'disease of the time' 'disease of curse', and other derogatory terms I do not want to mention. They also discriminate them ... not all people living with the virus in both urban and rural areas are our members. Only those who are weak and need help joined us. Others, though they may be weak and need help, hide themselves for fear of discrimination by their neighbours or those who know them. We have been trying to help them to overcome the fear and become members. But we have not succeeded as expected because most of the people living with the virus in rural areas have not yet become members. (Interview, Hawi chair; Appendix E, p. 226)

As can be understood from this excerpt, attempts made by the association for PLWHA were not significant in making people enrol as members of the

association. To those who became members, getting help to sustain themselves was significant because they were weak and helpless. But others, though they were weak and helpless, did not join the association. To them, what is more significant than the material help they can get from the association is the psychological impact of the “*discrimination from their neighbours or those who know them*” and derogatory terms used by people to address the disease. Tura said that the association did its best to make those living with the virus overcome fear of the existing discrimination and become members. Nevertheless, they preferred hiding themselves to accepting the call for membership and acknowledging their serostatus just to avoid social discrimination. They found bearing the burden of discrimination much heavier than the weakness and helplessness they had to suffer as a result of the virus. This situation shows the severity of the discrimination people living with the virus in rural areas have to face. We can see here that those living with the virus give more significance to social pressure and discrimination than the advantage they may gain from the association and this attitude has undermined the association’s effort to attract more members from the rural areas. It also contributes to the spread of the virus since these people do not acknowledge that they have the virus and other people do not take the necessary measures to protect themselves from the virus.

In the extract discussed here, we see that Discourse, other ‘stuff’ in addition to language is at play. That is Discourse of division between the infected and uninfected (Lafort et al. 2010). We see that those who are not infected segregate and use derogatory terms against those who are infected and, in turn those infected give up the benefits they could get from the association fearing the segregation. This Discourse does not only force those who are living with the virus to give up the help but also forces them to hide their serostatus from the general public for fear of the segregation. What can be understood from this response is that those living with the virus are aware of the fact that the society has negative attitude towards them and they try to hide their serostatus even to denying themselves the possibility of getting support that could sustain their lives. The point to make here is that these people know that the society hates them and it is difficult to expect care and love from someone who knows that he/she is hated. That means there is already a discourse of fear and hatred between the patients and the people who suppose that they are free from the virus. And the very reason that they know they are hated may trigger those living with the virus to take revenge on the rest of the society, for example, by spreading the

disease. In general, it can be understood from this extract that there is discourse of alienation and segregation against those living with the virus which is expressed through people's use of language. As a result of this segregation, the patients are living in fear and hide their serostatus as much as possible. The fact that people do not call HIV/AIDS by its name and use other terms also shows the hatred they have against the epidemic and those who have it.

The respondents also express significance of what the people have been taught about being faithful to one's marriage partner. This is shown in the following extract.

Gudeta: What do people say when they speak about being faithful to ones' partner?

Kumeshi: They say nothing. They accept what is taught. But they may not be faithful to their partner as taught. This I have answered above. (Interview, Wives; Appendix A, p.185)

As can be understood from this extract, people accept what has been taught but may not be faithful as taught. There seems to be a paradox in Kumeshi's response here. People accept something means they welcome it and make it part of their actions. But here we see that accepting and rejecting take place at the same time. The secret to this paradox can be revealed if we look at the first sentence of the respondent. She begins by saying "They say nothing". In the next sentence she says, "They accept what is taught". The situated meaning of 'accept' in this extract is 'not to object verbally or not to oppose'. So when they are taught, they 'accept' what is taught without any sign of resistance. But when it comes to practicing it, they do what seems right to them, which may possibly be contrary to what has been taught. Therefore, what is taught in relation to marital faithfulness did not have significance in bringing the desired behavioural change in the audience in reforming their actions.

Yadeta also says that forming government structures at various levels did not show significance in bringing the desired behavioural change.

Gudeta: From what you know, how do you explain the spread of HIV/AIDS in rural areas currently?

Yadeta: ...The government has extended different structures down to teams that embrace not more than 20 or 30 households. There are also two health extension workers assigned to each rural kebele. The problem, however, is not with the existence or nonexistence of the structures but the functionality of the existing structures. The structures are already there but they could not do as expected

especially concerning HIV/AIDS. Training is given at different times and at different levels. But still there is a problem on implementation. We do not often see people changing their behaviour This may have different causes. One of the causes may be lack of incentives. Those working in the structures are not paid for what they do. This may weaken their initiation for work. Besides, they are working among people who know them and whom they know previously. They might have been engaged before in behaviours they are now teaching people to denounce. They may be practicing the behaviours even now. ...Therefore, the government should have a controlling mechanism as to what the reports say is really what is done. (Interview, OSSA; Appendix F, p. 231)

Yadeta makes it clear that there have been efforts on the part of the government to bring change in people's behaviour. Forming different structures, assigning health workers and giving training at different levels are part of the government's efforts. But these structures are simply there and are not functioning as expected. Although trainings are given on different issues, what is given on the training is not implemented. According to Yadeta, the reason for this failure lies in lack of incentives which undermines workers' initiation for work, people working among their acquaintances, workers being advantage oriented and absence of checking reports against what is actually done. One can conclude from these causes that there is a problem practicing what they preach on part of people working in different structures. Yadeta doubts that these people themselves are practicing what they were doing before but what they are teaching others to give up now. This shows that the behaviour change messages did not affect even the behaviours of those expected to be agents of change. If agents are not changed and practice what they denounce in words, it is unlikely that others implement what they hear from these agents. This is because their action speaks against their words. We can also see that these people working in different structures report what they have not actually accomplished and the higher governing body accepts these reports without verification as to whether what is reported is what is done. This means that the connection is mostly dominated by paper work. This in turn shows that those working at lower level are not being followed up and getting the necessary support for the effectiveness of their work. As a result of these factors, government efforts did not show significance in bringing the desired behaviour change. Yadeta's response here makes one doubt the existing reports concerning achievements on HIV/AIDS. He says that the government should have a controlling mechanism as to ensure that what is

reported matches what is done. This indicates that people working in these structures report what they are expected to do but not what they have done.

In this extract, Yadeta used intertextuality to express significance. He used political activity, dividing the people into manageable structures, as a means of enhancing the fight against HIV/AIDS. He also mentions the assignment of health workers as the government's attempt to intensify the fight against the virus. He also says that the result was ironic in that both the formation of the structures and assignment of the health extension workers fell short of attaining the desired goal. The blame for this failure, according to the extract, goes to the government. This is because, the structures were formed and workers were assigned but there was no proper follow up as to whether those working in the structures and health workers themselves were discharging their responsibility fully. The higher governing body even accepts HIV activity reports without any mechanism to check what was reported was really what was performed. Through the use of intertextuality, the respondent here was able to expose the mismatch between what was expected and what was actually attained.

The interview data also show that there is no significance for intervention messages to focus on husbands separately as can be understood from the following extract taken from interview conducted with Diriba.

Gudeta: Was the content of the intervention prepared for husbands and for wives separately?

Diriba: We have started to focus on women. But we have not prepared lessons separately for husbands. It was the practice that whenever we called meeting of any kind, it was only men who attended. So there is no need to teach husbands separately. (Interview, District HAPCO; Appendix I, p.248)

According to this extract, men used to attend meetings whether the meetings were meant for men or women. Previously, men used to attend all meetings but now there is no need to focus on them. By implication, women were not attending meetings and should get focus in the interventions now. What should have been taken into consideration, however, is whether the messages have focused on behaviours of men. Attending meetings does not directly benefit men since the messages do not concern them. By the same token, preparing intervention messages that focus only on women and ignoring men also may not result in success since the messages attempt to change only women leaving men out. It seems that this opinion is based on the

premise that women should be given attention since they have been ignored so far. But shutting men out from the information will at least retard the struggle to empower women and to help them fight against the spread of HIV/AIDS. Though HIV/AIDS is a gendered disease and can be prevented by minimizing gender inequality, making men too aware of their role in gender relations and the impact of gender in the spread of HIV and its effect on both men and women is an effective means of empowering women. If men are not aware of their role in spreading and combating HIV, they may not know their responsibility and may not be able to contribute to the ongoing struggle to stop the disease. The interventions made in the district so far, according to Diriba, therefore, did not find it significant to prepare messages focusing on men.

Hunduma also shares the same view concerning the involvement of men in health care activities. He says:

I think it is of no use if we teach men about prenatal care. It is not that important if we teach men about family planning. If we take the importance of toilet, it is more important to women and children because men spend most of their time away from home and do not care whether there are toilets at home or not. (Interview, District Health Office; Appendix G, p. 236)

Hunduma first tells us that it is not important to teach men about prenatal care and family planning. Looking at this statement, one may be tempted to think that reproduction is solely a responsibility of women, which it is not. It is true that issues of sexuality and reproduction so far have been dominated by men. To control and prevent HIV/AIDS, it is important to increase involvement and decision-making role of women especially in issues concerning sexuality. But ignoring the role of men may result in conflict between husbands and wives where coordinated effort could have borne more fruit. Hunduma also says that it is not important to teach to men about toilets. This response seems to have been based on the assumption that women look after the home while men engage in other activities including bread winning for the family. It even goes to the point of considering men as strangers to their own home. It says that men do not care whether there are toilets or not at home.

Even if one can say that prenatal care is more a concern of mothers, it would be unreasonable to leave men out of family planning. This is because decisions that concern family planning used to be men's responsibility where women had little involvement, a practice that was gendered and needs to be changed. The objective of behaviour change messages, however, is to bring attitudinal and behavioural change

in people about a given practice. So the best course of action to take is to teach men the importance of their involvement in prenatal care, family planning and issues related to the home and maximise their participation. Leaving them out of the interventions is widening the gap that is already there and keeping men in ignorance, a decision that benefits neither women nor men. Such decisions even contribute to perpetuating gender roles since they hold women accountable for issues related to the home as it used to be, by freeing men for other responsibilities. The intention of behaviour change interventions should not be to take revenge for social ills that were done in the past. Rather, it is to get rid of the social ills and make life better for the future.

We can see from Hunduma's response above that HIV interventions, particularly in the district studied were dominated by discourse of 'finger pointing' that dominates most interventions in Africa (Dion, 2011). He focused on magnifying the rift that existed between men and women and, instead of narrowing this rift, he preferred to widen it more by making prevention messages focus on women only and leaving men out of the game. Such discourse, says Dion, distracts attention from the bigger image, that is gender discourse, and only complicates the struggle against the virus. The extract we saw here shows the existence of not only 'finger pointing' but also the 'discourse of revenge'. According to this discourse, men are not only to blame for their past acts, but they have to pay for that by being excluded from the interventions.

Findings from health research also confirm that discourse of 'finger pointing' have negative impact on the success of HIV/AIDS interventions. Gollub (1995) says that HIV/AIDS interventions which target women mostly focus on enabling women to communicate and negotiate with their male partners concerning safer sex practices. Thus, they attempt to make men change their behaviour through the negotiation skills of women. This, according to Gollub (1995), makes women primarily responsible for safer-sex practices, ignoring the impact of gender power differentials. It puts women in charge of persuading their male partners to develop healthy behaviours such as the use of condom. Campbell (1999) also objects to such interventions for their perpetuating traditional beliefs concerning gender roles and holding women responsible for the health behaviours of their partners. Campbell says that this focus on women leaving men out makes it difficult to know whether men can

respond to prevention messages if targeted. She states that in order to empower women, it is important to change men's behaviour.

Hunduma's response in the above extract indicates that there is no need to include men in interventions intended to bring behavioural change concerning home and sanitation. In the following extract, where he responds to the question as to whether there were interventions that focus on couples, however, he seems to have a contrary view to the above.

We did not have interventions that specifically focus on couples. What we have started recently is to request the presence of husbands when the wives are oriented about contraceptive methods. We are also encouraging husbands to be tested with their wives when the latter are tested when they come to health centres for pregnancy test. We are also encouraging indirect involvement of husbands in family planning. Family planning so far focused exclusively on women since it was they who take pills or injections. But now, we are initiating men to be involved by caring for their wives at home and accompanying them to health centres when the need arises. We are also trying to encourage the husbands to use condom as part of family planning.... (Interview, District Health Office; Appendix G, p. 235)

The extract discussed before the present extract indicates that there is no need to include men in family planning. But in the extract presented here we saw that the health office is encouraging husbands to get indirectly involved in family planning. The respondent also says that family planning has been the responsibility of women up to now. As an example to support the fact that women used to have responsibility in issues of family planning, he says that women, but not men, were taking pills or injections. If his intention is to indicate that women have suffered as a result of bearing such responsibility, leaving men totally out of family planning issues or diminishing their responsibility may not be a solution. Rather, helping men to see themselves as part of family planning and encouraging them to take practical action by, for example, using condom may be more acceptable and also fruitful.

In the extract presented and discussed before the current extract, however, Hunduma says '*it is of no use if we teach men about prenatal care. It is not that important if we teach men about family planning.*' But here, he says that men have to be encouraged to be involved in family planning, though indirectly. If family planning is an issue that concerns both the husband and the wife, why should women be directly involved while men are involved only indirectly? He also says that men are encouraged to be tested with their wives when the wives are tested for pregnancy. If it is necessary that husbands and wives have to be tested together, what could be the

reason to restrict the time to pregnancy test? If the couples are convinced that making blood test is advantageous, planning the time to be tested may not be that difficult. Concerning condom, Hunduma earlier said that the health office did not work on promoting condom in rural areas. In the extract that is presented here, however, he says that they are encouraging condom as part of family planning. This means that the use of condom is promoted one way or the other. These conflicting views as to what the health office has done about condom may indicate lack of consistent and workable plan concerning promotion of condom on part of the office.

What we can see from the extracts just discussed is that there is still a discourse of ‘finger pointing’ or discourse of ‘division’ though this division has been toned down in the second extract. This is because, as discussed here, Hunduma seems to have accepted the importance of having men as partners in HIV/AIDS interventions. Still, women are the main actors in the intervention whereas men have to play a secondary role by supporting women in what they do. Hunduma’s response in the second extract is dominated by the discourse of revenge just as it was in the first one. The only difference one can observe in the second extract is that the revenge is not as explicit as it was in the first extract.

4.1.2 Activities

Participants have also expressed their own or other people’s activities in different ways. One of the ways in which they expressed activities is in relation to how a person’s activities determine his/her vulnerability to HIV/AIDS. The following extracts, taken from in-depth interviews, confirm this situation.

Gudeta: Can you tell me how it [HIV/AIDS] can be transmitted and also prevented?

Jorge: It [HIV] is transmitted through sharing sharp instruments such as razor blades, needles and so on that can carry blood. It can also be transmitted through having sexual contact with a person having the virus in his blood. It can be prevented by using private instruments such as needles, being faithful to one’s marriage partner or using condom. (Interview, wives; Appendix A, p.191)

Morka: They [health extension workers] also told us that it is transmitted through sexual contact. So to prevent the disease, they told us that we should not share sharp instruments even among family members. Each person should have his/her own instrument. We also should not have sex except with our marriage partners. (Interview, husbands; appendix B, p. 205)

These extracts suggest that it is possible to prevent HIV/AIDS through taking care of one's activities. They indicate that HIV is transmitted through blood and avoiding instruments used by another person that may carry blood can prevent the disease. They also show that sexual contact is one way of transmission of the virus and hence, faithfulness to one's partner is one way of preventing the virus. In general, the respondents here say that HIV/AIDS is a disease that people can contract or prevent through their own actions.

The two respondents in these extracts use intertextuality to express activities through their utterances. Through this, they acknowledge that there were behaviour change communication messages about the virus and these messages were delivered by the health extension workers.

Jorge, in her utterance, uses discourse of finger pointing or blame. When she expresses how HIV can be prevented, she says "*It can also be transmitted through having sexual contact with a person having the virus in his blood.*" In this extract, she is unconsciously categorising men as carriers of the virus or those who infect, while mentioning women as receptors of the virus. This also places the responsibility of taking care of their sexual relations on women since they are presented as the infected having to take care of themselves from the infectors, that is, men.

The respondents have also used language to express activities in relation to interventions about condom. They say that neither the health workers nor other concerned persons taught them about condom. This can be understood from the following extract.

Morka: No one taught us but I heard it when people talk. For myself, however, I have not even seen it with my eyes. I do not know why and how it is used. I do not want to use it because I am not young and do not talk [have sexual contact] with other people's wives. People say they find it on the road and in farms. (Interview, husbands; Appendix B, p. 206)

Gari: I do not know whether it has been taught or not. But I am sure from what I hear that they do not know about condom. Most of the people, including me, do not know even what it looks like. (Interview, husbands; Appendix B, p. 198)

Kumeshi: Yes, health extension workers taught us that it prevents diseases that are transmitted when men and women talk together [have sexual relation]. (Interview, wives; Appendix A, p. 185)

Of the above four respondents, Morka and Gari reflect similar stand in that they say no one taught them about condom. Morka says that he has not even seen it

with his eyes and only heard from people who found it on the roads and in farms. Though he has not been taught, he has had the chance to hear rumour when other people talk about it. Based on the rumour, he seems to have developed a negative attitude towards condom for he says that he does not want to use it. His reason for not wanting to use condom is his not being young and promiscuous. That means only the youth and those married people who are promiscuous are expected to use condom. We also observe in Morka's statement two contradicting views. He says that he did not know why and how condom was used. In the next sentence, however, he says that he does not want to use it because he was not young and did not talk [have sexual contact] with other people's wives. We see here that Morka really knows why condom is used but does not want to admit that. This may be because the society has negative attitude towards condom and he does not want to associate himself with something that has negative connotation.

Gari, unlike Morka, does not utterly deny that the issue of condom has been taught. He rather says he does not know whether it has been taught or not. Based on what he heard, however, he states that people know nothing about condom. He says that he and the people he knows have not seen condom with their eyes. Here, though it might be true that Morka and Gari have not seen condom with their eyes, this statement might also be used to express their hatred towards condom. We can see from the responses of the two male respondents that they prefer to express ignorance or hatred towards condom, which indicates that their representation of condom is as something that is socially undesirable.

Kumeshi differs from Morka and Gari in that she admits that she has been taught about condom and explains what it is used for. We see here that there is a discrepancy between the two male respondents on one hand and the female respondent on the other. The two male respondents say that no one taught them about condom and even state that they have not seen condom with their eyes. One can excuse their not learning about condom because of their absence on the day when health workers taught about condoms at kebele gathering or because of health workers' not demonstrating condom when teaching. But Morka's opinion that he does not want to use condom raises doubt as to whether his statement is true or not. So, the two male informants' denial of seeing condom might have emanated from their negative attitude towards the use of condom. On the contrary, Kumeshi's admitting

that she has been taught about condom and her expression of its use might possibly indicate her positive attitude towards condom.

Generally, Morka and Gari on the one hand, and Kumeshi on the other, have expressed the activities of health workers or others concerned with teaching about condom differently. Morka and Gari denied that anyone taught them about condom while Kumeshi admitted that she was taught. This difference in opinion can also be the result of the focus given to women in teaching about condom. It might be the case that women are taught about condom while men were ignored in the teaching.

Health workers also express their own activities in relation to their teaching the people about condom. The following excerpt, taken from an interview conducted with HIV/AIDS prevention and control expert, shows that the district health office did not focus on teaching about condom, and gives his reason for this failure.

Diriba: We have not focused on rural areas in teaching about condom. (Interview, District HAPCO; Appendix I, p.249)

Gudeta: Would you explain why you focused on urban areas only?

Diriba: Rural people are not interested when we teach them about condom. In the first place, they say they hate condom because it minimizes sexual pleasure. Second, they say teaching about condom is encouraging people for adultery. (Interview, District HAPCO; Appendix I ,p. 249)

Diriba here says that focus has so far been given to urban areas in teaching about condom. This is because of the resistance of rural people to the teaching about condom. Rural people dislike condom because it interferes in their personal pleasure and accepted cultural norm. Therefore, not enough has been done to develop people's awareness about condom.

Diriba uses intertextuality in his response to express how rural people express their feeling about condom. He says that his office did not teach about condom to rural people because they resisted it. Though the use of intertextuality here is intended to shift responsibility for not teaching about condom, the problem still lies with his office. This response seems not to have taken into consideration why interventions are needed. If it is the case that interventionists give up their effort whenever they face resistance, it may mean that interventions are needed just to scale up what is acceptable but do not try to change unhealthy behaviour. In other words, it means that they teach people only what they [the people] are interested in. However, what interventions do is to help people accept new idea or technology or to change

unhealthy behaviour. Therefore, we cannot say that Diriba is saying this as a result of ignorance or not knowing why interventions are needed. It is intended to shift responsibility to the public for his office's failure to teach about condom.

Interview with district health official also testifies to the same truth.

Gudeta: What did your office do to bring attitudinal change towards condom?

Hunduma: I think we have not done enough to change people's attitude towards condom. In the first place, condoms are meant to be used by men but our health extension workers, who have to teach about condom, are women. The problem here is that these female health extension workers do not have the boldness to teach to men about condom. They are ashamed. They especially cannot demonstrate condom on penile models in front of men. They of course teach what a condom is and what it is used for. But they do not have the courage even to show a condom where there are men. This may be because these workers are working where they were born and brought up. There are elderly men and women whom they fear. They are also products of a culture where women are expected to be ignorant about sex-related issues. ...(Interview, District Health Office, Appendix G, p. 238)

Hunduma accepts that his office has not done enough to change the existing negative attitude that existed in rural areas. He attributes this failure to the single sex composition of health extension workers. These workers could not go beyond the traditional belief that women should be ignorant about sex and sexuality. Instead of trying to change the existing tradition and misconception in the rural areas, they are themselves held back from discharging their responsibility. They, in fact, spoke about condom only orally but could not demonstrate what it looked like and how it is used. If health extension workers, who are expected to be changed themselves and then change the society, are overcome by and yield to the existing traditional views, the success of the interventions may be under question. The official himself admitted that this is a hindrance to teaching about condom in rural areas but said nothing as to what course of action needs to be taken to solve the problem in the future. He simply says *'This is also what we have to work on in the future'*. Both the HIV/AIDS prevention and control expert and the district health official knew that there existed popular hatred towards condom and failure of health workers to change this hatred, but thought of no mechanism how this can be challenged. Both the health office and health workers seem to have submitted to existing cultural norms rather than trying to

change them. Hence, their activities did not bring the desired social change because of fear of resistance from the target audience.

In Hunduma's response here, we see gender discourse at work. Whether his statement that condom could not be taught to rural people because of the health extension workers' failure to demonstrate how it is used is right or wrong, his response reflects gender difference. It means that if the health workers were men, there would have been no problem in teaching about condom. That means gender roles are playing their part not only in creating difference in people's access to information. They are also hampering efforts to narrow this gap by making women unable to discharge their responsibilities as men.

We can also see discourse of finger pointing in this response. Just like Diriba, Hunduma is also pointing his finger at health extension workers for his offices failure to teach about condom when he says "*they do not have the courage even to show a condom where there are men*". He simply states that he observed this problem but does not mention any remedial measure he or his office has taken to overcome the problem. Here too, we see that Hunduma is shifting responsibility to health extension workers freeing himself and his office.

Respondents also expressed their view as to whether there are circumstances under which married people can be tolerated to use condom.

Gudeta: What about if people have sex with other people outside marriage?

Ragdu: In that case, they have to go [die]. Hereafter, I think even teaching about the disease has become boring except to children. The adults and the youngsters have been taught more than enough. If they want to change, what has been taught is enough. If they do not want to change, it is their preference to die. I wonder why we should worry to save those who preferred to die. (FGD, wives; Appendix A, p. 212)

Abdeta: It may be preferable for a person to use condom than to die if he cannot control his emotion. But I think he should be able to control his emotion when he is at other places if he is loyal when he is at home. He will be tempted to engage in sex outside marriage when away from home only if he is accustomed to doing this when he was at home. He does not stay for months or for a year. It is only for weeks that he stays and he has to control his emotion during this time and should never use condom. (FGD, husbands; Appendix B, p. 224)

Ragdu believes that those who cannot be faithful to their partners after all these teachings are those who cannot be changed and it is of no use to try to save them. If they continue to be promiscuous, it means that they have preferred to die,

from Ragdu's point of view. There are only two alternatives to choose from-either be faithful or die. The use of condom is a third alternative and should not be considered. Thus, if they die, that is the consequence of their activities and there is no one else to blame. Ragdu's response indicates that what has been taught focuses only on faithfulness but not on the use of condom to prevent the virus. She is saying that condom is not part of the teaching. Based on such misconceptions, she passes judgment on those who violate to abide by what they have been taught.

Abdeta does not say directly that those who cannot control their emotions should die but insinuates this. He says that married people should be able to control their emotions when they are away from home. This means they should never use condom at any cost when they are at home. The indication is that spouses should not use condom whether they are at home or away from home. He seems to have been lost in between two ideas-that unfaithful spouses should never use condom at any cost or they should use condom when away from home rather than die. It is obvious that Abdeta's stand is against using condom but he is not bold enough to say 'people should die if they are not loyal to their partners'. Abdeta's use of the pronoun 'he' in referring to going away from home presupposes that it is men who go away from home for different reasons and by implication may be forced by circumstances to have extramarital sex. Condom should never be used within and outside marriage means these men, who are often away from home, should be infected and then infect their wives who are always at home and have less likelihood of contracting the virus.

Abdeta's and Ragdu's response contains Discourse of intolerance. If we take Ragdu's response first, she expresses intolerance to those who had been taught but could not adhere to what they had been taught. She wonders even why people bother to '*save those who did not want to save themselves*'. To her, if what these people had already been taught could not help them to change their behaviour, there would be no point to waste time and resource trying to change them. They were unchangeable and, hence, they had to perish. She says that they should not be tolerated any more.

Abdeta's response is also dominated by Discourse of intolerance though he expresses that subtly. He begins by saying, "*It may be preferable for a person to use condom than to die if he cannot control his emotion.*" Although this statement seems to show tolerance, the word 'may' indicates that there is still a doubt. He did not say '*it is preferable*'. The use of the modal 'may', here is intended to show less commitment to the statement that the use of condom is preferable because 'may', as a

modal verb, indicates certain measure of likelihood or possibility but not certainty (Barker and Galasinski, 2001). His stand becomes clear in his second sentence where he says, ‘ *I think he should be able to control his emotion when he is at other places if he is loyal when he is at home.*’ His intolerance to the use of condom by the married people becomes clearer in this sentence. Here, he makes it clear that a husband becomes unfaithful when he is away only if he is unfaithful when at home. By implication, if a husband is faithful when at home, he does not need to use condom since he has to be faithful when away from home. Generally, Abdeta says that the use of condom by married people should not be tolerated since it shows promiscuity irrespective of where it is used. Both Ragdu Abdeta represent condom in their responses as something intolerable.

We also see from the respondents’ language that people give priority to their emotions than to their life. In the interview conducted with Ibsa, we see that he and his partner avoided blood test for fear that their parents would hear of their love and separate them. When responding to my question that says, “Have you got your blood tested before you were married?” Ibsa says:

We did not. We know each other because we had been in love for two years by the time we were married. Even if we wanted to be tested together, we were afraid of her parents. They would find out that we were in love. If they found out that we were in love, they would take her somewhere else. Now we have been married for almost a year and are healthy so far. (Interview, husbands; Appendix B, p. 208)

Gudeta: Why have you not been tested after getting married?

Ibsa: We did not find it important because we are healthy. We are now planning to be tested. (Interview, husbands; Appendix B, p. 208)

What mattered to Ibsa and his partner at the time was not whether they had the virus in their blood or not but their separation if the parents heard the secret. Of the burden they would have to carry if one of them were infected by the virus and their separation if the parents found out their love, they preferred to carry the virus and stay together. They did not regret their action in not being tested even after they were married. They take their living together healthily for a year as a sign that they are free from the virus. These couple have been practicing risky sexual behaviour both before and after marriage. Before marriage, they were overcome by emotion and preferred risking their lives to being separated. After marriage, however, they were

led by the misconception that not to suffer from illnesses is always a sign of negative serostatus.

We see here that there is a Discourse in Ibsa's response above-Discourse of 'fear'. Ibsa says that their refusal to be tested was based on 'fear of separation'. The alternative they took to avoid this fear, however, could have a more serious and disastrous effect. In case one of them was HIV positive, they both would have been infected and worse, they would not have got timely counselling and treatment. Even after their marriage, they did not seem to have understood their mistakes and taken the necessary measures. Ibsa takes their being healthy after their marriage as evidence that they are free from the virus. In addition to 'fear' of separation at work and preventing couples from HIV test here, we can also observe a misconception that those who look healthy are free from the virus. This means that people have the virus only if they are sick or bed-ridden.

Respondents have also expressed that people still engage in risky activities which contribute to the spread of the virus and which they have been taught to give up. One such activity, according to Hunduma, is extramarital sexual relation.

Gudeta: From what you know, how do you explain the current extramarital sexual relation of couples?

Hunduma: Though I cannot say confidently that people have given up the practice as a result of what has been taught, it is not supported as a culturally accepted practice, especially wife sharing among blood relatives has been stopped. Wife inheritance is also no more practiced. But it is clear that people still practice extramarital sexual relation though it is not as widespread as it was before. Some men seek other women for sex though they have wives. Some women also look for sexual partners in addition to their husbands. There are even some women who remarry other men leaving their husbands. That shows they had relation with the new husbands even when they were in relation with the previous ones. Some people could not change the old ways although they were taught to change that. (Interview, District Health Office; Appendix G, p.236)

The activities of those engaged in teaching the impact of backward traditional practices on the spread of HIV showed success in at least minimizing some practices. These activities, however, did not affect all practices equally. They, for example, did not discourage extramarital sexual relation as they did other practices. People have already given up wife sharing among blood relatives and wife inheritance. However, both husbands and wives engage in the practice and sometimes

there are remarriages leaving former relations. What is questionable here is how a distinction can be made between wife sharing among blood relatives and extramarital sexual relation. If we take the settlement of rural people, people that are related by blood usually live in the same locality. And relations of any kind including sexual relations usually take place among people living in the same locality. So this may be acceptable only if people move to other places to find extramarital sexual partners or the composition of people living in a given rural locality is people not related by blood. Though this is questionable, the activities of those who give the teaching have not been accompanied by the expected behavioural change.

Irrespective of whether people have really given up extramarital sexual relation or not, one can understand from Hunduma's response that there is a new Discourse emerging with regards to extramarital sexual relations. That is, the people discourage this practice though whether they have given up the practice or not cannot be answered for certainty. Hunduma says that it was possible to stop the practice of wife sharing and wife inheritance. Though it is possible to say that wife inheritance is practiced no more, it is difficult to say that wife sharing among relatives had been stopped but extramarital sexual relation continued. This is because, since wife sharing itself is subsumed under extramarital relation, one cannot put a demarcation between the two and say this is stopped but this continued. Though it might be difficult to accept what was said concerning the practice of wife sharing, one can observe that this extract indicates there is a change in the sexual discourse. This is evident from the fact that Hunduma compares the past and the present practices when speaking about the change. We can, thus, say that the intervention has at least affected how people perceive extramarital sexual relation.

The data gathered also indicate that rural people engage in risky sexual activity and this aggravates the spread of HIV/AIDS in rural areas. This is clear from interview conducted with Yadeta.

Gudeta: From what you know, how do you explain the current spread of HIV/AIDS in rural areas?

Yadeta: ...[I]f we take the rural areas, I do not think that the status of the disease has been researched well. Most of those who have known that they have the virus are hiding themselves fearing stigma and discrimination. Only few people know their serostatus though there is an encouraging attempt to convince the people for VCT [voluntary counselling and testing]. Even those who are tested are tested once and go away never to come back. They think that once free from the

virus, they have nothing to worry about thereafter. When you put these points together, you can see how dangerously HIV is spreading in rural areas.

[... If you go to clinics and ask now, you will find that there are lots of abortions. Those practicing abortion include both married and unmarried people from urban and rural areas. This can be taken as evidence that both married and unmarried people engage in unprotected sex. (Interview, OSSA; Appendix F, p. 230)

Yadeta's response begins by mentioning the existence of the Discourse of blame or finger pointing among the people. He says that those living with the virus are stigmatised. In the second part of the extract, however, he seems to have shifted to totalising the blame through his use of 'married and unmarried' and 'urban and rural areas'. But a close examination of the extract shows that there is still a discourse of 'finger pointing'. This is because Yadeta's main concern in this second part is abortion, an act which is performed by women. So we see that it is women who are taking the blame for exercising abortion. Men, who should have taken half of the blame, are free from the blame. Here, we see nature serving as a basis for creating difference, gender bias, between men and women.

This extract shows that though there are encouraging remarks regarding HIV/AIDS in rural areas, there are also more alarming conditions. Due to the stigma and discrimination in the rural areas, those who have been tested and known that they have the virus are hiding themselves. There is also the practice of unprotected sex by both married and unmarried people. If those having the virus in their blood do not acknowledge their status, and if people condemn the use of condom and engage in unprotected sex, it would not be difficult to imagine how vulnerable rural people are to the virus. The said encouraging move itself, *convincing the people for VCT*, is not without its own problem. People are convinced of its advantages and are tested for HIV. But once they know their negative serostatus, they go away to celebrate that and never to come back. This has a far-reaching negative effect than not knowing one's serostatus because it only gives courage to people that they are free and makes them engage in risky sexual relations with those they think are free from the virus. There are two different Discourses at play exacerbating the spread of HIV in rural areas: discourse of blame and Discourse of secrecy. The one is a sequel to the other. Thus, the people blame those living with the virus for their serostatus. In turn, those living with the virus hide their serostatus and continue to infect those stigmatising them. We can understand from this situation that to get rid of the Discourse of secrecy, it is

important to do away with the Discourse stigmatisation. Otherwise, the one will trigger the other and the cycle of infection continues.

Bontu also confirms the fact that health lessons, as activities, are not accompanied by corresponding behaviour change:

Bontu: (Yes, I have but) our people do not show change. They understand and accept what we teach them. When we teach them and immediately ask them to be tested for HIV, they become very eager to know their health status. They line up to give their blood to the point that there are no kits for all of them. After a month or so after the teaching, however, you find them indulging in the same risky behaviour which they were taught to abandon. They know that the behaviour is risky but they persist in doing that. (Interview, health extension worker; Appendix H, p. 240)

Gudeta: Why do you think they cling to the behaviour?

Bontu: I think they find it difficult to give up what they have been accustomed to from birth. (Interview, health extension worker; Appendix H, p. 240)

Bontu says that people accept what is taught without resisting but do not practice it. This, according to Bontu, is because they could not give up in a short period of time what they have been accustomed to from birth. Though this is true from Bontu's point of view, there might also be other causes. It might be the case that the teachings need to have continuity. Bontu herself says that the people could not change their behaviour easily because they have been accustomed to the behaviour that needed to be changed. This means that the behaviour has been deep-rooted and has become part of their whole being. It would be difficult to attempt to change such behaviour through teachings given for a day or two. It requires sustained effort to convince people the negative sides of the behaviour and develop healthy behaviour. The fact that people line up to be tested immediately following delivery of the teaching may be due to their curiosity to know about their serostatus after learning about the severity of the disease. The fact that they never come back for HIV-test after being tested for the first time may be lack of sustainable education on the advantage of the test. This situation calls for investigating why people relapse into the behaviour after knowing its negative impact and deciding to commit themselves to change it.

In the extract presented here, we can see that there are two Discourses. These are Discourses of blame and discourse of generalizing. In the first place, Bontu blames the people for not showing change as expected. They change only temporarily and then relapse into the old behaviour. She simply says '*the people*' putting all the

people in one basket which shows all the people exhibit the same reaction to the teaching which is difficult to believe. Though it can be said that the people were not changed as expected, it would be difficult to say all show the same behaviour. To say this, again, means the intervention bore no result at all. This contradicts her own statement in which she says, “It [extramarital sexual relation] is not practiced now as we heard it was before. People started to consider it as a shame and culturally unacceptable.” (Interview, health extension worker; Appendix , p. 300). Here she is speaking about the same people who were exposed to the intervention. She is comparing the practice that existed before the intervention and the current practice and saying that there is a change. Bontu’s response contains two contradicting Discourses, that of blame and praise, which show contradicting results of the intervention, that there is a change and that there is no change which makes accepting what she says so difficult.

Yadeta mentions another factor that is exacerbating the spread of HIV in rural areas. He says that universities are serving as a bridge between urban and rural areas.

Yadeta: ...Take our universities and colleges, for example. There is what they call ‘contract marriage’. I think the term shows that the relation lasts only a short period of time. Universities and colleges have become places where the students practice ‘free sex’. These students are from both urban and rural areas. Especially girls from rural areas were under strict control before coming to universities or colleges. When they come to universities, they begin enjoying life free from parental control and cultural influence. I do not think these students even use condoms for some of them visit different clinics to seek abortion. These students go back to their parents who live in rural areas either after they graduate or for vacation before they graduate. During their stay at the universities, they have had sexual contact, most probably unprotected, with students from urban and rural areas of different regions of the country. Do not you think that these students have friends in the areas where they were born and brought up? I believe they do. So the cycle goes on. My fear is that universities and colleges have become places where students share not only knowledge and skill but also the virus. Given that our people living in rural areas do not like or use condom, and they are not often tested for the virus, it is not difficult to imagine how severely the virus is affecting them. (Interview, OSSA; Appendix , p.230)

Yadeta’s concern here is that universities and colleges are serving as a spreading ground for the virus. These institutions have become places where students do things free from fear of any kind. Prior to their coming to universities or colleges,

these students, especially female students, were under parental control and the society itself exercised some cultural influence on their behaviour. When they come to universities, these students find themselves in a free island, where there is no parental control and little cultural influence. On top of this, the fact that these students are teenagers makes them give more priority to their immediate satisfaction than the consequence of this satisfaction on their future lives. The term 'contract marriage' here shows the extent of freedom they have in the university. Though any marriage is a contract, these students use the term to show that the sexual union is stronger than casual relation, but still short-lived. It may be as a result of this 'stronger relation' that the girls are exposed to unwanted pregnancy and later to abortion. Each party to the contract brings the consequence of whatever sexual behaviour he/she used to have before coming to the university. This consequence of previous sexual relation can be HIV/AIDS or other sex-related diseases. So the contract is an agreement to share not only sexual pleasure but also diseases and whatever consequences there can be. The fact that the relation is marriage-like makes these students develop a sort of mutual trust just like husbands and wives which encourages unprotected sexual relation. After living in such a relation for whatever time they stay in the university, the students return to their localities and resume sexual relation with their former acquaintances. As we saw above, extramarital and premarital sexual relations are practiced in rural areas. So, there is a possibility that these university and college students engage in intergenerational sexual relation with the married people too in which case couples become exposed to infection by the virus.

In the extract under discussion, Yadeta uses gender discourse. This can be understood from the reference he makes towards the middle of the quotation. He says, '*I do not think these students even use condoms for some of them visit different clinics to seek abortion*'. The word '*these*' in this sentence refers to who the whole text is about. So it can be generalised from this that the whole extract is about women. This is because, it is women but not men who seek abortion. Though sexual act in heterosexual relations involves both men and women, when it comes to unwanted pregnancy, it is the women who have to seek abortion or bear the burden if abortion fails to work. Here again we see nature serving as a basis upon which gendered norms are constructed.

It is not only through the activities of university students that HIV/AIDS is spreading to rural areas. Tura observed that primary and secondary schools are also becoming places where students practice risky sexual relation.

Gudeta: Some people say that HIV is stabilizing in towns. This is because towns' people took the necessary precautionary measures to protect themselves from the virus. Inversely, there is a fear that the disease is spreading into rural areas. Do you also share this fear?

Tura: Yes, I do. If we take our schools, for example, we do a lot of things to raise students' awareness of the disease. When we tell them, they do not care about what we tell them. This may be because they are in a sexually active age and do not want to hear anything that may affect their sexual pleasure. In spite of what we teach them, we find them in the bush moving in pairs possibly for sexual contact. I do not think these youngsters use condom. Some of them even get married without the consent of their parents and without being tested for HIV though we have told them not to be married before being tested. (Interview, Hawi chair; Appendix E, p. 228)

We see in Yadeta's response above that students begin to enjoy sexual freedom when they come to universities or colleges. But Tura's response makes it clear that students are sexually active and engage in risky sexual relation beginning from lower grades and while they are with their parents. The students do this in spite of the teachings they are given. We can understand from this that primary, secondary and tertiary educational institutes are places where students are exposed to sexual practices. Though they are taught about the dangers of unprotected sex, these students still practice unprotected sex and expose themselves to pregnancy and other possible infections. Data also show that people engage in extramarital sex (Bontu and Hunduma above). This means that there is a relation between married and unmarried persons. We can conclude from this that the sexual activity of students at all levels is contributing to the rapid spread of HIV/AIDS in rural areas. Respondents have also expressed whether intervention activities include men as part of the efforts made to fight gendered vulnerability to HIV/AIDS. The following extract from interview conducted with Yadeta makes it clear that men, even if they dominate issues related to sexuality, have not been targeted by interventions.

Gudeta: What do you think should be the role of men in stopping the spread of the virus?

Yadeta: ... in rural areas, men still dominate issues related to sexuality. Therefore, it is important to devise mechanisms that focus

on participation of men. A lot remains to be done here. No one tried so far to convince men that they [men] are part of the problem and part of the solution too. Interventions focusing on gender issues always take women into consideration. Still men dominate women to the extent of refusing them permission to attend these meetings. I think this is natural. They are defending their position. I do not think that it is wise to use only force to make them relinquish their power. They should be convinced to sympathize with women. They should not be targeted as enemies. That way they will offer resistance which will at least delay the process of empowering women (Interview, OSSA; Appendix F, p. 232).

Yadeta says that interventions so far have not taken into account the objective realities in rural areas as far as gendered vulnerability and empowerment of women are concerned. They focus only on women and leave men out. But in reality men are part of gender relations and can influence either negatively or positively issues related to gender. Yadeta believes that it is natural if men resist moves made to empower women. They have been brought up to believe that women have a secondary role and position relative to men, and they do not see any crime in defending this position. They are trying to hold on to power that belonged to them for years. It might be possible to make them relinquish this power with force, though this may not be the best course of action to take. Yadeta believes that the present generation should not be made to pay for something that has been handed down from generations, and doing this will only complicate matters. But if men are convinced that they are part of as well as solution to the problem, it is possible to make them supporters and not saboteurs against the right of women.

Yadeta's view here is framed by opposition to discourse of division. He says that intervention messages so far have neglected men and this has a negative effect on the success of the interventions and on women themselves as far as empowerment is concerned. In his view, men should not be condemned for what they committed against women in the past. Rather they should be given the awareness about the impacts of gender inequality and their role in it. Dion (2011) also says that many empowerment campaigns failed to hit their target as a result of popular discourses that depict African women as victims of differential power relations and tyrannical male domination. According to this view, though empowerment of women has an important place in stopping the spread of HIV/AIDS, leaving men out of the campaign does more harm than good.

An excerpt taken from an interview conducted with the district health official and presented below confirms that men have not been targeted by HIV/AIDS intervention.

Gudeta: Do you train both sexes?

Hunduma: We used to train the public in general without focusing on any single group. But this year we trained women separately on issues related to gender and HIV. The training was prepared at bureau level and focused on women in reproductive age. We gave the training in all kebeles for one week. The major contents of the training were problems related to backward traditional practices, reproductive health and HIV/AIDS. Over 4,000 women were trained at district level. All these women were tested voluntarily for HIV at the end of the training and those who tested HIV-positive were given appropriate counselling (Interview, District Health Office; Appendix G, p.234).

Hunduma says that they “used to train the public without focusing on any single group”. That means neither men nor women or any other section of the society had been focused prior to the training given this year. He says that the training this year focused on women in reproductive age and, reproductive health and gender issues are among the points covered by the training. Hunduma seems to be saying that gender issues concern only women. Even if we say that gender issues concern only women, reproduction is not something that can be taken care of by women only. It can be said that women did not have as equal right as men on issues of reproduction until now. But as far as the training is meant to raise awareness of the trainees concerning reproduction and HIV/AIDS, there can be no reason for leaving men out of the training. The reason why men accept their superiority and women’s inferiority as natural may be due to lack of awareness that this relation is man-made. If this is the case, it is more peaceful and economical to do away with this lack of awareness through training and awareness raising than through exclusion and use of power. It would be wiser to tell men too that they have treated women unjustly than to tell only women they have been treated unjustly and have to emancipate themselves.

It is clear from this extract that Hunduma is using discourse of division as a strategy in empowering women. The dominant discourse in relation to gender and HIV/AIDS has been ‘the suppression of women by men’, which exposed the former to a number of social ills including infection by HIV/AIDS. Whether suppressing or segregating men could solve this problem is what needs to be answered. According to Hunduma’s view here, the answer is ‘yes’. That is why men were left out from the

training. What is surprising in this particular training is, the division was not restricted to men only. Women who were not in reproductive age were not part of the training as far as the content of the training is concerned. The main reason behind this division is not clear. Hunduma says that the contents of the training included '*problems related to backward traditional practices, reproductive health and HIV/AIDS*'. If this is the case, there is no reason to leave out women who were not in reproductive age because HIV/AIDS is not restricted to sexual relation and reproduction only. Hunduma himself says that backward traditional practices were one of the concerns of the meeting and it cannot be argued that these backward traditional practices affect only those who are in reproductive age. Scholars say that interventions which focus discourse of division are not likely to succeed (Booth, 2004; Dion, 2011). What we observe here, however, is creating division not only between men and women but also among women themselves, which may affect the success of the intervention in this particular instance.

Hunduma, in the following excerpt, says that a new scheme has been developed following the training given to women.

Hunduma: According to the current scheme, women are required to prepare their own health plan supported by health extension workers, such as plan to get prenatal care. All existing government structures are expected to give these women any assistance they need to overcome obstacles they may encounter in implementing what they plan. (Interview, District Health Office; Appendix G, p. 237)

This scheme requires women to prepare plans independently of men. These plans include, among other things, issues such as getting prenatal care. It might also include plan such as limiting the number of children they want to have. Men are not part of the preparation of the plan but they have an obligation to help in implementing the plan. Hunduma says that, "*All existing government structures are expected to give these women any assistance they need to overcome obstacles they may encounter in implementing what they plan*". The obstacle here may be husbands who have not been accustomed to such practice before. Women may plan whatever seems proper to them and men must cooperate in implementing that. The fact that the assistance is unbound [any assistance] shows how serious the matter is in view of the administrators. The said government structures may assist the women in financially fining, arresting, warning or by taking any other measure deemed appropriate since they are expected to give 'any assistance'. It seems that the scheme is prepared to enable women to

independently plan for themselves excluding men from the planning. Enabling women to plan for themselves is a good idea but intentionally excluding men and threatening them with legal measures may make them self-defensive and complicate the struggle. Even women themselves may refrain from implementing the scheme fearing that it may create discord between the husband and the wife. Or even if they plan, they may not pursue its implementation, again deterred by the possible conflict that may arise as a result of the husband's refusal.

It cannot be denied that women have to be empowered to overcome health-related issues including HIV and other gender-related problems. Nevertheless, this change has to be gradual process in which men relinquish their power and women gain status without inciting the one on the other and creating discord in the family. What is done in the extract under discussion here is using discourse of coercion to do away with another coercion, or repaying evil for evil. It can be generalised from this that the interventions mostly focus on discourse of difference and discourse of coercion.

People's practice after the intervention concerning female circumcision is another topic where respondents expressed activity. They say that the intervention has brought little change in affecting people's attitude towards circumcision of females. Hunduma has the following to say in relation to this issue.

Gudeta: What about circumcision of girls?

Hunduma: We get feedback on workshops and trainings that it is still practiced in secret. But no one is circumcising girls in public in all kebeles found in the district. The fact that people circumcise their daughters in secret shows they are forced by the law to give up the practice without their accepting the negative consequences of the practice on the girl. They want to avoid legal consequence without giving up the practice. We can understand from this that people's attitude towards the practice has not been changed. What has been changed is how circumcision is viewed before the law. (Interview, District Health Office; Appendix G, p. 235)

According to the extract presented above, people have been discouraged from circumcising females only publicly. Hunduma admits that people are made to fear the law but not convinced to abandon the practice, which shows that the intervention has succeeded in changing legal discourse. It could not challenge the underlying beliefs about circumcision but externally imposed on people that the practice should be abandoned. The lessons about female circumcision have used fear

as a strategy rather than teaching about the benefits of giving up the practice. The people, therefore, are not avoiding circumcision but are trying to avoid being caught while in the act and the legal consequences that follow. What is changed is only the legal discourse without affecting people's attitude towards the practice. This is well expressed in Ragdu's words as stated in the following extract.

Gudeta: If it is believed that uncircumcised women break utensils, are disobedient and disloyal, if not to be circumcised also results in complicated labour and has an impact on delivery, do not you think that it should continue?

Ragdu: No, no it should not continue. That would be working against what the time demands. It is a government directive. It is obligatory to do what the government wants to be done. Even if it is obligatory to do what the government wants us to do, insulting the uncircumcised ones could not be stopped. Girls are still insulting those who have not been circumcised in spite of the legal enforcement (FGD, wives; Appendix A, p. 211).

Ragdu juxtaposes two opposing views here. On one hand, she says that females should not be circumcised. On the other, she says insulting those not circumcised cannot be stopped. The reason why she uses these contradicting statements is clear from the extract itself. She says that to say females have to be circumcised is '*working against what the time demands*'. She then goes on and says, '*It is a government directive. It is obligatory to do what the government wants to be done.*' Here, she uses this expression as a 'disclaimer', in Potter and Wetherell (1987) terms. That is, she is using it to defend herself from the possible legal consequence if she is accused of speaking against government directives. The people also have to give up circumcision not because of its negative impact but it is what is demanded by the time irrespective of whether it is harmful or not. The 'time' in this case has a situated meaning. It means the dominant discourse, or the powerful, which is invincible. 'Time' in this case is taken as responsible to make someone strong, make him weak, bring change and work in favour of or against the change. The time demanded them to do that means it is decided by those who are favoured by the 'time', which is the government. Whatever the government wants its subjects to do has to be done irrespective of the consequence. Here she is saying that whether the people are convinced or not, they have to abide by what the government says as failure to do this may have legal consequences. But at the same time, she is saying that the people have not yet accepted what the government is saying. She says,

'insulting the uncircumcised ones could not be stopped'. Those who are not circumcised are being insulted means circumcision is culturally supported. Here we see that people's activities are not in line with what interventionists want to be done. That is because the intervention could not challenge cultural beliefs the people have concerning circumcision.

One can also see shifting of responsibility in Ragdu's response. She says that *'Girls are still insulting those who have not been circumcised in spite of the legal enforcement'*. Here, neither Ragdu nor other parents are to blame for insulting the uncircumcised. This may be because these girls are not grown up and may be considered immature before the law. But in reality, even though it may be true that it is the circumcised girls who insult the uncircumcised ones, what is worth insulting and what is not is part of the culture and is handed down by the parents to children and it would be difficult to blame the girls for this. Ragdu's shifting of responsibility, nevertheless, indicates her attaching the issue to legal action and shunning this legal action as a grown up person.

4.1.3 Identities

Respondents in the study have used language to construct identities in different ways. Based on their socio-cultural background they have categorized themselves, their marriage partners and those around them one way or another. Even if they do not intentionally express who they are or who other people are, how they express identity can be understood from what they say.

In this section, participants' construction of identities will be presented supported by excerpts from the data.

First, we see that respondents categorize themselves and others based on different attributes. In the following extract, for example, Hirpe and Gari, when asked whether husbands or wives are more interested in discussing promiscuity issues, respond by categorizing men and women based on different criteria. Hirpe's argument is based on sexual behaviour whereas Gari's argument is based on mental capacity.

Gudeta: Of husbands and wives, who do you think is more interested in this kind of discussion?

Hirpe: Women are interested more, because husbands, if they begin extramarital relation, tend to forget their marriage. They find the new extramarital love more enjoyable and their marriage boring. Women do not want this to happen and, to avoid this they want discussion. (Interview, wives; Appendix A, p. 189)

Gudeta: Why are men not interested in such discussion?

Hirpe: Men cannot stop seeking extramarital sexual relation .This makes them lack confidence and avoid discussion as much as possible. (Interview, wives; Appendix A, p. 189)

We can understand two things from Hirpe's response above. In the first place, she says that men are disloyal to their marriage partners. She says that they are not only disloyal but also they easily forget their marital partners and stick to their new lovers. This is the reason why women seek discussion more than men do. They want to stop men from adultery and to make them loyal in their relation. Men also lack confidence because of their unfaithfulness, which in turn results in lack of interest in discussion with their marriage partners. In this extract, men are depicted as promiscuous and irresponsible to their partners and family members.

The following extract, however, presents a view contrary to that of Hirpe.

Gudeta: Of husbands and wives, who do you think is interested in this kind of discussion?

Gari: Men are interested more. (Interview, husbands; Appendix B, p.197)

Gudeta: Why?

Gari: Because men think broadly than women but women, even if they know that there is a risk, may not prefer to discuss and may resort to conflict. There is a difference in their mental capacity. So men have the capacity to settle problems peacefully and can achieve what they want through discussion. (Interview, husbands; Appendix B, p. 197)

Hirpe makes two distinct categories of people through her response. Men (husbands) as a totally promiscuous and irresponsible group on one hand, and women (wives) as loyal and caring group on the other hand. She says that men do not only seek extramarital relation but, once they start such relation, they forget their family altogether. Thus, she depicts men as given to lust and caring little even about their family. The reason why they [men] avoid discussion is their guilty consciousness and lack of confidence on themselves. Wives, as opposed to this, want discussion to stop their husbands from beginning love outside marriage and forsaking their family. Men, as depicted in this extract, are concerned more with their sexual pleasure than their marital responsibility whereas women give prominence to their marital relation.

In the extract we saw above, Gari seems to have a completely different point of view from Hirpe. To him, men are more interested in discussing promiscuity issues than women. The reason for this is men's superior mental capacity compared to that of women. Women may know that something has a risk but do not have the capacity

to discuss and convince men. As a result of their lack of capacity to discuss, women often resort to conflict. Men, to the contrary, have the capacity to deal with things and bring peaceful solution. Consequently, they can achieve their goal through discussion without resorting to conflict. According to Gari, men can use discussion to achieve whatever they want irrespective of the nature of what they want. Hirpe says that men try to avoid discussion as much as they can because they lack confidence as a result of their promiscuity. But Gari believes that whatever the point of discussion and whether men are guilty or not, they can convince women using their mental capacity only. Men are naturally mentally superior to women and they use this mental superiority to convince women. The difference between these two respondents is that Hirpe identifies men and women based on their sexual behaviour, which shows that her response is influenced by discourse of sexuality. There is also discourse of blame and difference. According to her, men are promiscuous and avoid discussion to cover up their promiscuity. But Gari bases his argument on mental capacity and identifies men as mentally superior and women as mentally inferior. Gari's response here is influenced by the Discourse model that 'women are naturally inferior to men' though whether Hirpe shares the same Discourse model has not been revealed in the data.

The findings of the preliminary study also indicated that women want discussion to save their husbands from exposing themselves to danger and to sustain the family. The study indicated that women do this at the expense of their own dignity and pleasure.

The data from interview and focus group discussion also reveal how women identify themselves relative to men in their social position. This is evident from Hirpe's response when asked whether she attended kebele meetings or not.

Gudeta: Does that mean you do not attend kebele meetings?

Hirpe: Yes, I am always busy and have no time. Men attend meetings and bring us the information. (Interview, wives; Appendix A, p. 190)

Hirpe speaks as an individual person representing only herself in the first sentence for she says '*I am always busy*'. But in the second sentence with the use of the pronoun 'us' she is speaking on behalf of women and not only herself which shows what she says is true for women of her locality. In the statement that says 'I am always busy' Hirpe indicates that she is always busy around the house and has no time left for social affairs whereas men are free from housework and can afford to

attend to social issues. She seems to have accepted that a woman's place is in the home. She seems to be saying it is all right if women always attend to house chores and men attend meetings. She has accepted men to represent her and bring her information, by implication, means she has accepted that they speak on her behalf too. She is one of those women who have accepted without question the subordinate role of women.

We can also observe another aspect where Hirpe's response gives us a clue as to her own and her husband's identity. That is her reference to herself as 'I' and to her husband as 'men' though he is one person. She dare not say 'my husband attends meetings and brings me information' for she thought that would be incriminating him. Although it used to be part of the tradition that wives do not call their husbands by their names in this locality, this lady is afraid of even saying 'my husband' though the husband was not physically present. We can see from this how strong power differential between the husbands and the wives is and how discourse of inequality has influenced the way women identify themselves relative to their husbands.

How husbands and wives enact their own identities in relation to resolving conflicts and getting their rights respected have also been expressed in the data. Dhibara, in the following extract, expresses two distinct identities of men and women.

Gudeta: What do you think will happen if the husband persists in his risky behaviour and refusal to discuss the issue?

Dhibara: If the husband refuses to change his behaviour and to discuss with his wife, she will first call two elders and raise the issue in their presence. If he says 'no' in the presence of these people or if he continues with silently punishing the woman without verbally saying 'no', she can bring the case before the law. This actually depends on the woman's strength. If she is strong enough, she may go to court. If not, she continues with her suffering. (Interview, husbands; Appendix B, p. 203)

Gudeta: Why does the woman need to be strong to go to court?

Dhibara: First, she has to be able to resist social pressure from men. All the men try to dissuade her lest this serve as a lesson to their wives. So they do everything to discourage her. Second, she does not even know that the law will work in favour of her. This is because she does not have the chance to attend meetings and develop experiences. (Interview, husbands; Appendix B, p. 203)

There are two distinct identities as depicted by Dhibara in this extract- the identity of men and that of women. Men are depicted as having risky sexual behaviour and reluctant to change this behaviour through discussion. They also

harbour grudge against the wife and silently punish her if she earnestly demands discussion on such issues. Women, on the other hand, are depicted as lacking the necessary negotiation skills and knowledge if they find their husbands to be promiscuous. Men, as individuals and as a group, work against women's becoming aware of their rights and fighting for this. So if women have to convince or force men to accept discussion and change their behaviour, they have to be able to resist men's pressure and need to know that the law works in favour of them if they are mistreated. But as depicted here, women lack both the courage and the knowledge. The results of the preliminary study also indicated that women fail to get their rights respected as a result of their lack of courage and knowledge. It was also indicated that even religious institutions work to perpetuate men's supremacy though they preach equality among believers.

Dion (2011) citing various studies conducted on discourse of HIV/AIDS in Africa indicates that researchers tend to categorise men as known for their risky behaviour, stubborn, not caring for their family and addicted. Owing to this, research and interventions focused on women and excluded men as a result of which African men have been disempowered and faced what Dion calls 'crisis of masculinity' or discourse of 'the marginalization of men'.

Men and women also differ concerning their welcoming defeat and apologising when found guilty. Men are depicted as stubborn even when they know that they are mistaken whereas women are always ready to apologise. Morka expresses this in the interview as follows.

Yes, especially men do not accept defeat in front of those they know. They may even prefer death rather than welcome defeat by a woman. (Interview, husbands; Appendix B, p.206)

Gudeta: Can it be concluded from your answer that it is men who are interested in discussing promiscuity issues?

Morka: No. Men resist discussion when they know that they are promiscuous. They do not want to say, "I am mistaken or I apologize". But if it is the wife who is suspected of promiscuity, she does not resist discussion. The wife is not like the husband as far as this discussion is concerned. Even nowadays, when they have legal backing where they are mistreated, they do not find it difficult to say "forgive me, I am mistaken". This they do even when they know the husband is disloyal. They want to keep the family intact at the expense of their own pride. What matters to a woman above all things is her home and family. (Interview, husbands; Appendix B, p. 206)

Morka says that men do not like to admit being defeated by women. Though it is obvious that no one accepts defeat happily, in Morka's opinion, to be defeated by a woman is more deplorable. This emanates from the low social position women are accorded in society. It is acceptable if someone is defeated by someone else whom he considers to be more knowledgeable or stronger than he is. But to be defeated in the hands of someone who is less knowledgeable or less strong is a shame. Women are considered less knowledgeable and less strong in the sight of these men and that is the reason why they considered to be defeated by a woman as a shame. It is this exaggerated self-esteem they have of themselves that hinders men from saying 'I am mistaken or forgive me' when they are found guilty of doing something wrong against a woman. Morka says that men know that they are promiscuous and that accepting discussion eventually leads to admitting promiscuity and its consequences. So they close the door to discussion from the outset than accepting that they are promiscuous. They value their personal pride above everything else. As opposed to this, women are ready to apologise and to forgive even when they know that the husband is promiscuous. The reason why they do this, in the first place, is the love they have for their family, including the husband himself. Second, they know that the society gives them low social status and they also accept this low social status. So it is not a surprise to them if they admit defeat by their husbands. Here we see men as promiscuous and at the same time reluctant to discuss and resolve promiscuity issues with their partners as a result of their personal pride. Women, on the other hand, are depicted as apologetic and forgiving and trying to keep the family intact at the expense of their own pride.

Morka makes use of intertextuality in this extract. He says men do not say, "I am mistakes, I apologise." He also says that it is difficult for men to say "forgive me, I am mistaken". He states that men are oppressive, hard to convince and irresponsible to the family. It can be said that he uses 'discourse of masculine criminalisation'. But when he depicts women, he says that they are faithful, forgiving and responsible to their family. One possible problem with this categorization is that of putting men in general in one category, and as opposed to this, women in another. Not all men may be promiscuous, oppressive, and irresponsible. The same is true for women. Not all of them are faithful, forgiving and caring. This does not mean that men do not oppress women or are not promiscuous. They may not be all irresponsible lacking the other

qualities. At least individual differences have to be acknowledged, rather than criminalizing all to the same degree.

4.1.4 Relations

In both the focus group discussion and interview data respondents express how people are related to one another. They express the relation that exists between different people, between people and their actions or their behaviours, etc. This section will deal with how relation is presented in the data.

One type of relation that is expressed through the data is how the health extension workers and inhabitants of the kebele are related. This relation is expressed in the following manner in the interview conducted with Bontu.

Gudeta: What was the content of the lesson you taught?

Bontu: We focus on how the virus is transmitted. Most of the time, after VCT, the nurses who carried out the counselling and testing congratulate them [those counselled and tested] for being free from the virus. But we tell them after the nurses have left that not all of them are free. We say that ‘there are some people who have the virus. We [the nurses and health extension workers] have a code to communicate who is free and who is not. Some of you have the virus and some are free. So you have to be careful in your relations’. We do this to create mistrust among them so that they may not indulge in unprotected sex thinking that they are free from the virus. We tell them preventive methods they have to follow. (Interview, health extension worker; Appendix H, p. 240)

Gudeta: But why should you tell them something that you know is not true?

Bontu: We know from experience that once they know that they are free from the virus, they start to engage in unprotected sex with those they know have been tested and are free from the virus. They convince themselves that once free from the virus, they are free forever. So, it is if you make them suspect one another that they take care fearing the disease. They do not think that one who is free from the virus today can contract the virus through unprotected sex. (Interview, health extension worker; Appendix H, p.241)

Bontu says that they use falsehood as a strategy to make the people take precautionary measures against HIV/AIDS. What the nurses who carried out the blood test tell the people and what the health extension workers tell them are quite different. The nurses say ‘you are free from the virus,’ but the health extension workers say ‘not all of you are free from the virus.’ The discourse behind this strategy is one of mistrust. What the health extension workers failed to consider is the problem

that may arise if mistrust on part of the health workers triggers mistrust from the target audience of the message.

The health extension workers' reason for using this strategy may be convincing but still has its own problems. The people, when they get two contradicting results about the same specimen and test, they may first be confused as to what their health status really is. If they experience this for two or three times, they may totally lose confidence on the test altogether and give up even the blood test thereafter. Or worse, they may lose confidence in both the nurses and health extension workers and reject whatever they teach after that. So although the health extension workers calculated the immediate result of their strategy, the negative consequences of the strategy may outweigh the positive ones. Generally, the relation that existed during message delivery between the health extension workers and the people from the point of view of the health extension workers is that dominated by mistrust.

People's attitude towards condom and what affects this attitude is another issue where respondents have expressed relation. They say that people's hatred to condom emanates from their relating it to adultery. This relation is expressed as follows in the data.

Gudeta: How do they relate condom to adultery?

Diriba: They say that people may refrain from sex fearing the virus and unwanted pregnancy. But if they are taught or allowed to use condom, they feel secure from both the virus and pregnancy and engage in extramarital and premarital sex. So, they prefer to be taught about faithfulness than about condom so that people may refrain from extramarital and premarital sex. (Interview, District HAPCO; Appendix I, p. 249)

Diriba says that people hate condom because it gives both married and unmarried members of the society freedom to practice unchecked sexual relation. When people use condom, they feel free from unwanted pregnancy and contracting disease. Hence, the society knows that condom is effective in birth control and disease prevention. So the real reason why condom is hated is not people's misunderstanding its function but its depriving the society of its right to control its female members. Condemning the use of condom is a way of putting a limit on sexuality and punishing those who attempt to go beyond this limit. Thus, members have to be faithful to their partners or if they are not faithful, they have to perish as a result of unprotected sex.

The word 'people' in Diriba's response has a situated meaning 'women'. Diriba says 'people may refrain from sex fearing the virus and unwanted pregnancy'.

Though it is true that both men and women fear the virus, men do not fear pregnancy. The fear Diriba is speaking about here refers to women and not men. It is a way of placing more responsibility on women because, in addition to fear of the virus, women have a cause of fear which does not bother men, that is pregnancy. If a woman engages in sex without condom, even if her partner is free from the virus, she is still haunted by the fear of becoming pregnant. As a result, she feels obliged to avoid sexual contact to be free from the social pressure she may encounter from the society. Men's resistance against condom, therefore, partially emanates from the fact that condom gives freedom to women from the fear of becoming pregnant.

Diriba's response contains intertextuality. He prefers to substantiate his speech with what the people say. This reference to what others say than assuming responsibility for himself may be intentional. Since it is the people themselves who rejected the teaching of condom, there is no one else to blame for that. The other point that can be derived from reference to others is that Diriba himself holds the same belief he ascribes to the people. He also does not want to teach about condom but looks for pretexts to avoid responsibility. This is clear from what Diriba says; he did not say 'we tried' instead he said the people rejected it. What his words mean is that 'they prefer to be taught about faithfulness than about condom and the health workers also respected people's choice.'

The interview data also show the type of relation that existed between couples concerning discussion. Here we see that two different types of discourse exist as the excerpts below indicate.

Gudeta: If a husband and a wife suspect each other of promiscuity, how do they express their suspicion?

Hirpe: Yes, the person who suspected can say, "I cannot have sex with you because you have sexual relation with somebody else." Health workers are also telling us to be tested and know our status. So where there is suspicion, couples can be tested and live with mutual trust. (Interview, wives; Appendix A, p. 188)

Ragdu: Yes, they can. If a husband has the habit of looking to other women for sex, if he stays out for a night for no tangible reason, for example, the wife can say, "I won't sleep with you unless you are tested". That is what the time demands. (FGD, wives; Appendix C, p.210)

Tola: My partner and I do not discuss because we fear each other. (Interview, husbands; Appendix B, p.200)

Hirpe and Ragdu on the one hand and Tola on the other give entirely differing responses to the above question. Hirpe believes that couples can have discussion if they suspect each other of promiscuity. She says that the one who suspects the other can even refuse to have sexual relation until they discuss the issue. We can understand from the extract that the discussion Hirpe refers to is not normal discussion intended to bring mutual understanding. It is discussion that exists only when a person finds his/her partner to be promiscuous and to announce refusal of sexual relation until they are tested. So it is not discussion in a real sense of discussion since it does not include free exchange of views. She says that this discussion is used as a means to come to terms to blood test. In Ragdu's view, it is always the wife who suspects her husband of promiscuity and raises the issue of HIV-test. That is, husbands are disloyal and it is this disloyalty that calls for discussion between the couples. Here again, discussion is something the couple or specifically the wife resorts to when suspecting a partner of risky sexual behaviour. Ragdu and Hirpe have one point in common-it is possible to discuss blood test when couples suspect each other of risky sexual behaviour.

Though this is not discussion where both the husband and the wife exchange their views, it is one step ahead since both the husband and the wife have equal right in the 'discussion'. This tells us that there is a new discourse emerging concerning HIV/AIDS and sexual relations. Hirpe and Ragdu represent those women who have begun to value their lives and try change the type of relation that existed between their husbands and themselves. The decision not to have sexual relation with the husbands if there is suspicion on promiscuity, though it needs determination to be materialized, shows a change from male dominated marital discourse to one where both can react if they suspect that there is an engagement in risky sexual behaviour. This also shows that the intervention started to take effect.

On the other hand, if we look at Tola's response, we see that there are still families whose relation is characterised by discourse of fear and domination. Where there is fear, couples cannot feel free to share their opinions or feelings. Under such circumstances, ideas or opinions are not entertained on equal bases and the opinions of the dominant side get their way with the dominated side submissively accepting whatever is proposed. This relation is typical of patriarchal discourse where men have the upper hand in the family. The reason Tola gives for their not discussing as couples is '*we fear each other.*' If we take Tola's response here at face value, one may be

tempted to conclude that the fear is shared by both the husband and the wife. But in reality it would be difficult to say that this is so in a situation where there is a power differential between husbands and wives. Though it may be true that Tola and his partner share fear to the same degree, it would be difficult to accept that this is true for all couples in a society where women are not equal to men. Tola's response shows that there still exist families who have not brought change on their relations in spite of the intervention.

It can be said generally that the intervention messages did not affect sexual discourse among all families. Some women are bold enough to express their suspicion to their partners and refuse to have sex until they both are tested, an act which shows emergence of new discourse where wives and husbands have equal right on issues concerning their lives. Others, as a result of power imbalance that fosters fear, continue in their relation without any reaction even where there is a ground to suspect one's partner, which shows that the patriarchal discourse is still lingering and having an impact on relations of the couples.

One major issue we can observe here is the problem with the language used to initiate discussion. The expressions used by both respondents, Hirpe and Ragdu, are provocative. Hirpe says that the suspecting person can say, "*I cannot have sex with you because you have sexual relation with somebody else*". Ragdu also says that the one suspecting the other can say, "*I won't sleep with you unless you are tested*". Both expressions trigger anger from the suspected person, especially if the suspected person is the husband like Ragdu said. So, language use can be a barrier to promoting discussion among couples and increase their vulnerability to the virus.

In the data gathered through interview and focus group discussion we also find how a husband's and a wife's relation is expressed in terms of their belonging to the society in which they live. This has been expressed well in the following extract where Fayo expresses what should happen if a husband and a wife quarrel and decide to end their relation.

Gudeta: What do you mean by 'she has to go'?

Fayo: She has to go back to her relatives since he hated her. What else can she do? He shouldn't go away because he is among his relatives; may be in his father's house. But the woman came from another area and has to go back to where she came from. (FGD, wives; Appendix C, p. 214)

In Fayó's view, a woman does not belong to the society in which she lives. Irrespective of the number of years she has lived in that society and the type of ties she has had with the people, she is considered alien when she is not at peace with the husband. Fayó says that '*He should not go away since he is among his relatives*'. The issue of whether the wife has to continue to live in that society or not depends on her having healthy relation with the husband. She came to where she lives because of the marriage and when the marriage meets with problems, she has to go to where she belonged. This shows that her relations and her possessions are meaningless once her relation with her husband is in question. In other words, she is just an alien resident in her own house. She is related to the society through her husband. The problem is if her relatives, where she has to go when hated by her husband, do not consider her as belonging to them. That leaves the woman without any destination. According to Fayó's view, the relation between a married woman and the husband's relatives is so loose and breaks immediately after she quarrels with her husband. All her social activities and ties are meaningful only as far as she has peace with the husband. So it is partly to avoid this danger that women submit to whatever the husbands demand in their marital life. If they try to resist and the conflict worsens, they have to leave not only the husband but also whatever they have, including friends and acquaintances.

The fact that this response comes from a woman shows the shaping power of discourse. Though she is a woman herself, she did not even question that this discourse deprives women of their right. When questioned by the researcher what she meant by '*she has to go*', she replies saying, "*She has to go back to her relatives since he hated her*". She has accepted that her ties with the society are secure only if she can live peacefully with the husband. She lives all her life with the consciousness that she does not belong to that society because she is from another locality. This is one cause of women's failure to fight for their right. This is because if they fight the husband and the situation leads to separation, they believe that they are going to lose not only the husband but also all their friends and acquaintances. To avoid this, they prefer to submit to whatever the husband has to say.

Gudeta: What is your worry concerning the spread of HIV into rural areas?

Tura: My worry is concerning the reaction of the people towards those who have the virus in their blood but who are hiding their status fearing social discrimination and condemnation that follow. People use discriminatory words such as 'those with disease of the time'

against them. As a result, these people do not acknowledge that they have the virus and our rural people do not take the necessary protective measures. I think this will contribute to spreading the virus into the rural areas (Interview, Hawi chair; Appendix, p.227).

Tura says that these people, if they acknowledge their serostatus, will become victims of discrimination and condemnation. To avoid this consequence, they have to hide their status and live just like any other healthy person. Tura also says that rural people engage in risky sexual practice. When we consider these three points together, that people who have the virus in their blood are hiding their serostatus, people engage in risky sexual practice and they do not use condom, we can see how prevalent sexual behaviours expose rural people to infection by HIV/AIDS. Hence, people's failure to improve their relation with those who have the virus in their blood triggers the latter for revenge and contributes to spread of the virus. People condemn those who have the virus but do not take care to protect themselves from the virus, an act which exacerbates the spread of the virus and increases vulnerability.

As can be understood from Tura's response, the relation between those who have the virus and those who are supposedly free from the virus is dominated by segregation and blame, and the use of degrading words against those living with the virus. The dominant HIV discourse has created a division between those who are infected as infectors, and those who are supposedly free from the virus as victims. This segregation and blame is forcing those who are infected to hide their serostatus. This segregation and hiding one's serostatus shows that there is no mutual concern for one another between those living with HIV and those supposedly free from the virus. Though people segregate those whose status is known, there is still an engagement in risky sexual relation. There, the existing discourse on HIV and stigma is one possible factor which is contributing to the spread of the virus in rural areas.

There are, however, research results which both support and falsify this view. Norman, Kennedy and Parish (1998) found out that exposure of one's negative serostatus increases the safety of subsequent sexual activity with informed partners. But Serovich and Mosach (2003) remarked that disclosure does not necessarily result in individuals using the information to protect themselves and others from infection because there are persons knowingly placing themselves at risk for infection, a condition they termed 'informed exposure'. Conversely, Marks and Crepaz (2001) argue that nondisclosure does not necessarily result in unsafe sex. They say that some HIV-positive individuals may withhold their HIV serostatus fearing negative

consequences of disclosure such as stigma or rejection. However, they may engage in protected sexual activity, perhaps out of a sense of personal responsibility toward their partners, a condition they termed ‘uninformed protection’.

The interview data also indicate that PLWHA themselves do not share their experiences with their family members. Gemene, a woman living with the virus, says that she does not need to tell her children but they have to learn just by living with her.

Gudeta: Why do not you discuss issues related to HIV with your children? Does not that help them to learn from you?

Gemene: We do not discuss. I think they can learn the impact of the disease by just living with me. It does not need telling them because they are experiencing it by living with me. As to telling them about the use of condom, condom protects us from contracting the disease through sexual contact. But as I told you earlier, I did not contract the virus through sexual contact. I was loyal to my husband. I still do not know how I got it. I do not think telling them to use condom can be the solution. I will pray that God protect them. (Interview, wives; Appendix A, p. 195)

In Gemene’s opinion, her children have to learn about HIV by simply observing her life. By this, she means that, if they do not want to suffer like her, they have to take care of themselves, which means that life itself is a good teacher. The problem, however, is that Gemene herself does not seem to know what they have to avoid to take care of themselves. She says that she was loyal to her husband and does not know how she contracted the virus. Consequently, she seems to have reached the conclusion that there is no use in teaching people about condom because condom protects people from contracting the virus through sexual intercourse whereas she did not contract the virus via this route. Gemene here seems to have reached hasty generalisation. The fact that she did not contract the virus through sexual relation does not mean that all people do not contract the virus through sexual means. Gemene is careful in her sexual relations again does not mean that others, including her children, are careful. Gemene’s failure to discuss with her children can be the result of keeping secret issues of sexual relation from one’s children, though she does not want to admit this. If there were no open discussion of sex-related issues between Gemene and her children prior to her contracting HIV, developing such relation just on knowing her serostatus may be difficult. Whatever her reason for avoiding discussing condom with

her children, we can understand from this extract that even those with the virus do not discuss issues of prevention with their children.

We can understand from Gemene's representation of HIV/AIDS here that it is a disease whose cause and prevention is not known. To support this, she takes her own experience as an example. She says that she does not know how she contracted the disease because she was faithful to her husband. Since she caught the disease in spite of her faithfulness, she says that it is useless to discuss how it can be transmitted or prevented. She says that she will "*pray that God protect them.*" This expression shows that it is a curse from God and it is of no use to try to protect oneself from the virus. God brings it and God takes it away. This means that education or raising awareness does not help to stop HIV/AIDS. This is a dangerous position since it kills people's initiation to protect themselves and forces them to depend on chance since it obscures how the virus is transmitted and prevented.

We also see from the interview conducted with Bontu that couples are not always honest to each other concerning the disclosure of their HIV test results. Bontu says that:

There are also cases where the husband or the wife, after knowing that he or she has the virus, keeps it secret from the partner. In such cases, we tell the other partner to be tested and know his/her serostatus. We simply stress that he/she has to be tested. If we tell them that one of them has the virus but is hiding it, this might be the cause for dispute and we might be blamed by the society for doing this. What we want is to save their lives. What is surprising is that men always blame their wives for contracting the virus even where it is they themselves [husbands] who were tested and knew their serostatus first. They do not blame their wives openly. They nag them and make them feel guilty. Women, even if they know that the husbands were tested and knew their serostatus first, do not answer back their husbands for fear that this may worsen the matter. (Interview, health extension worker; Appendix H, p. 241)

We see that a husband or a wife, after knowing that he /she has the virus, keeps it secret from the other partner. The reason for this may be the fear of condemnation from the other partner. On top of that, we saw above that the society reacted negatively and segregated those persons found to be HIV-positive. This may also indicate that partners do not show sympathy towards each other in cases where one of them is HIV-positive and the other is not. Since the unsympathetic partner may get angry and expose the issue and exposure of the issue may have serious social consequences, the infected person prefers to keep the issue secret. Bontu also says

that it is men who blame their wives upon discovering that they themselves or their wives have the virus in their blood. They do this irrespective of whether the husband's or the wife's status is known first and irrespective of the fact that almost all the participants agree that men are always more promiscuous than women. Thus, as a result of lack of sympathy from the spouses and discrimination and stigma against those infected by the virus, infected partners keep their serostatus to themselves and continue to infect their partners.

It can also be observed from the excerpt that this situation puts even health workers themselves in a difficult position to discharge their responsibility. Bontu says that the health extension workers "*simply stress that he/she has to be tested*". This is because if they "*tell them [husband and wife] that one of them has the virus but is hiding it, this might be the cause for dispute and we might be blamed by the society for doing this*". The health workers do not tell the partner that did not know his/her serostatus to be tested but simply stress that he/she has to be tested. But they cannot tell him/her the partner's status for fear of the conflict that may arise between the couple and the social consequence exposing the status may have on the health workers themselves. Thus, we see that the health extension workers' conformity to social pressure is exposing couples to infection by the virus.

The excerpt under discussion contains discourse of blame or discourse of finger pointing. It is often the case that wives or the society condemns men for being promiscuous, oppressing women and lack of concern for the family. In this excerpt, however, Bontu says that husbands blame their wives when they realise that they are HIV-positive irrespective of whose serostatus was known first. She says "*What is surprising is that men always blame their wives for contracting the virus even where it is they themselves [husbands] who were tested and knew their serostatus first*". Though it may be groundless for either the husband or the wife to condemn the other for contracting the virus first based on whose serostatus is known first, Bontu's premise to condemn men for blaming women is erroneous. She says that men blame women irrespective of whose status was known first. According to Bontu, it seems that the partner who knew his/her status first has to take the blame for contracting the virus first. Though it may be the case that men blame their wives for contracting the virus owing to their gendered role, the premise on which the allegation is based in this extract is not based on solid facts.

In agreement to what the respondents say here, research findings (Abrahams, Jewkes, Hoffman and Laubsher's, 2004; Medley, Garcia-Moreno, McGill and Maman, 2004) also indicated that women are deterred from seeking HIV testing due to fear of violence. It was also indicated that women are afraid to ask for money or permission from their husbands to attend HIV/AIDS facilities or seek information. In addition, it was found that women refrain from disclosing their positive serostatus owing to their fear of violence. According to these findings, women are barred from seeking health information or from disclosing their positive serostatus as a result of gender bias.

This extract is a good example of how HIV/AIDS discourse is dominated by fear. We have seen in the preceding discussions that people refrain from circumcising their daughters due to the fear of legal measure. We have also seen that youngsters refrain from HIV-test due to the fear of separation. We have also seen that people do not speak outwardly against condom because of the legal measure that follows. In this extract, we saw that women keep their HIV-test results secret due to the fear of the husbands. Diriba says that women make health workers not to expose the test result because, if the husbands happen to know it, "*the whole family will be dispersed*". We also saw that those living with the virus refrain from becoming member of PLWHA due to the fear of the husband and that of the society. We can understand from this that most of the actions people either take in support of or in contrast to the intervention are shaped by fear of something or somebody. This in turn shows that the interventions mostly employed fear as a strategy to make the people accept the messages. Similarly, those trying to act against the interventions are also using the same strategy to subvert the intervention messages.

Both interview and focus group discussion data show that men do not want their wives to attend meetings but they do not tell them so verbally. This has been expressed well in the following excerpt.

Gudeta: But has anyone counselled you as couples?

Lelo: Men do not want women to attend meetings either with men [husbands] or alone [with women]. Women also do not consider attending meetings as their right. They do not care whatever men say about women. So, women do not go to meetings when they are called. They themselves [women] give bad names to those few women who go to meetings. They call them uncontrollable or disobedient. ... Men were using different reasons so that women may not attend the training itself. They were saying "My wife is busy, she

is sick “. They were speaking on behalf of the women. ... (FGD, wives; Appendix C, p. 214)

This respondent says that men do not want women to attend meetings. She also says that men use different false reasons to hide their real motive. Their real intention is to control women’s movement and contact but they never say so. Instead, they appear concerned and caring for the women. Among the reasons men use to limit the movement of their wives are the wife’s being busy and her inability to do physical work. These ones and other reasons are pretexts to limit the women’s contact with other people. In reality, however, most of the physical work around the home is accomplished by women. The real reason, therefore, is to deny women access to social gatherings and meeting with other men or women but not to care for women because of their physical inability. This is an attempt not only to control and limit the women’s physical movement but also their access to information and thereby their socialization. If women are allowed to attend meetings and meet different people, they will acquire information concerning conditions outside the home. So to confine their knowledge about the world outside the home, men deny their wives the opportunity to contact the outside world which can offer them information. It can also be an attempt to control their sexuality as meeting different people may broaden their acquaintance with people. This strategy seems to have worked because Hirpe, being a woman herself, seems to have accepted her low social position.

Lelo in this extract makes use of intertextuality. She uses this tool to express what both husbands and wives have to say concerning meetings. In what she says here, we can find discourses of gender and of blame. She says that women are instrumental themselves in sustaining domination of women. They use such words as “uncontrollable or disobedient” to label those who attend meetings or social gatherings. The women whom Lelo condemns for speaking against those women who attend meeting have accepted patriarchal domination as natural and unquestionable. To them men are born superior and women are inferior by nature. Those who oppose this, whether they are men or women, are trying to reverse the natural order of things and should be resisted. In this, we find discourse of gender at play.

Lelo also condemns men for secretly working against empowerment of women, using such words as “*My wife is busy, she is sick* “ where the woman is not really sick though she may be busy doing house chores. She

says that they do not directly speak but work secretly to maintain their superior position and tries to present men as saboteurs. The reason for men's inability to directly resist the empowerment of women or their attending training sessions in this particular case is fear of legal measures. If they speak their mind, they are exposing themselves to legal measures. The best strategy for them, therefore, is to tighten their grip on women at home while verbally accepting what is acceptable from legal point of view. They do this to escape the legal measure interventionists use as a strategy.

Hirpe, though does not directly state her husband's hatred towards her attending meeting, expresses his unhappiness when she mentions the issue of attending meetings.

Gudeta: Is it because your husband forbids you to attend meetings?

Hirpe: I do not know. He has never said to me "You do not attend a meeting" but he is not happy whenever I raise the issue of attending meetings. Since I have been accustomed to this, I do not say 'I will go to a meeting' when there is one. If the meeting concerns only women, I may not get information as to what is said on the meeting since he cannot attend it. But if it is for men and women, my husband gets the information and shares it with me. (Interview, wives; Appendix A, p.188)

Hirpe says that it is acceptable if husbands seek and share information with their wives while the wives attend to issues around the home. She seems to have put her trust in men. She is content with the information her husband brings her and it matters little to her if she does not get information as a result of his lack of access to the information. The wives, thus, are made to think not through their own minds but through that of their husbands. Responses of the above two participants are shaped by the Discourse model that says 'a woman's place is in the home'. In Hirpe's opinion, what men do to control women is acceptable, though whether she is happy with that is another question. But in Lelo's view, women, beyond welcoming men's move to limit their movements, condemn those women who violate this restriction and attend certain social gatherings.

This extract also highlights the power of socio-cultural discourse on individual actions and reactions. The women we saw in the extract accepted that they belong to the home and men have to attend to issues outside the home. They have not only accepted this as natural and given but condemned those women who violated this. Though it is obvious that such norms limit their movement and contact, they

could not consider this as restricting their rights because they have once shaped their mind that this is normal way of life. To them, the question of inferiority and suppression between men and women is meaningless since this is what has been handed down from generation to generation.

A look at how Hirpe begins her response can give us a clue that she knows that she is unjustly treated though she was held back from exposing this. She begins by saying '*I don't know*'. That '*I don't know*' does not refer to her not knowing the answer to the question because she started to respond without taking time even to think. That '*I don't know*' refers to whether she has to speak the truth or not. It indicates that she was torn between the idea of telling the truth and telling what the discourse of gender dictates her to tell. Eventually, we see that she resolved to tell what the discourse demands her to tell. We can understand her position even by looking at how she responds. She says, "*He has never said to me "You do not attend a meeting" but he is not happy whenever I raise the issue of attending meetings*". As a grown up person, she distinguishes between saying 'no' verbally and saying the same without uttering a word. We can understand from this that husbands do not always use words to tell their wives to do or not to do things. She also says that she was accustomed to this, which means she was often discouraged and came to make it a way of her life. We can understand from her response that she is not interested in the way her husband treats her. She, however, is living that way because she could not envisage any way out of that.

The difference observed between Lelo's and Hirpe's responses indicates that there are two gender discourses competing for upper hand. If we compare what each of them say, Lelo says "*Women also do not consider attending meetings as their right. They do not care whatever men say about women*". This shows that she is not happy with the way women act towards men. She indicates that attending meetings is the right of women though women do not know that. But Hirpe's response is contrary to that of Lelo. She says, "*Since I have been accustomed to this, I do not say 'I will go to a meeting' when there is one*". She says that though attending meetings may be her right, she was not accustomed to that and it does not give her sense. She also says that she does not care if her husband attends the meeting and brings her the information. It seems that she does not care whether the information he brings her is distorted or not since she knows that she is not going to use it. The two discourses that we see here are the new discourse, the discourse of demanding equality and, the old

discourse, the discourse of submissiveness. Lelo represents that of demanding equality whereas Hirpe represents that of submissiveness.

Respondents have also expressed their views on extramarital sexual relations of couples. They all shared the view that extramarital sexual relation is still practiced though the number of people engaging in such an act has declined as a result of people changing their behaviour following the intervention. The following extracts can represent views given concerning extramarital sexual relation of couples.

Fayo: People do not practice this in our area because they have been taught about its effects. Even if we practiced it, the men would get angry and punish us severely. (FGD, wives; Appendix C, p. 215)

Dhibara: There is the practice after all the teaching although the number of people engaging in such an act has been minimized. Some people could not change their behaviour. (Interview, husbands; Appendix B, p. 203)

Bontu: It is not practiced now as we heard it was before. People started to consider it as a shame and culturally unacceptable. You hear no one speaking in favour of the practice. We do not hear rumours that men have sexual relation with other people's wives. Nevertheless, we cannot say that people have given up the practice altogether. (Interview, health extension worker; Appendix , p. 243)

These respondents agree that extramarital sexual relation is still practiced. They also accept that the teachings given contributed to lessening the number of people engaging in the practice. They all say that the intervention against extramarital sex has yielded the desired fruit, except Dhibara who believes that the teaching given should have borne more result. Although the three informants believe that reduction in the practice of extramarital relation has been brought by the teachings, Fayo says that even if they practice it, their husbands "*would get angry and punish us severely*". Thus, women, in addition to the lesson given, refrain from the practice because of the fear of punishment by their husbands. The husbands have the power to punish means they are in control and there is still a power differential between the two.

Bontu's response also indicates that men play a decisive role in issues related to sexuality. As evidence to the fact that extramarital relation is not practised as it used to be, she says '*We do not hear rumours that men have sexual relation with other people's wives*'. Here, she mentions men as active participants in the act of sexual relation while placing women in a passive position or even not mentioning them. Thus, women are assigned passive role not only in making decisions concerning sexual matters but also in the sexual act itself.

Dhibara and Bontu have one point to share. That is, they say that extramarital sexual relation is still practiced though to a lesser degree than it was before. But Fayu has a different point of view from the two in that she says it is not totally practiced in her locality though she has not said whether it is practiced or not at other places. This confirms Bontu's response that extramarital sexual relation is considered as something culturally unacceptable and a shame. That is why Fayu says it is not practiced in her locality. This response might have been triggered by the fear of men who were not physically present but still have a bearing influence up on what she says. Her second sentence, in which she makes it clear that women gave up extramarital sexual relation due to fear of men but not due to behaviour change, makes it obvious that there is discourse of fear behind the change in sexual behaviour.

We can conclude from the responses of these respondents that there is a change in extramarital discourse. Bontu says that it is not practiced as it used to be previously. Dhibara also says that there is a change though he is not satisfied with the change brought. Though there are people who have not changed their sexual behaviour even now, the respondents say that there is a change in extramarital discourse. Bontu and Dhibara ascribe the change brought in discourse of extramarital relation to the intervention. Fayu, nevertheless, partially ascribes the change to the fear of husbands. Thus discourse of fear plays a role in her situation.

In the data gathered through focus group discussion, respondents also express the relation between men and women concerning rape. They express this relation in connection with who rapes women and where, and what women encounter when raped. In the focus group discussion held with women, for example, some said that men rape or force women into sex. Others say that men cannot force women into sex without partial consent from the woman. Let's look at what Ragdu and Fayu have to say in relation to this issue.

Fayu: ... Women may be forced for sex by men if they go away from their area. Men who know the women and their husbands do not rape them...Women cannot resist men when alone. They cannot even accuse them and get justice before the law because the court asks for witness. But men do not rape women in the presence of witnesses. Raped women cannot even tell their husbands that they have been raped. This is because if a husband hears that his wife has been raped by another man, he would get into physical confrontation with the person who raped the woman. In the confrontation, the husband may be injured or, even if he hurts the other person, he may be arrested. The woman also gets tarnished names as prostitute and incontinent

for causing the conflict. The husband also does not stop by fighting the man. He will punish the wife too. ...So if she speaks that she has been raped, the consequence may be serious. (FGD, wives; Appendix C, p. 213)

In Fayo's opinion, it is only those men who do not know the woman and her husband who rape her and for that matter when she is away from home. In rape, women suffer in many different ways. First, they cannot physically resist men's move for sex and are forced to have sex against their will. Second, they are asked for evidence, which is not there, when they go to court with cases of rape and consequently do not get justice. They cannot even share with their partners the fact that they are raped fearing the conflict that may arise between the husband and the one who raped the wife and the ensuing consequence on the husband or both the husband and the one who raped the woman. Even if they decide to tell the husbands the truth, the husbands do not accept them at their words. If they keep quiet and the husband hears about the issue as a rumour, they have to suffer for keeping it secret. Thus, women are in problem both to protect themselves from rape and to manage the situation once they are raped. This secrecy increases vulnerability of both the husband and the wife to the virus because, the wife, even if she suspects the rapist of having the virus in his blood, cannot tell her husband the truth and suggest blood test or the use of condom.

This excerpt clearly shows the complexity surrounding the discourse of rape. In the first place, women are forced to have sex against their will, which affects them psychologically. This psychological impact continues as they find themselves in a difficult position to decide whether to expose the act or not. Exposing will have the consequences of conflict with the husband and getting tarnished names as 'prostitute and incontinent', which do not really represent them. That means they are wrongly represented. Keeping it secret will have the dangers of infecting one's marriage partner and again conflict with marriage partner if the act is exposed through other people. This is one of the serious issues surrounding gender discourse, where women take the responsibility for an act over which they have little or no control.

According to Ragdu, however, women have a share in rape in that men do not simply force women into having sex with them.

Ragdu: I do not accept what you are saying about rape. I do not think that men force women into sex especially considering my locality. Let me ask you a question, does your husband himself dare to sleep with you if you frown at him? I do not think. Men do not simply

force women to sleep with them where the woman is totally not interested. They must get some sign from the woman. Even if men take the initiative to ask for sex, they do not proceed if the woman discourages their move. There must be the woman's consent in rape (FGD, wives; Appendix C, p. 216).

Ragdu believes that women engage in sex when and where they are interested to do so, and there can be no sex without the consent of the woman. According to her, the word rape itself does not refer to a coercive sexual relation since it is performed with the consent of the man and the woman. She is also of the opinion that there is no power imbalance in sexual relations. She says that men 'take the initiative for sex' but wait for the woman's consent to proceed. If the woman shows signs of reluctance, men stop there. Therefore, men and women are equally responsible for rape. Nevertheless, though there may be the woman's indirect agreement in rape in certain cases, it would be denying them justice to say that women engage in sex when and where they find it necessary. If a woman is raped by someone infected by the virus and contracts HIV, according to Ragdu, she is as responsible as the man who raped her.

Ragdu's response minimizes the degree of blame that has often been placed on men or rather, haves it. She says that both the man and the woman have equal responsibility in rape because no rape can take place outside the consent of the woman. If men are to blame for taking the initiative, women also have to blame for welcoming the move. Though this view is good in that it shares the responsibility between men and women, it is faulty because it is based on hasty generalization. It is true that women have a part to play in both marital and extramarital sexual relations. Their consent is expected to some degree. But it is inappropriate to say that women play decision-making role in all sexual relations. There are possibilities that they are forced even in marital relation itself. Studies indicate that the major reason behind women and girls' vulnerability to HIV infection is the existing gender inequalities, particularly violence against them. Of the different forms of violence committed against women, one is sexual violence perpetrated by intimate partner, which includes rape, coercion and abuse (WHO and UNAIDS, 2006). Thus, a woman can be raped by her intimate partner, let alone by those distantly related to her. Ragdu's opinion rather shows the multi-layered problems women face in rape.

4.1.5 Politics

Respondents in the study have used language to express their perspectives on people, actions, things and so forth. They have expressed who is guilty or innocent or what is wrong or right from their point of view. One of the issues in relation to which they express their perspective is their view concerning kebele meetings as can be understood from the following extracts.

Gudeta: Are there people who do not attend kebele meetings?

Hirpe: Yes, women generally do not attend meetings (Interview, wives; Appendix A, p. 188).

Gudeta: Why?

Hirpe: They think that what is taught at kebele meetings does not change the state of affairs. They say that those who teach do so just to get their per diem (Interview, wives; Appendix A, p. 188).

We see here that women have low attendance of kebele meetings. According to Hirpe, the reason why women do not attend meetings is not only because their husbands do not want them to do so, it is because they do not see the importance of attending meetings as these meetings do not change the 'state of affairs'. Though it is impossible to know for sure the state of affairs Hirpe is referring to, it is not difficult to conclude that she is speaking of undesirable conditions since a person does not wish to change desirable conditions. So the condition she is referring to can most probably be the inequalities women are made to suffer. Meetings or no meetings, Hirpe did not see any change on her life. So the meaning of meeting to her is a way of earning money for those who teach at the meetings and meetings are summoned just to benefit those who arrange them.

Participants have also expressed their view on the current social position of women. They say that little has been changed concerning how women are treated by the society. Extracts taken from interview and FGD conducted with women reflect this view.

Gudeta: If elders or relatives try to resolve such conflict through arbitration, whose idea will be accepted more (husband's or wife's)?

Kumeshi: A woman's case is often unacceptable. (Interview, wives; Appendix A, p. 184)

Gudeta: Is it because they are not mistreated or it is just not acceptable?

Kumeshi: They are mistreated but what they say is not acceptable because this has been the practice. (Interview, wives; Appendix A, p. 184)

Dilale: The elders always consider the woman as a wrong doer. The husband covers up his fault through the use of words. But the woman, even if she is wronged, is shy to express that in words. And again, even if she decides to explain her case, she refrains from doing so because of her concern for her house and family. But the husband, if he wants to leave the woman, thank God, we do not have such husbands in this area, uses every means to win the case or even if he cannot win and they divorce, to make people give the woman tarnished name. (FGD, wives; Appendix B, p. 211)

Morka: ... If it is elders trying to resolve the conflict, the husband's opinion clearly dominates. But if the case is taken to court, the dominance is minimized. The problem is that only few women go beyond traditional arbitration. (Interview, husbands; Appendix B, p.206)

The three respondents here say that women are not as equally treated as men just because they are women. Kumeshi knows that women are mistreated but they cannot speak about their mistreatment. When asked why, she said that '*it has been the practice*'. She has taken for granted that husbands can mistreat their wives and there should be no question about that. Dilale also says that women are considered as wrong doers irrespective of what they do in issues where conflict between men and women is considered. This is because the husbands can cover up their wrong doing through the use of words though women cannot do this as they are shy. Even if women decide to defend their right, they cannot do this because they fear that it will have negative consequence on the family. Husbands, on the other hand, do not care about the family as women do and are concerned with winning the case only.

It is important to look at how Dilale expresses husbands in her locality here. She says '*thank God, we do not have such husbands in this area*'. This expression itself indicates her insecurity at speaking against men. It is a sort of hedging that if what she says is exposed, she only spoke about men living in other areas but not the ones in her area, discourse of fear operating. But in reality, even if it can be said that there is an improved relation between husbands and wives, it is difficult to say that all men in Dilale's locality reflect such a change at the same time.

Dilale stresses the fact that women are more concerned for their family than men. Women give up even their rights to avoid something that threatens survival of the family. Contrary to this, men take any measure to accomplish their personal

desire. What matters to men is attainment of their goal but neither the family as a whole nor their partner's interests.

Morka accepts the existence of dominance of men's ideas but makes distinction between legal discourse in traditional arbitration and at modern courts. Thus, though men's opinions dominate more in traditional arbitration, courts themselves are not free from reflecting men's dominance, which shows that both reflect gender bias. Both Morka and Dilale share that women are mistreated by traditional arbitrators which shows that traditional arbitration is more gender-oriented.

In this extract, Dilale condemns men for their refusal to admit their mistakes and cruelty against their wives, thus reflecting bias common to HIV discourses, that of blaming men. The other two respondents, however, did not directly make men responsible for the social ills mentioned. Especially Kumeshi does not make anyone accountable for the mistreatment of women. She says that women are mistreated but "what they say is not acceptable because this has been the practice". She does not say either men or women refuse to accept. This may be intended to mean either both men and women do not acknowledge women's problems. Or, it may be intended not to mention men's refusal to acknowledge this problem, in which case her response is dominated by fear. From these respondents' point of view, women are depicted as members of society who are mistreated but denied justice.

The issue of whether it is husbands or wives who are more interested in discussing promiscuity and who is more promiscuous of the two is also where participants expressed their point of view. Morka and Regasa, as can be understood from the following extracts, say that women are interested more in discussing promiscuity and offer their reasons for saying so.

Morka: The wife is interested more... This may be because men are suspected of promiscuity. So women need the discussion to convince men to be loyal. (Interview, husbands; Appendix B, p.206)

Regasa: Mostly women are interested. They suspect their husbands of promiscuity. This is because men often go away from home. They drink and engage in sex when they are drunk. Even if they do not drink, men are not loyal to their wives. Due to these reasons, women like to discuss promiscuity issues with their husbands. They want to alert their husbands about the danger engaging in extramarital sex may bring. (FGD, husbands; Appendix D, p.222)

These men accept that it is women who are interested in discussing promiscuity issues. The reason they gave for this interest is that men are not loyal to their wives. So women want the discussion for convincing their husbands not to be

promiscuous. Among the factors contributing to men's becoming promiscuous is their going away from home. But even if they do not go away from home, Regasa says that men are disloyal to their wives. So their staying at home or not does not affect men's degree of disloyalty. They are disloyal irrespective of where they are. By implication, it is not as a result of their staying at home that women are less promiscuous than men. This means that they are loyal whether they are at home or away from home.

Not all respondents agree that women are interested in discussing promiscuity issues. An extract presented below shows that men are more interested in discussions than women.

Jorge: Men are interested more. (Interview, wives; Appendix A , p.248)

Gudeta: Why?

Jorge: Because men have power over women and want to impose their interests on women through this discussion. (Interview, wives; Appendix A, p.191)

Gudeta: What reason do they [wives] give for their refusal to discuss?

Jorge: They look for pretexts to initiate fight. They may even demand divorce. This is because they know that husbands want the discussion to impose their own needs and interests. (Interview, wives; Appendix A, p.191)

According to Jorge, discussion is not a means of sharing views and decisions but a way of imposing one's needs and interests over the other. Thus, men want discussion to impose their needs and force women to accept their views. Therefore, women resist discussion as it is a way of making them accept what they do not want to accept. Morka's and Regasa's views we saw above have similarity with Jorge's in that they consider men as promiscuous. In Morka's and Regasa's opinion, women show interest in discussion because they suspect men of promiscuity. Inversely, men are interested in discussion because they want to impose their needs on women concerning promiscuity. In both cases the participants express that men are promiscuous. Thus, whether women accept or resist discussion, it is because they are loyal to their husbands and the discussion is intended to suppress women's right or to ascertain men's right in favour of promiscuity. To these respondents, discussion is a tool by which men impose their will concerning promiscuity upon women or which women use to dissuade men from promiscuity. That is, there is a misunderstanding of the meaning of discussion. They believe that discussion is needed only when the wife suspects her husband of promiscuity or when the husband wants to impose his will

upon the wife and not a means by which participants express their views or opinions equally for mutual trust.

What is interesting here is that men are depicted as evil doers and problem makers whether they accept or refuse to do something. Preceding discussions revealed that men avoid discussion because they fear that discussions help to expose their promiscuity. In the data discussed here, however, they are depicted as supporters of discussion. Their interest in discussion, nevertheless, has been interpreted negatively: they use it to impose their interest upon their marriage partners. Whether they accept or resist discussion, it is always for an evil purpose. The tendency to condemn men for whatever they do in relation to HIV/AIDS is part of HIV/AIDS discourse. Of the researchers who studied masculinity and HIV/AIDS discourse, Sweetman (1997) warns that as a result of the tendency to always depict men as problem creators and women as victims of problems created by men, gender-sensitive interventions may fall short of addressing effectively issues of equity and empowerment.

In the data, respondents also use language to connect discussion about HIV/AIDS and sexuality to education. In the extracts given below, all the respondents agree that discussion is connected to education.

Gudeta: If a husband or a wife suspects his/her partner of risky behaviour, can they freely discuss the possibility of using preventive methods?

Dhibara: They can, as far as my partner and I are concerned. If I suspect her or if she suspects me, we can discuss how we can prevent the virus. I do not know whether this is true for other people. Educated people do this but the uneducated ones do not. The uneducated ones do not discuss at all. (Interview, husbands; Appendix , p. 203)

Gari: We do not discuss. Only the educated ones do. (Interview, husbands; Appendix B, p. 197)

These respondents share the view that couple's discussion of HIV and related issues is connected to education. This view can serve as a self-inhibiting factor to those who are uneducated since they believe that only the educated ones are likely to discuss. Given that majority of the rural people cannot read and write as can be understood from the figure in respondent background (p. 66) above, we can conclude that only a few of rural people discuss HIV and related issues. These respondents, therefore, are labelling themselves as someone who cannot discuss sex issues because they are not educated. That means the intervention messages did not

develop the self-efficacy of the target audience as far as discussing and resolving HIV/AIDS and sex-related issues are concerned. This may undermine the initiation of the spouses to discuss important issues and delays the process of behaviour change. Data gathered for preliminary study also indicated that only educated people discuss issues related to HIV/AIDS and sexuality. In agreement with this view, Central Statistical Agency [Ethiopia] and ICF International (2012: 197) say that “accepting attitudes are generally more common among respondents in urban areas than among those in rural areas and increase with education and wealth.”

In Dhibara’s opinion, couples need discussion only when the one suspects the other of promiscuity. To him, discussion is a remedial measure couples take when one of them is involved in or is suspected of promiscuity. Where there is no suspicion, there is no need to discuss. This indicates that couples do not use discussion as a means of protecting themselves from infection by the virus.

Respondents not only express their view concerning people. They also personalize HIV/AIDS and present it as someone who does not touch others unless touched first as shown in Ragdu’s words in the following extract.

Gudeta: What do they say when they talk about the virus?

Ragdu: It has almost become a proverb that AIDS said, “do not touch me so that I may not touch you. Once I mount you, I won’t dismount you.” [“Natti hinbu’in sitti hinbu’uu, si yaabbannaan sirraa hinbu’uu”]. Those who have the virus in their blood themselves do not want to mention it. They say they are TB patients though they know that it is HIV. (FGD, wives; Appendix C, p.212)

Ragdu uses intertextuality, quoting HIV/AIDS as if it were a human being speaking, to present her view. She treats HIV/AIDS as a human being that attacks only if provoked. Thus, the fact that HIV/AIDS is a disease which can be prevented if people take care of their actions has become part of HIV discourse. In this excerpt, pointing finger to other people has been replaced by pointing to oneself. So if people contract HIV, it is they themselves and no one else who is to blame. This change of discourse from blaming HIV/AIDS or other things to blaming oneself if one contracts the disease can be a result of the intervention. Though it has been possible to make people aware that HIV/AIDS is a preventable disease and is contracted through risky behaviour, we see in this extract that there is stigma against those who have the virus in their blood. We can understand this from Ragdu’s response that where she says “*Those who have the virus in their blood themselves do not want to mention it*”.

Rather they say that they are suffering from TB, a result of discourse of blame. This is because if they acknowledge that they have the virus, they will be stigmatized. The society gives those living with the virus bad names, and when they hide themselves to avoid the names, again condemns them for doing so. So to avoid this stigma they prefer to call themselves TB patients, a disease for which there is cure and which does not engender segregation and stigma. This is a tendency, as we saw above, that exacerbates the spread of HIV/AIDS in rural areas.

The respondents have also expressed their perspective concerning whether they consider the use of condom appropriate. They have said in both the interview and focus group discussion that it is not appropriate for both married and unmarried people to use condom. This can be understood from Abdeta's response given below.

Gudeta: What is people's reaction to the use of condom?

Abdeta: ... [A]lthough condom protects people from the virus, it is making the youth undermine our culture and at the same time spreading the disease. Before the introduction of condom, the youth refrained from having sex before they were married because, if they have sex, they may become pregnant and be exposed. After the introduction of condom, however, girls became free from the fear of becoming pregnant and started to engage in sex at an early age. The use of condom only emboldened them to begin sex at an earlier age than before and to have multiple sexual partners. But they do not use it consistently. You can see that they are not using condom consistently from the fact that a number of girls become pregnant and give birth to fatherless children or face health problems while trying to abort... (FGD, husbands; Appendix D, p.225)

According to this extract, condom should be condemned in any form of sexual contact because it gives 'girls' freedom to engage in adultery. It should not be used in premarital sexual relation because it is undermining the culture by encouraging the girls to engage in sex free from the fear of becoming pregnant. As a result of this freedom from fear, the youth are let free to begin sex at an early age and have sex with multiple partners. Thus, Abdeta believes that fear has to be used as a strategy to make people refrain from sex and avoid the virus. Abdeta directs his grievance at the use of condom at girls. He says that, "*After the introduction of condom, however, girls became free from the fear of becoming pregnant*". His opinion is that the society can stop the spread of the virus by controlling sexuality of its members. The problem with this view, however, is that the society can control the sexuality of its female members but not that of males. This is because men do not become pregnant and they have nothing to fear if they engage in sex anywhere

anytime. This is holding females responsible to protect themselves and the society from the virus while giving men freedom, and hence, is gendered.

We also see inconsistency in Abdeta's argument. On the one hand, he admits that condom can prevent pregnancy and the virus. On the other, he says that it spreads the virus and exposes girls to pregnancy. If it is believed that condom is effective for birth control and for preventing the virus, and lack of consistency in its use results in pregnancy and contracting the virus, the best strategy is not to condemn the use of condom but to advocate its consistent use. The true reason behind Abdeta's condemning the use of condom does not seem its problems on health. It is, its 'undermining the culture', in Abdeta's words, a culture that gives licence to men to control sexuality of its female members. This is a re-emergence of traditional practice, by means of which men try to control women and girls and their sexuality under the disguise of preventing HIV/AIDS as commented by Campbell and Gibbs (2009).

The data gathered through interview also contain respondents' view about men's attitude towards empowerment of women. The respondents say that men resist the idea of empowering women as can be understood from the following excerpt.

Gudeta: How do you explain the cooperation of husbands when you try to mobilize women to protect themselves from infection by the virus, for example, when you call the women for meetings?

Humduma: ... They do not say women should not be made to know their status. They do not say women should not learn or assume power. They do not say women should not go to meetings because they are inferior; but they speak through their actions. Let me tell you what happened during the training of women I mentioned above. We received a report that a husband beat his wife for attending the training. We asked the woman who was beaten and she told us that it was true. She told us that he beat her because she refused to accept his order not to go to the training. We called the husband to office and asked him about what happened. He did not deny that he beat her. But when we asked him why, he said that because 'the woman refused to go to the training'...(Interview, District Health Office; Appendix G, p.237)

As can be seen from this excerpt, men try to block any move that is made to raise awareness of women about their social position and that this social position is constructed. They want to assert that the power difference that exists between men and women is natural and God-given. Their intention in doing this, however, might not be to violate women's rights intentionally. They themselves have been brought up shaped in the belief that men are naturally superior to women. Women themselves

accept that their inferior social position is given and natural and this condition cannot or need not be resisted. So whenever something that challenges this status quo is about to happen, men try to subvert it. When they do this, they believe that they are keeping the natural order of things. The men Hunduma mentioned in the above extract also believe that they are superior to women and could not accept the current teaching that men and women are equal. It is acceptable to them that women's activities and movements, including whether they have to attend meetings or not, have to be decided upon by men. But they could not resist this teaching since it is from the government. What they do is try to maintain their belief by not confronting the government face-to-face since this may have a legal consequence. Verbally they accept what is taught but practically they do what they can to subvert it, like the man whose story is narrated above. The reason why these men resist the government's attempt to empower women may be partially due to their ignorance. What is being done by the intervention, as can be understood from the data, is forcing men to accept what is taught by the interventionists without trying to raise men's awareness about the consequences of gender. This, in turn, is provoking men for resistance. The nature of how the messages are presented, the use of force to make people accept the change, is backfiring and contributing to delaying the attainment of the goals.

Hunduma says in the extract above that the training was given to women separately. Consequently, women have been made aware of their position and the fact that this position has to be challenged. But men have not been included in the training. The training was concerned with gender and gender is about women as well as about men. Including men into the training or arranging similar training for men too could have been advantageous. This is because men may be suppressing women out of ignorance and making them aware of the effects of gender may help them re-examine their old beliefs. But the official did not mention about men being targeted by the interventions. It seems that the intention is to empower women by leaving men out of the endeavour, implementing 'discourse of marginalizing men'. But this may make men defensive and complicate the process of empowerment itself. Greig (2003), in agreement with the idea that men should be targeted by interventions focusing on gender, says that men are both agents and victims of patriarchy and should be given the opportunity to heal from and take responsibility for patriarchal oppression. This is because they lack information and knowledge concerning the effects of gender on women as well as on men themselves.

Ragnarsson et al. (2010) and Were (2008) concerning the discourse of male marginalization comment that attempts to promote agency for women by excluding men are creating doubt in men and causing suspicion and hostility between men and women. This apprehension African men have concerning shift of power and threat to masculinity often resulted in violence of men against women as well as men against men.

The respondents say that people refrain from speaking what they believe not only due to the fear of legal action but also to avoid diminishing their social value. This is stated in the following extract taken from interview conducted with Jorge.

Gudeta: How do people react to the idea of being faithful to one another so as to prevent HIV?

Jorge: Even if they are not taught, people have at least heard that sexual faithfulness is necessary to prevent the virus. In spite of this teaching, not all people are faithful to their partners. Even if they are not faithful, they do not express this in words. This is because by speaking against marital sexual faithfulness, they expose their promiscuity which diminishes their social value. (Interview, wives; Appendix A, p.192)

Here we see that there is a change as a result of the intervention for we can perceive from the data that some people have changed their behaviours and become faithful to their partners. But even those who could not change their behaviours and become faithful to their partners themselves do not speak against marital faithfulness. This is not only due to legal action this may bring about but because of the social sanction against marital unfaithfulness. Thus, there is a change of social attitude towards promiscuity that has been brought as a result of the intervention. People have started to view the practice as socially unacceptable though some people still lack the determination to give up the practice.

This change may not be called a behaviour change, because it is only people's attitudes that have been changed whereas behaviour remained unaffected, a condition Darnton (2008) calls 'attitude shift'. The people perceive that promiscuity is socially unacceptable but this belief is not reflected in how individual members of the group behave.

This extract shows that people do not always use language to represent reality as it is. They also use it to represent reality as it is or in an opposite way depending on the choice of the speaker or writer. We saw in the extract that people do not speak

against marital faithfulness though they are not faithful themselves. They use language to express actions in such a way that they are socially acceptable.

Whether it is men or women who is more promiscuous is another issue where the respondents expressed their perspective. There are differing views on this issue as it can be understood from the following extracts.

Gudeta: Who do you think is more promiscuous- husbands or wives?

Bontu: ... Wives sometimes come to me complaining about the promiscuity of their husbands. Especially some strong women I have been working with in this kebele say, “I suspect that my husband has had an affair with another woman. Therefore, I cannot sleep with him unless we are tested together for the virus.” ... In some two or three cases, the husbands accepted us and were tested for the virus. None of them were found HIV-positive. We did this just to calm down the women and bring peace to the family for we know that the virus cannot be detected in the person’s blood before three months from infection. Still some men say ‘I am loyal to my wife; why should I be tested’? When the husbands become stubborn, the wives drop the issue and resume their normal life as before. We also keep quiet because we do not want to incite disagreement in the family...(Interview, health extension worker; Appendix H, p.241)

Bontu, as a health worker, has had the chance to have contact with dwellers of the farmers association. Based on her experience, she says that women sometimes come to her complaining the promiscuity of their husbands. But when she explains which women come to her with complaints concerning their husband’s behaviour, she restricts that to ‘*some strong women*’ which indicates that not all women who suspect their husbands of promiscuity come to her and complain. Even these women whom she labels as ‘strong’ give up the issue if the husband becomes stubborn and refuses to be tested. These women are strong enough only to suspect and ask the husband to be tested. But if he refuses, their strength ceases and they drop the issue and resume normal life. This shows that there is a change in sexual discourse. It means that wives have started to challenge the power of their husbands even though they could not carry the case through to the end due to the existing cultural domination.

Bontu’s language also indicates that the health workers are not discharging their responsibility fully, preferring conformity to cultural norm to discharging their duty as professionals. She says, “*We did this just to calm down the women and bring peace to the family for we know that the virus cannot be detected in the person’s blood before three months from infection*”. This raises the question as to whether

these workers are discharging their duty of preventing the virus and saving life. They are also putting their personal relations before duty for that matter cheating the people by denying them the right to get information about their health concern. Bontu and her colleagues know that these couples who have been tested and diagnosed free may have the virus in their blood. But they did not tell them that there is this possibility for, if they do this, the couple may quarrel. This, though may be unethical, is not without reason. If they push forward and try to convince or force the husband to be tested, this may result in conflict between the husband and the wife and expose the health workers to social disapproval. Even if they try to push harder and to convince the husband irrespective of the social pressure, they may be betrayed by the women who brought the issue for, as Bontu says, the women drop the issue if husbands become stubborn. We can understand from this extract that there is pressure from men against HIV-test and health extension workers are overcome by the pressure and failed to discharge their responsibility.

One can understand from what Bontu says that awareness about how HIV/AIDS is transmitted and prevented does not benefit women in a society dominated by discourse based on gender inequality. This in turn shows the importance of considering social factors in designing BCC messages. Weissman (1991) concurs with the idea that social factors play a role in changing people's behaviour and says that women fail to implement what they have learned not because they do not understand it but due to their lack of power. Mays and Cochran (1988) also found out that especially women might fail to implement what they have learned because of possible threats to their economic survival, relationships and culturally assigned roles.

The language used also shows that there is a misconception about HIV-test. Bontu says that husbands refuse to be tested for HIV/AIDS. The reason they give for their refusal is 'I am loyal to my wife; why should I be tested?' HIV-test, from their perspective, is necessary only for those who are not faithful to their marriage partner. This means that, just like condom, HIV-test is also a sign of promiscuity. This is a dangerous notion since it makes people avoid the blood test associating it with promiscuity.

4.1.6 Connections

In both the interview and focus group discussion data, respondents express that certain things are connected to or disconnected from others. In this section, some

expressions the informants used to show connections and what connections they intended to express will be analyzed.

Based on their knowledge from HIV lessons, respondents say that women are more vulnerable to HIV/AIDS than men. They, however, disconnect their vulnerability from gender. None of the respondents in the following extracts mentions gender relations as contributing to vulnerability of women to the virus.

Fayo: Women are more vulnerable because they bleed during delivery. This loss of blood affects them. (FGD, wives; Appendix C, p. 214)

Kumashi: The virus affects them [women] more.... It affects both but women do not have resistance. (Interview, wives; Appendix A, p. 241)

Gemene: They did not say there is a difference. They told us all contract the virus equally if they do not care. (Interview, wives; Appendix A, p. 187)

The respondents are aware of the difference between men and women concerning their degree of vulnerability to HIV/AIDS. The reasons they give for this difference are based on natural factors such as delivery or lack of resistance. They do not seem to be aware of social factors that cause this difference. Gemene herself, a person living with the virus, is not better than the other women as far as knowledge about vulnerability of women is concerned. We can conclude from these responses that HIV interventions have focused on transmission and prevention of the virus in general but not on gender vulnerability. Hence, women do not know that HIV/AIDS affects them more than it does men due to their gendered roles and cannot protect themselves from infection. One can conclude from this that these respondents do not know about the role of gender discourses in creating difference between men and women concerning their degree of vulnerability to the virus.

The participants also disconnect government organs from HIV and health-related activities as can be understood from the following extract taken from interview conducted with Tura.

Gudeta: Who do you think should play major role in averting the current situation in relation to the spread of HIV in rural areas?

Tura: I think it is the government because it has the resource and the power to make people change risky behaviour. We see that different government organs work day and night for political success. The same effort has to be exerted to create a healthy society. A lot has to be done to raise people's awareness about the virus. It should not be left to NGOs and charity organizations as it is now. For example,

people sometimes refuse to show up for meetings when we call them. Those in power also do not show concern whether people come for meetings or not. But if the meeting has a political purpose, the administrators would take severe action on those people who miss the meeting. Health issues, especially those relating to HIV, have not been given due attention. (Interview, Hawi chair; Appendix E, p.227)

In Tura's opinion, government organs give emphasis to political affairs and health issues are not given due attention. They use force to make the people take part in political activities but when it comes to health issues, including HIV/AIDS, they do not steer the people for action. What matters to them is the immediate political gain and not the long lasting effect health issues have on the lives of the society. Tura says that health and HIV/AIDS issues have been left to NGOs whereas these NGOs do not have the power to force the people to implement intervention programs. It can be deduced from this that in the absence of enforcement, it is unlikely to make people change their behaviour.

A discussion made with a kebele cabinet member also indicated that issues of health are seldom raised in cabinet meetings except when there is training or there is a directive from higher governing organs. It was also disclosed during the discussion that especially HIV/AIDS-related issues are considered responsibilities of health workers. (Personal communication with Guyasa Chala, 25/07/2004). Hence, there is lack of collective effort among government organs working at kebele level to prevent and control the spread of HIV/AIDS, a condition which can have a negative impact on the overall success of intervention messages. This also shows that there is a gap between what is stated in the guidelines and frameworks on the one hand, and what is implemented in the society. Strategic Plan II (HAPCO, 2010) and HIV Behaviour Change Communication Framework (FHAPCO, 2011), for example, state that multi-sectoral coordination and involvement of political leadership at various levels, from region to kebele, must be ensured in all HIV/AIDS intervention endeavours. In spite of this, however, there is lack of coordinated effort especially at district and kebele levels.

Tura uses intertextuality as a tool to present two types of discourse: political and HIV/AIDS discourses. He says that political leaders did not pay due attention to issues of health and HIV/AIDS. He believes that interventions can succeed only if they are supported by force. He says that the government is responsible for

intensifying the struggle against HIV/AIDS because '*it has the resource and the power to make people change risky behaviour*'. Resource here may mean material, financial, human power, etc. but the power he refers to is anything the government has at its disposal to make the people accept change. In his opinion, people can respond to interventions only if there is a legal enforcement from authorities and failure on part of the political organs to accompany the messages by force affects the success of the messages. He says that government involvement is mandatory to make the people accept the messages. The problem with this strategy, however, is if fear does not bring the desired behavioural change in the targets of the messages.

One type of connection that the respondents make in the data is connection between condom use and negative attitudes. In the following extract, Bontu explains the negative attitudes people connect to the use of condom.

Gudeta: What are the rumours that circulate around in favour of or against the use of condom?

Bontu: Men often tell us that women do not like it. They only tell us that women hate it without telling us the reason. Men say they do not like it themselves because they fear it would be torn. They also say condom itself carries and passes the virus. They say 'it is a false friend' because it gives them confidence to have risky sexual relation but does not really protect them from the virus. (Interview, health extension worker; Appendix H, p. 242)

As can be understood from this excerpt, both men and women dislike condom. Bontu did not tell us the reason why women hate condom though she said that men hate it because they fear it would be torn. Men say they hate it for three reasons: '*it carries and passes the virus, it would be torn and it is a false friend*'. Men's reason for hating condom here seems to have been based on health issues and free from cultural bias. But the fact that women hate it for no reason or they hate it for a reason but do not want to express it may be gendered. Bontu's opening sentence itself tells us something about the role of men and women in decision whether to use condom. She begins by saying '*men tell us*', but what men tell her is about women's reaction to condom. Reading this sentence makes us create the impression that it is because women hate condom that men also hate to use it. In the second sentence, however, she says that the men do not tell her why women hate condom. If these men really know that women hate condom, they should also know the reason behind the hatred. Bontu herself does not want to know, or even if she knows, does not want to mention why women do not like condom, if they really do not like it. Whether the

reason for the hatred is known or not known, the expressions used in the extract just discussed show that there is a negative attitude towards condom.

The remaining sentences of the excerpt tell us that men hate condom because it is not reliable. We can see from the whole excerpt that men speak on behalf of women whereas women are silent. We can conclude from this that the very idea of women hating condom itself is men's idea and women are forced to accept this idea due to their gendered role. This coincides with a research result that indicated women refrain from asking for the use of condom because of the expectation that they have to give priority to men's needs and wishes. The research also found out that women are deterred from openly discussing sex due to fear of being labelled promiscuous (Greig, 2003). Here too, it is likely that women do not express their own will and simply succumb to men's will or speak what they think is in line with men's need and interest. Women may withhold their views about condom due to their culturally expected role in relation to sexuality.

We also find two contradicting statements in Bontu's expression of men's opinion about condom. On the one hand, she says that one reason for men's hatred towards using condom is their fear that it would be torn. In this case, they believe that condom can protect men from infection by the virus but they hate to use it because it may be torn. On the other hand, she says that men hate condom because it carries the virus. According to this view, condom does not prevent the virus and should not be used. The fact that men give contradicting reasons for their hatred of condom here may indicate that this hatred is groundless.

Respondents also connect condom use to other undesirable consequences. Hunduma and Bontu make this clear in the following interview excerpt.

Gudeta: How do people express this disliking in what they say?

Hunduma: They say that they feel burning sensation when they use condom; it weakens the woman's sexual feelings; and it carries the virus itself. They say all these without trying it for themselves. As I have tried to tell you, we have not done enough on this issue. But I know that it is not because they do not know that condom saves life that these people object to its use. They once conceived that it is a sign of promiscuity and we failed to help them get rid of that misconception. We proved that people want to use condom but are ashamed to express this need in words because if they express it, they will be labelled as promiscuous. (Interview, District Health Office; Appendix G, p. 238)

According to Hunduma, the reason people give for their disliking condom is connected to gratification of sexual feeling. The specific reasons they give are its causing burning sensation and weakening women's sexual feeling. In addition, they say that it carries the virus. They give all these reasons without trying how using condom feels. They once developed negative feeling towards condom before using it and they could not be convinced about its advantage and change their mind ever since. So when they speak about condom, it is not what is true that they speak but what they think can increase people's hatred towards condom. What we can understand from this is that, once people form an attitude towards something, it takes great effort to make them change that attitude irrespective of its advantage or disadvantage. Hunduma admits that health office has not done enough to change people's attitude towards condom. The major reason behind people hating condom is its being connected to promiscuity. Whatever is said or spoken thereafter could not displace this misconception and people still maintained their hatred.

The other point that can be derived from Hunduma's response is that it is men, but not women, whom he has in mind as sources of what he says. This can be understood from part of the extract that says, "*They say they feel burning sensation when they use condom; it weakens the woman's sexual feelings...*". Here, he used the pronoun 'they' to refer to his sources, which is men. In the second phrase, however, he says 'it weakens the woman's sexual feelings', which shows 'woman' is spoken about by men. We can see from this that men are speaking about their own feelings and that of women too. Hunduma's response in this part of the extract may be based on the Discourse model 'active men' and 'passive women' in issues related to sexuality. Men speak on their and women's behalf concerning the bad sides of condom may mean that what is said about women's reaction to condom is fabricated or decided by men and women are forced to passively accept this fabrication or still to reverberate this fabrication to conform to the social norm.

Bontu also shares the view that people have negative attitude towards condom as can be understood from the following extract.

Bontu: Let alone other people, members of kebele leadership who have attended different trainings and are expected to speak in favour of its use tell us face to face that we should not even mention the name of condom. They say, "You teach that the youth should not begin sex before marriage and the married should be loyal to each other; and again, you say that we should use condom. That is, you are telling us not to be loyal. Why is it necessary to use condom if people

delay sex until married and are loyal to each other once married?” We always tell them that we are not advising them to use condom with someone else’s wife or another woman outside marriage. ... But still, many of them say that condom should not be accepted under any circumstance. Some of them, however, especially the married youth, directly tell us that they are not loyal to their wives and accept condom from us. (Interview, health extension worker; Appendix H, p.243)

According to this extract, people are happy to learn about abstention or faithfulness, though abiding by what is taught is still questionable. When it comes to teaching about condom, however, they strongly resist it, including those in political leadership. The fact that kebele leadership, after receiving trainings on various health issues including the use of condom object to the use of condom makes the responsibility of health workers complicated and casts doubt as to the success of future intervention messages concerning condom. The interventions, in the first place, could not change the attitude of the leaders who are expected to play facilitative roles in efforts to change people’s behaviour. If the training about condom failed to influence the behaviour of those in leadership role, it would be difficult to expect that it will have an impact on the general population. We see that there is a prejudice about condom in the society which the trainings or interventions could not affect so far. Attempting to influence people’s behaviour about condom without identifying the cause of the prejudice may still not bear the desired fruit.

The fact that the married youth started to show behavioural change by admitting their promiscuity and showing care for their partners indicates that there is a change in marital discourse about concern for one’s partner on issues of promiscuity and is an encouraging sign that the intervention is taking effect. This shows that openness concerning one’s sexual behaviour and concern for one’s marriage partner started to exist. This is in contrast to the discourse of secrecy and lack of care for one’s partner that used to exist.

Based on the above data, it is difficult to say that both men and women hate condom equally. If we look at Bontu’s response, we can understand that she is speaking only from men’s point of view. She says, “*We always tell them that we are not advising them to use condom with someone else’s wife or another woman outside marriage.*” This part of the response shows that both the teachings about condom and the resistance to this teaching do not refer to women. Though condom is meant to be used by men, teachings as to why and how condom is used should not be confined to

men. Since heterosexual sex involves both men and women, both should be targeted in the teachings too. Bontu's response, nevertheless, depicts men as active partners in the sexual relation and ignores women's involvement in the act. This indicates that women are not part of the decision making as far as the issue of condom is concerned or in the sexual act itself. This focus on only one sex may delay behaviour change because as suggested by FHI/AIDSCAP (1997) HIV/AIDS interventions cannot succeed by focusing only on one sex and leaving out the other.

People's fear to speak against using condom is partially their connecting it to the government. They know that it is the government who is promoting condom and resisting what is promoted by the government is punishable. This is evident from the following excerpt taken from interview conducted with wives. In this extract, in response to the researcher's question about the function of condom and people's reaction to it, Kumeshi responds as follows.

They speak of its good sides...I also say what the government says is good, but I have not seen or used it and neither do I want to use it... I do not say it is bad for those who want to use it. I did not say it is bad for me too, but I do not want to use it. (Interview, wives; Appendix A, p. 184)

Kumeshi begins her response by mentioning what people speak about condom. She expresses that people have positive attitude concerning condom, but in the second sentence she says that '*what the government says is good*'. Following that, she says she had neither seen nor used it which shows that she is using hedging or evading directly answering the question. It is in the second part of the second sentence, where she says "neither do I want to use it," that she makes her stand clear. Even after this sentence, she begins to avoid answering the question 'why'. She says that it is not bad for those who want to use it and it is not bad for her too but she does not want to use it. She seems to be saying "do not ask me why". We can conclude from Kumeshi's response that she is trying to communicate two things. One is that one cannot resist what the government says, expressing discourse of fear. Second, even if one cannot resist what the government says, one can practically stick to one's belief, which shows people's hidden resistance. This shows that the intervention concerning the use of condom could not challenge the belief that surrounds condom. We can understand from this extract that using fear as a strategy to change behaviour can only make people device means of avoiding the source of fear, which is legal consequences, without really changing their behaviour.

Even those who support the conditional use of condom connect it to either premarital or extramarital sexual relation. Both respondents in the following extracts make such connections in their responses. When asked what people say concerning the advantage and disadvantage of condom, they responded that,

Tola: They say it is good, but I do not want to use it because I am loyal to my wife and also trust her. Those who are not loyal to one another can use it. (Interview, husbands; Appendix B, p. 200)

Dhibara: They say condom is anti pregnancy. They also say it reduces sexual pleasure. So, married people do not use condom because they want to have children. Besides, they are loyal to each other and raising the issue of condom with one's partner is suspecting oneself and also one's partner. (Interview, husbands; Appendix B, p. 204)

The two respondents in the above extract, Tola and Dhibara, share that condom is necessary in relations where there is no faithfulness. If a husband or a wife raises the issue of using condom, the other partner considers him/her as promiscuous. Since mentioning the use of condom is taken as admitting one's promiscuity or suspecting one's partner as one, couples prefer to speak against its use to show that they are loyal and trust their partner.

To Dhibara, condom is used by unmarried people but not by the married ones. This indicates that unmarried people are allowed to have multiple sexual partners, as condom according to this respondent, is a sign of unfaithfulness for the married ones. He also says that couples avoid condom because it is 'anti-pregnancy'. His use of '*anti-pregnancy*' instead of the familiar word 'birth control' itself shows Dhibara's preconceived hatred towards condom. Dhibara's use of this emotion-laden word is intentional to express his strong hatred towards condom and to create the same feeling in others. Condom is anti-pregnancy means those who use it cannot have children, which means condom stands in the way of propagation and should be hated. So associating condom use to 'anti-pregnancy' is intended to show the degree of hatred the respondent has towards the use of condom.

Tola's response also shows that he is not confident about his response or that there is fear. He is careful not to be taken as advocating against the use of condom. He begins by saying, "*they say it is good,*" and goes on to say "*but I do not want to use it because I am loyal to my wife and also trust her*". The first part, where he says 'it is good' is a disclaimer (Potter and Wetherell, 1987) and is used to show that he is not opposing the use of condom for those who want to use it. But at the same time he

states his stand that he does not want to use it because he is faithful to his partner and also he trusts her. So the meaning of the whole extract is that there are those who say condom is good. These people can use it because it is their belief. I, however, take it to be a sign of promiscuity and, hence, do not want to use it. The assumption is to avoid accountability for resisting and speaking against the use of condom if brought before the law. What can be understood from this response is that there is fear in expressing his opinion frankly due to fear of legal measures doing so may engender as condom use is promoted by the government.

The data gathered through interview also indicate that people's refraining from certain practices is connected to the fear of legal action but not changed behaviour. One such practice is circumcision. They say that this practice has been discouraged due to people's fear of legal consequence but not because they accepted its negative consequence on health as can be understood from the following extracts.

Gudeta: Do you teach what backward traditional practices are and how they are related to HIV/AIDS?

Bontu: ...Circumcision, however, though not practiced publicly, is done in secret. They take the girl to a neighbouring house or a relative far away and circumcise her there.... Courts always require evidence and no one performs such acts as circumcision in the presence of other people who would testify against them. Offenders are escaping unpunished and the practice is hidden but not stopped...We taught them that circumcising girls does not make the girls modest and sexually calm. To the contrary, it has negative effects on the girl's health. It complicates delivery and causes the death of many mothers. (Interview, health extension worker; Appendix H, p. 241)

According to this respondent, only few people have been affected by the teaching that girls should not be circumcised. It has been possible to discourse people from circumcising their daughters openly. That is, circumcision has been considered offense only from legal point of view but the popular belief underlying circumcision has not been challenged. Consequently, people try to keep their act secret because they do not want to be exposed and to suffer legal consequence that may follow.

Bontu complains that there is no evidence to bring the offenders before the law. This does not mean that no one knows the act but it shows that people are not willing to expose those who commit the offense. This reluctance on part of the people to expose the offenders shows that they did not accept it as an offense though the law regards it so. We can understand from the extract that the health extension worker, an

agent in the behaviour change, herself gives emphasis to legal actions than other means of changing behaviour. She says that offenders escape unpunished, which indicates her belief that behaviour can be changed through punishment. But the reality on the ground shows that the practice could not be stopped through threatening people with punishment. The fact that people indulge in the same practice they have been taught to give up, even when threatened with punishment if they do not give up the practice, shows that there is a problem either with the method of teaching employed or somewhere else. Although it may be justifiable to take legal action against those who persist in their refusal, trying to abolish the practice by appealing to people's intellect also should be given room. In general, the intervention brought change on legal discourse but could not affect people's view towards circumcision as expected.

Dhaba, as is clear from the following extract, tactfully suggests that it is difficult to ban circumcision through legal action.

The old belief concerning circumcision was that girls, if not circumcised, would be sexy and immodest. But now, this belief has been challenged and people have given up circumcision though unwillingly. I think that we have to wait and see whether what health workers say or what was publicly believed is true. Let those girls who have not been circumcised grow up and let us see if they really acted modestly or not. If they act modestly, it is a proof that not to be circumcised does not make girls act immodestly. But if they acted immodestly and are sexy, I think the traditional belief is right and we have to continue with circumcising our girls. (FGD, husbands; Appendix B, p. 222)

He says that it is impossible to say that either the new idea or the old traditional belief is right, time has to prove that. This again shows that the idea of whether circumcision has to be stopped or not has to be suspended. Rather than directly opposing the idea that circumcision should be banned, Dhaba says 'let us wait and see' and tries to put off the issue. Dhaba here wants to insinuate that it is not appropriate to punish people for something that has not been proved. His response also indicates that it does not matter if people continue to circumcise their daughters since those who remained uncircumcised are enough for making comparison. Whether circumcision decreases a woman's degree of sexuality or not, what Dhaba has not taken into account is that, circumcision is a crime committed against the right of the girl circumcised. It is a means of controlling females' sexuality by violating their birthright and exposing them to infection by the deadly virus, severe pain during and after the operation and eventually, to death.

Dhaba in this extract uses intertextuality to compare the view about circumcision from traditional point of view on the one hand, and from interventionists' point of view, on the other. Though he does not want to show that he supports one of the two stands, it is clear from what he says that he supports the traditional practice. He says that people were forced to stop the practice. He uses procrastination as a technique to reject the teaching about circumcision. Dhaba uses this technique as an intermediary between accepting and rejecting the issue of circumcision. This is because he did not believe what the health workers say about circumcision. Again, he could not say 'no' to what they say because that would have undesirable legal consequences. So procrastination is what he devised as a safe option between these opposing views. He is saying 'do not blame those who circumcise their daughters. Take time and see if what you are saying or what they believe to be true is right'. Though he could not say that because of the legal consequence, Dhaba is saying that the use of force against those who circumcise their daughters is unreasonable. To make it reasonable, wait and see the result on those who are not circumcised.

There are also respondents who connect the old belief concerning circumcision to cultural preservation while connecting the new idea to cultural invasion and negative health consequences as communicated through the following excerpt.

Dureso: ... There is something worse in how they circumcise the girls nowadays. Previously, girls were circumcised at 14 or 15 years of age. Delaying the circumcision up to this age had its own reason. That is, if the girl had sexual intercourse before she was circumcised, the woman who performed the circumcision would know that the girl was not virgin and sometimes refused to circumcise 'a woman' [a girl without virginity]... The girl at that time avoided any sexual intercourse at least before she was circumcised. This is one advantage of circumcision as it was practiced previously. But nowadays people know that circumcision is an illegal act. To avoid legal action, people started to circumcise girls at an earlier age-two or three years. ... Imagine the agony these girls have to undergo at such an early age. (FGD, husbands; Appendix B, p. 222)

Dureso compares the old and the new practices of circumcision. He says that circumcision, as it was practiced according to traditional belief, was intended to preserve culture by keeping chastity of the girls. Girls were expected to be

circumcised at the age of 14 or 15. The reason behind delaying circumcision was to force the girls to delay sexual debut. If the girls had had sex before their circumcision, the circumcising woman would know and expose this, in which case the girl would be condemned for defaming her family. Thus, the society was using circumcision to control the sexuality of its female members both before and after marriage, a fact that has been confirmed by research (Henrion, 2003). It is used to control sexuality before marriage in that girls are condemned and punished if it was found that they had sex before circumcision. Thus, girls were forced to prove their chastity to escape the condemnation and punishment. And again, the main reason behind the circumcision of women was to minimize the degree of sexuality and make them act modestly after marriage.

Dureso places on girls the responsibility of preserving culture. He says that *'the girl at that time avoided any sexual intercourse at least before she was circumcised'*. Here, it is the girl who has to avoid sexual intercourse to escape the social condemnation and physical punishment that would follow. She had to resist her own internal emotion as a human being. She has also to resist moves made by men as an external pressure. Men, on the other hand, are free from fear to begin sex at any time for, in the first place, there is no way of knowing whether they have sex or not. Here, we see that nature is used as a basis upon which gendered attitudes have been founded.

In Dureso's opinion, attempting to stop circumcision has had more severe effects on the girls than allowing circumcision. As a result of the ban placed on circumcision by the government, parents began to circumcise their daughters at an earlier age than it was before. Consequently, the girls were forced to bear the pain of the wound before they mature for such pain. The consequence of banning circumcision, therefore, is much worse than allowing it. This is because the girls have to bear the burden of circumcision on their sexual and reproductive lives just as it was before. In addition to this, they are made to suffer the pain before they are mature enough for the pain. Here we see that there are two discourses on the issue of circumcision: a discourse in which circumcision is legal and acceptable and a discourse in which circumcision is considered as an illegal practice. Generally, the excerpt indicates that women are victims in the old discourse that allowed circumcision as well as in the new one that outlawed the practice.

Dureso's narration about the negative consequence of circumcision may have one of two motives. It may be out of sympathy for the girls. He might have been moved by the suffering of the girls. It may also have a hidden agenda that since banning circumcision resulted in such catastrophic effect on girls, reinstating it has to be considered to stop the suffering of the girls. This second motive is an indirect way of saying 'no' to the intervention without facing legal measures opposing the intervention may cause.

Both the interview and focus group discussion data contain information about respondents' knowledge concerning how HIV/AIDS is transmitted. They connect transmission of the virus to sexual behaviour and the use of sharp instruments as expressed in their responses to the question 'How is HIV transmitted?'

Dilale: It can also be transmitted if a husband lives [has sex] with a woman that has the virus. He will contract the virus from the woman and transmit it to his wife. (FGD, wives; Appendix C, p. 210)

Tola: We have to avoid sharing sharp objects with those we suspect. We have to give up sexual relation outside our marriage. I did not have any concept of HIV before health extension workers gave us training at kebele. (Interview, husbands; Appendix B, p. 200)

We can see from this excerpt that the respondents connect HIV transmission to either sexual contact or the use of sharp instruments. Thus, we can say that they are aware that HIV/AIDS can be transmitted through sexual contact and contaminated blood. Tola, nevertheless, says that one has to mind his/her contact with those he/she suspects of having the virus. This means that we can avoid HIV/AIDS by avoiding sexual contact and sharing instruments with those people whom we suspect of having the virus. The fact that this respondent has come to know how the disease is transmitted is in fact encouraging and is one possible sign of the success of the intervention. Nevertheless, there are misconceptions in the preventive ways he proposed. In Tola's opinion, preventive care has to be taken only in relations with those suspected of having the virus. That means there is a misconception of thinking that a person's serostatus can be known through personal judgment. Such a notion leads to avoiding only those people whom one suspects and engaging in risky behaviour with those one believes to be free from the virus and hence increases vulnerability. FHI/AIDSCAP (1997) says that people who have the awareness about HIV transmission may still lack knowledge that the virus can be transmitted through asymptomatic individuals.

In the above extract, Dilale makes use of discourse of blame by connecting promiscuity to males. She says, “It can also be transmitted if a husband lives [has sex] with a woman that has the virus.” She indicates through this response that men usually have extramarital relation, contract the virus and infect their wives.

4.2 Analysis of Data Gathered from Documents

The major focus of document analysis in this study was to find out how the target audiences were represented in the intervention material. It also focused on what the assumptions were behind these representations. The first step in document analysis, say Kalof, Dan and Dietz (2008) and Ezzy (2002), is identifying the sampling unit and then deciding what to analyse out of the sampling unit. Hence, out of the BCC materials available at the target district health office, Social Mobilization for Prevention and Control of HIV/AIDS: Community Conversation Training Manual (HAPCO, MOH 2007b) was identified as a sampling unit (?) using availability sampling. This was because this manual was used for both teaching from and reporting HIV/AIDS-related activities in the district.

After thus selecting the material to analyse, the next step was to select issues that focus on representation of audiences. Thus, contents of the material relating to audience representation were highlighted using deductive analysis (Neuman, 2007). Though not all the contents of the selected material could be categorised under this topic, the researcher focused only on this issue as the selection was dictated by the research questions.

In analysing the selected texts, the whole context in which the extracts were used was taken into consideration as meaning is affected by context. To guide the analysis, Gee’s theoretical tools were used. These tools were situated meaning, social language, intertextuality, figured worlds (discourse models) and big ‘D’ Discourse tools. These tools were selected because they enable the researcher to see what discourses are operating and what assumptions there are behind the representations.

4.2.1 Representation of the audiences and assumption behind the representation

In this section, contents of the material that are related to representation are discussed. The discussion will be supported by excerpts taken out of the material selected for analysis- community conversation training manual. Both representation and assumption are discussed together since attempting to treat them separately results in repeating the same snippet.

One of the activities presented in the training manual is an activity where members of the conversation session are requested to formulate rules and show them through pictures. This activity has been presented as follows.

Discuss and agree on the importance of mutual respect, approach and behaviours that should exist among members during the workshop.

Ask groups to explain the ground rules in picture form. For example, the rule 'No smoking in the meeting room!' could be shown by putting 'X' on a cigarette picture.

Form a group comprising 4 to 5 members.

Distribute papers and markers to each group.

Ask each group to present their picture to the larger group and also ask them to explain the rules they would like to be adhered to. (Appendix 'J', p. 256)

This extract contains intertextually because the rules are prepared by different groups and then brought together and discussed. The instruction demands the participants to explain the rules in picture form. It also instructs the facilitator to distribute paper and markers to each group. We can assume from this that the participants of the session are all educated people. The setting in which this material was in use, however, was a rural area which makes it difficult to accept that all participants are educated. This can be seen from the respondents' background given on page 66. This material may be functional only in cases where those who can read and write are selected. To accept that again, the material has to say something regarding the composition of the members of the session. Even if the material stated that only educated people would be members of the conversation session, that would be leaving out those who are not educated. The assumption during the design of the material seems that the activity was meant for educated people, as uneducated people cannot draw pictures. The actual participants of the community conversation, however, are mostly uneducated people, which shows that there is a discrepancy between what the designers assumed and the actual people who use the material.

The material also presents population groups for whom the material was intended. In the following extract, it says that the general public and the youth in school have been focused as target audiences.

In order to strengthen the country's coordinated multi-sectoral anti HIV/AIDS response, preparation of different policies, programs, guidelines

and plans are in progress; and Social Mobilization Implementation Manual is one of them. This implementation manual is developed based on the previously prepared Social Mobilization Intensifying Strategic document. The main programs included in this manual are the community conversations in the general population as well as youths in schools. (Appendix 'J' p. 252)

This extract was taken from the introduction to the manual. In this extract, there is intertextuality since it tries to deal with issues of the general population on one hand and that of youths in schools on the other. The assumption from the point of view of this particular statement is that the material addresses these two population groups. Nevertheless, examination of the whole material indicates that the contents are all about the general public and, the youth either in or out of school have not been considered. One can generalize from the way activities are represented here that the youth in school would be given certain portion in the contents though this is not the case in the contents. How activities were represented in this part and how they were presented in the body of the material do not match. What the introduction says the material would do has not been materialised in the design of the activities. Hence, we can say that presentation of the activities in the material was not governed by how the activities are represented in the introduction because school youths have not been considered as mentioned in the introduction.

The community conversation manual also deals with activity where it instructs facilitators how they have to document points raised on discussion sessions.

Facilitators will...[r]ecord lessons learned and weak points mentioned in order to build on and expand experiences that worked well and improve those that did not work well, after facilitating conditions for the group to reach an agreement. Finally, they will distribute the documents to the concerned bodies, discuss the information on different forums and collect responses thereof. (Appendix 'J' p. 277)

The producers of the material used intertextuality in this section. They tried to connect the past with the present or the future. It says that the purpose of the recording and documentation is to expand the experience that worked well and to improve what did not work well. This document will finally be distributed to concerned bodies, discussed on different forums and responses collected. The

assumption here is that these concerned bodies are known. Nevertheless, the material does not give any clue as to who these concerned bodies are. So it is difficult to implement this part of the material without knowing who 'bodies' refers to.

Wrap-up activities are also among activities presented in the manual. The manual says that points covered in a session would be presented by representatives selected from the participants as can be seen from the following extract.

- *Tell the group to nominate one or two participants to wrap-up the daily discussion points.*
- *The selected reporters will organize their notes and sequentially summarize the activities and ideas discussed during the day.*
- *The same individual(s) will present the wrap-up, in fifteen minutes at most at the beginning of the next session. ..*
- *Convey resolutions of the discussion to administrators, partners, stakeholders, pastoralists, farmers and other members when they get together. (Appendix 'J' p. 275)*

This part of the material instructs the facilitators on how to guide participants to wrap-up activities and ideas discussed during a day. The participants of the discussion are represented to be educated. This is because the instruction says that reporters have to be nominated from the participants themselves. It also says that these reporters have to wrap-up the points in fifteen minutes. It can be judged from this that the reporters must have at least secondary education so as to be able to wrap-up in just 15 minutes what was done in a day. This makes the material beyond the capacity of rural population because it is unlikely to find such educated people in smaller groups in the kebeles.

The other problem is the problem to identify different organs to whom the report is due to be conveyed. The manual states that the facilitator has to convey the resolutions to administrators, partners, stakeholders, pastoralists, farmers and other members. One important question here is that, is this material meant for only these groups of people who have been mentioned here? If that is the case, what about other sections of the society who have not been mentioned here? Again, who are the partners and the stakeholders? Who are the administrators? Are they local, district, zonal or regional administrators? Do they all live in one kebele, for example, pastoralists and farmers? The instruction also says that the resolution has to be conveyed when these different groups of people get together. This also raises the

question of time. When do these people get together and where? We see that there is a problem with the representation of the people to whom the resolution is to be conveyed. Without knowing who these people are, the facilitator may not be able to discharge what is expected of him/her.

In the activities, we also see that a new discourse is emerging concerning the involvement of the society in intervention endeavours. The following extract says that community conversation attempts to encourage the community to take part in the prevention and control of HIV/AIDS.

From the perspective of HIV/AIDS response, community conversation is a process in which the community uses the material wealth, social knowledge and positive norms to prevent and control HIV/AIDS epidemics, and curb the social crises imposed as a result of the epidemic. It also encourages the community to use the available health and related services and build sustainable capacity to manage the social challenges as the owner of the problem. (Appendix 'J' p. 252)

The community here is called upon to actively participate in prevention and control efforts using its material wealth, social knowledge and positive norms. The community is not only expected to contribute to the ongoing struggle to contain the epidemic. It is also encouraged to use the available health and related services and also to build sustainable capacity. The community is expected take part in these activities as an owner. The community, in relation to this particular issue, has been represented as a responsible entity to participate in the activities, get the services and manage the prevention process.

Mapping their local areas is among activities participants of community conversation have to accomplish. It is stated in the material that maps drawn by the participants would be used to identify certain locations and community concerns.

Assessment and Mapping

Objectives

Describe that mapping is used to identify community concerns.

Help participants map their own surroundings.

Use strategic questions to draw out community concerns using the map.

Emphasize that mapping is a tool that can be used throughout the process to identify and explore community concerns and make decisions...

Explain how mapping is carried out, and tell community members to select areas where they can exercise mapping. Individual members of the community should contribute their share in the mapping process. Location of schools, business areas, residential houses and other detailed places should be included in the map...

Facilitators should use the maps to ask strategic questions to find out concerns of the community. (Appendix 'J' p. 262)

It is stated that maps would be drawn by community members and should include locations of schools, business areas, residence areas and other places in detail. The objectives part also says that the facilitators should help participants to draw maps of their own surroundings. One can conclude from the representation of the participants in this section that they are educated and have the know-how of drawing maps or even there are grounds to consider them as experts. This is because the instruction says that they have to show on the maps locations of schools, residential and business areas and so forth. When we look at how participants are represented in this particular section, we can say that this material was prepared to be used by experts at higher level but was mistakenly sent to rural areas. The assumption behind the preparation of this material, therefore, is to train experts for preparing maps to be used at either regional or zonal level.

There is also another reason that leads us to assume the material was prepared for use by educated people. The format of activity report forms used in the manual indicate that the material is to be used at local or kebele level. There is a clue that the conversation sessions are conducted even at sub kebele levels. If this is the case, one would question the importance of using maps to locate schools, business or residence areas that are located within sub kebele. For one thing, there cannot be more than one school in a given farmers association and there are hardly any areas designated for business purposes. This makes the very importance of drawing maps questionable if the said maps are needed for locating these institutions. The representation of participants as well as the activities in this case makes one doubt that the material is prepared to be used in rural areas.

The issue of mobilizing the community to collect and use social assets for fighting HIV/AIDS is another area where the material encourages participatory approach.

1. *Enable participants to identify the social assets in their communities*
 2. *Assist participants to collect, coordinate and control social asset in the community to fight the spread of HIV/AIDS and associated impacts. (p. 24)*
- Involving all community members in the implementation process develops a sense of concern and ensures success and sustainability. Furthermore, the kebele administration, cultural and religious leaders and other members of the community have a broad role to play in coordinating and advocating the decision to be more acceptable if they attended the kebele conferences and other meetings. (Appendix 'J', p. 270)*

This extract encourages the community's involvement in the fight against the virus through the existing social assets such as societal, cultural makeup and communal relationships, customs and community based organization shared by the society. In this activity, the community has been represented as taking active role in collecting, coordinating and controlling social assets for the purpose of combating HIV/AIDS. There are also other players on the scene in relation to the use of social assets. These actors are kebele administration, cultural and religious leaders and other members of the community. These actors, however, can play decisive role only if they attended kebele conferences, as stated in the manual. The actors include other members of the community not clearly known. The condition these actors have to meet is attending kebele conferences but to which conferences reference is being made is again vague. Though the community's role is clearly stated in this section of the manual, the fact that the role of other participants is expressed conditionally makes the implementation questionable. It says that these participants, kebele administration, cultural and religious leaders and other members of the community, can play their share only if they attended the kebele conferences and other meetings. A couple of questions can be raised here. How are these conferences and meetings related to community conversation? If it is believed that these persons can contribute to the conversation, why were they not included in the conversation and why was it put just conditionally? We can understand from this excerpt that the manual did not clearly state the identity and the role of the participants.

The training material also calls upon community members to reflect upon their own behaviours. They are also requested to think of their own behaviour relating it to HIV/AIDS. This can be understood from the following extract.

Inform participants to make deep thoughts about HIV/AIDS individually and encourage them to reflect about what is expected of them.

- *What am I doing?*
- *Why am I doing this?*
- *What initiates me for transgression?*
- *Do I have any behaviour that exposes me to HIV/AIDS?*
- *Which of my behaviours/attitudes contribute to the spread of AIDS?*
- *What can I contribute with respect to anti- HIV/AIDS movement?*

(Appendix 'J' p.275)

The participants are requested to think of their own actions such as what they were doing and why they were doing that. They were also asked to think of their behaviour in relation to the spread of HIV/AIDS and what they could contribute to enhance the movement that is under way to combat the virus. Above all, they were urged to think about what initiates them to transgress. In this extract too we see an attempt to bring about participatory discourse. The people were urged not only to reflect on their behaviour but also on what they can contribute to the struggle to curb the epidemic. When we look at the representation of the participants here, we see them as individuals trying to fight transgression and asking what triggers them for transgression. This shows the writers' assumption that there is transgression in the participants concerning HIV/AIDS and healthy behaviour. The fact that the participants were requested to reflect on their own transgression shows that they know the rules but could not abide by them.

Story creation is also an activity the participants are expected to perform. The manual instructs the facilitators how to guide the participants in developing their own stories and to analyse the stories developed by participants.

- *Facilitators analyse the views of the community responses.*
- *Facilitators share the findings from their analysis with participants.*
- *Explain how to prepare, analyse and present stories.*
- *Ask participants to be in groups and practice the creation of stories, document viewpoints, respond and analyse them.*
- *Facilitators conclude the session after discussing and commenting on the report presented by each group.* (Appendix 'J', p. 265)

In this extract, participants are encouraged to create stories, document viewpoints, analyse and present stories. Participants as community members were asked to create stories that focus on concerns identified by the community about HIV/AIDS. The participants were asked not only to create stories but also to analyse the stories created by other participants. The assumption behind this activity was that the participants were educated and could analyse stories and report what has been analysed. This again shows that there is a mismatch between the type of participants for whom the material is being used and the type of participants the producers of the material had in mind when preparing it. That is, this material was in use to guide community conversation sessions and for reporting the activities accomplished concerning the training in rural areas. The content, however, is far beyond the capability of the people living in rural areas. Therefore, the representation of audiences in this particular instance did not take into consideration the abilities of the people for which the material was in use.

The following extract was also about story creation but presented for discussion.

Story Creation

Abebe Kebede and Masresha Tesema are couples residing in Addis Ababa. They are faithful and love each other, and also exemplary to others. They have two children and Masresha is 3 months pregnant. Her husband Abebe is an engineer and works for a private company. Due to the nature of his work, he frequently travels out of Addis Ababa. Masresha is a civil servant working as a secretary in one of the government agencies.

As usual, Abebe went to Bahir Dar for a two-week mission. He has planned to make his return trip next day and wanted to watch television news in the hotel bar. He started drinking beer and continued taking more while watching the television programs and it happened that he passed the night with one of the bar ladies. The next morning he realized that he had sex with a young lady without condom and was highly depressed.

As he noticed that return to Addis Ababa is approaching, he picked his luggage, went to the airport and checked in. In the mean time, he started recalling the events of the night, which were unique and unusual practices of his life. The situation bothered him so much and he started thinking by asking himself the following questions:

- *The situation might have exposed me to HIV/AIDS.*
- *What am I supposed to do?*
- *How can I inform my beloved wife?*
- *Can the situation create problems in my relationship with my partner and beloved family?*
- *Whom should I first inform about the situation?* (Appendix 'J' p. 266)

This is a story about a faithful husband who happened to have unprotected sexual relation with a bar lady while under the influence of alcohol. This was not the first time that he journeyed to another place. But it was the first time that he has had risky sexual relation. As a result, we see this person disturbed and asking himself many questions about the possible negative outcomes of his behaviour. He is raising questions about the impact of his act on his health and his relation with his beloved partner and family.

When we come to the characters and to the content of the story, it is about a man from the town, educated and on business journey to another town. This person was relaxing, taking beer when he was intoxicated and eventually tempted into having unprotected sexual relation with a bar lady. The story started in Addis and the event in the story took place in Bahir Dar which shows it totally focused on urban areas. The characters are from urban areas and the setting is also urban area. This would be reasonable if this material was meant for use in urban areas. But this material was in use in rural area where the research was conducted. If it was to be used in rural areas, attempts should have been made to include as many settings and characters from the rural areas too. It would have been possible to mix the characters as well as the settings. The story, as it is now, therefore, is not representative of the areas the material was intended for.

The manual also includes how the facilitators can deal with the participants. As can be understood from the following extract, it guides the facilitators on how they can question and elicit responses from the participants.

Prepare question that can provoke discussion

Example

- *Talking about HIV/AIDS and the idea of using of condoms in faith-based organizations should be encouraged.* (Appendix 'J', p. 280)

This statement is given as an example of discussion-provoking statements to be raised by the facilitators under the topic ‘facilitators’ skill and behaviour’. The statement has been constructed using the tool of intertextuality. It contains two different discourses- the health discourse and religious discourse. It recommends the idea of members of health discourse talking about the use of condoms in religious discourse. It was believed that this question would provoke discussion and discussion and exchange of ideas would pave the way for mutual understanding and change of attitude. Intertextuality has been used here to show the existing conflict between the two discourses concerning the use of condom: health discourse promoting the use of condom and religious discourse, strongly condemning this.

The assumption behind this statement is that there is a problem talking about condoms in religious organizations. The material attempts to resolve this problem through community conversation. It intends to bring out opposing views about the issue and create understanding through dialogue.

The issue of stigma and discrimination against those living with the virus is one of the concerns of the community conversation materials. The following extract deals with this topic.

Stigma and discrimination of people living with HIV/AIDS among the community shall be minimized. (Appendix ‘J’, p.254)

This statement presents one of the expected outcomes of community conversation. It acknowledges that there existed discourse of blame among the society which can be minimized through community involvement. There is an assumption that those who are supposedly free from the virus discriminate and stigmatise those living with the virus. There is also the assumption that this can only be resolved through time and aims at minimizing it.

Knowledge about HIV/AIDS, its transmission routes and preventive methods an issue focused in the manual. The manual presents this issue for discussion by the participants as given in the following extract.

Group discussion Questions

- 1. What are HIV and AIDS?*
- 2. What are the ways of HIV transmission?*
- 3. What are the methods of HIV Prevention?*
- 4. Explain HIV stages.*

5. *How do sexually transmitted diseases transmit? Explain their nature of manifestation.*
6. *Discuss the relationship of HIV/AIDS and other sexually transmitted diseases.* (Appendix 'J', p. 258)

In this extract, the writers make use of social language that is dominated by health discourse. This is realized through the use of such words as transmission, prevention, diseases, linkage, etc. This extract is based on two assumptions concerning the identity of the participants and activities they are expected to perform. Concerning their identities, the participants are taken to have some knowledge about the issues presented for discussion- transmission and prevention of HIV/AIDS. This can be understood from how the discussion questions have been presented. They have been presented in such a way that the persons being questioned have some knowledge about what is being asked. So we can say that the participants in the conversation are people who have some knowledge about HIV/AIDS.

Concerning the activities the participants are expected to perform, there is also an assumption that, though the participants have some rudimentary knowledge about the virus, there is a gap that has to be filled through refreshing the memories of the participants and providing additional information. That is not only an assumption since the material clearly states that the issue of “comprehensive knowledge and skill development programs were conducted regarding HIV/AIDS. However, there is still a gap to be filled and it is this gap that community conversation is expected to fill by equipping the participants with basic knowledge and skills about the epidemic”. (Appendix 'J', p.314) There is an acknowledgement about two important issues here. One is that the people have already been introduced to the concepts of HIV/AIDS but there is still a gap to fill. The other is that effective way to fill the gap is equipping the community with the necessary knowledge and skill.

Socio-cultural factors that contribute to the spread of the epidemic are among major issues focused by the community conversation manual. It presents the conditions where socio-cultural factors can increase or mitigate the spread of the virus. It presents these two conditions with the help of metaphor.

The socio cultural dynamics that cause the rapid spread of the epidemic are called “arid grassland”. If you strike a match and lit it in dry grasses, the fire will spread quickly. On the other hand, there are also factors within community cultures that mitigate the spread of HIV/AIDS and minimize the

impact. These factors are referred to as “green grassland”. (Appendix ‘J’ p. 260)

There is also another use of social language in the manual- the language of geographers. There are two concepts used to express cultural practices that either contribute to the rapid spread of the virus or that mitigate its spread. Those practices which contribute to the rapid spread of the epidemic are referred to metaphorically as ‘arid grassland’. Here, arid land is a land that does not have sufficient rainfall to support trees or plants. The practices that are likened to arid grassland in relation to the spread of HIV/AIDS are those which do not support the spread of the virus. These are practices like male circumcision, faithfulness to one’s partner, etc. ‘Green grassland’, on the other hand, refers to land that supports the growth of trees or plants, indicating practices which support the transmission of the virus. These practices are practices such as female genital mutilation, risky sexual relations, etc.

There are many issues that cast doubt as to whether this manual was meant for rural areas. Under different topics in the manual, participants are presented as coming from different geographical areas or as not knowing one another. In the following extract, participants are presented as coming from different geographical areas.

The facilitators will tell participants to get into pairs with the person whom they do not know and ask them to introduce themselves to each other:

o Name

o Community of origin

o Favourite hobbies

o Strengths/what they most like about themselves

o Name by which one wishes to be called

After sharing this information, each person presents his/her partner using the information collected during the discussion. At community level introduction will take place on the stage. (Appendix ‘J’, p. 255)

There is an implied intertextuality in this text. This is because the participants have to quote their friends when introducing one another saying ‘He says that his name is...’ or ‘She says that her name is...’ The activity of introducing oneself to friends presupposes that the participants do not know one another before the session. This contradicts what the activity report forms in the manual indicate. The report forms indicate that the material is to be used at kebele or sub-kebele level. Since

people living in a kebele are acquaintances, it is not clear why it is necessary to introduce the participants to one another. This is also an indication that this manual was prepared to be used in other settings but is being used for guiding community conversation at kebele levels in rural areas.

We have seen that participatory Discourse or involvement of the community in the prevention endeavour is one of the focus areas of the manual. This participation is not restricted to different members of the community. Different government organs are also included in the process of fighting HIV/AIDS. As can be understood from the following extract, government workers working in different sectors in the kebele and religious leaders are included in discussion about the epidemic.

Talk to and discuss with kebele agriculture extension workers, teachers, and religious leaders, prominent figures of the community as an individual and in a group. (Appendix 'J' p.277)

This instruction is given to the facilitator of community conversation under the topic of collecting baseline data for documentation. The material urges the facilitators to talk to government workers serving in the kebele. Though the issue of including different sectors and individuals is strong side of the manual, there are issues that are unclear and affect the implementation of the manual. That is, the material lacks clarity as to clearly stating who should be the facilitators. The facilitator role in the following extract, for example, is stated using 'if', which makes responsibility very vague.

If the discussion is to be carried out by health extension workers, unaddressed issues have to be addressed and the information has to be included. (Appendix 'J', p. 277)

As can be clear from this extract, the issue of who should carry out the discussion is unclear. It seems that health extension workers are the most likely people to carry out the discussion. But still, the manual says '*If the discussion is to be carried out by health extension worker... '.* The problem here is that, in the first place, who is expected to carry out the discussion if it is not done by health extension workers? The other question is if the said discussion is carried out by someone else other than the health extension worker, what will be done to the unaddressed issues? Still another question is what is the framework to know these unaddressed issues? So what has to be done and who should do that is not clear in this section of the material.

There is also another problem related to activity and responsibility issue as can be clear from the following extract.

Note: If the information is going to be collected by facilitators with the help of health extension workers, then the document need to be kept in the kebele.

(Appendix 'J' p. 277)

Here also, what is to be done and who should do that is stated vaguely. It simply says '*If the information is going to be collected by facilitators with the help of health extension workers,...*'. Who is the other person going to collect the information if the facilitator does not do that? What will happen if the health extension workers do not assist the facilitator? Where will the document be kept if the information is not collected by the facilitator? These extracts indicate that the role and the identity of the facilitator are vague and this vagueness can result in confusion as to who is concerned with the training. This does not result in confusing the facilitators only, it also confuses the higher governing bodies to follow the conversation activities and assign accountability.

The following text is taken from part of the manual that focuses on documentation of community conversation. Before proceeding to the methodology to be followed in documenting the conversation, the manual presents the objective of the documentation as follows.

Objectives

- *To enable the participants agree on the definition of documentation.*
- *To discuss different means of documentation with facilitators and the community.*
- *To be well aware the benefits of documentation in community capacity building.* (Appendix 'J', p.333)

Questions for Discussion

- *Ask participants to write the replies for questions on a flip chart*
- *Why do we need to document community conversation process?*
- *Where shall we place the documents?*
- *Who should be in custody [charge]?*
- *Who are the users?*
- *What means can we use to document? (Mapping, current events, video and audio system and photographs)* (Appendix 'J', p. 277)

As can be seen from these objectives, the issue under consideration is not the documentation of community conversation materials, but that of documentation in general. This is because the first objective is about the definition of documentation. The second one is about different means of documentation. And the last one is about benefits of documentation. It seems that this part is prepared to enlighten the participants about documentation in general without reference to what to document. As opposed to this, questions presented for discussion on the same topic indicate that the discussion is not about documentation in general but about documenting community conversation materials. Therefore, there is a mismatch between the objective and the content of the section on documentation. The objective does not reflect the process and the content means, the activity is done without the knowledge of specific purposes to be attained.

In this extract, there is a participatory discourse at play. The material calls upon the community to take part in the documentation and preservation of community conversation. The material requests the participants to take part in deciding where to keep the documents, who should be in charge, who should be the users and the best means of documenting the community conversation. When judged from this section of the material, the participants are represented as experts with the necessary knowledge of documentation. The alternatives presented as means of documenting the community conversation were mapping, videos, audios and photographs upon which the participants are requested to decide. Since it is difficult to find experts with such knowledge in farmers association given the current technological status, it might be hard to believe that this material was developed for rural areas. It might be the case that a material that was developed for training the trainers was used to guide the community conversation.

Gender discourse has been one of the major issues focused by the community conversation training manual. The manual in its main objectives states that:

Cognizant of the fact that social, economic and cultural suppressions have highly exposed women to HIV/AIDS, they should be encouraged to fully participate and contribute to community conversation along with men (Appendix 'J' p. 254)

According to this objective, women have been exposed to infection by the virus more than men due to socio-economic and cultural reasons. To do away with

this imbalance, it is suggested that women '*should be encouraged to fully participate and contribute to the community conversation along with men*'. The reason behind including this discourse is to at least minimize socio-economic and cultural suppression that exposed women to HIV/AIDS. In other words, it is to minimize gender vulnerability. The statement of the objective, however, is gendered by itself. It gives women a second position in their contribution to the community conversation. This phrase indicates that men take the lead while women have to work in company with them. It reverses the position because women should play the leading role and men accompany them in issues that concern women. Men have to take the lead on socio-economic and cultural issues that are intended to empower women means women are still in secondary position in emancipating themselves. Though it is true that women cannot effect change on gendered issues without the participation of men, putting men in the driver's seat and placing women in a back seat position is prolonging the existing patriarchal system. Women, in this objective, are represented as lacking the capacity to take for themselves issues that concern them and waiting for guidance from men.

The use of language in addressing issues related to HIV/AIDS is also one focus area of the training manual as is expressed in the following extract.

Facilitators will identify words or sayings that have negative connotations and the reasons behind. List the words agreed upon by the discussants to replace them and submit the topics discussed to the concerned bodies.
(Appendix 'J', p. 262)

This extract shows that identification of words or sayings with negative connotation and reaching agreement on what words or sayings to replace them is one of the concerns of community conversation. This is based on the assumption that there is the use of words and expressions which have negative implication. This is, of course, necessary and encouraging, since the use of such words can have impact on the relation of those interacting and on the emotions of the person addressed with these words. But there seems to be a problem of putting the cart before the horse. The material mentions nowhere the possibility of discussing attitudinal problems towards both HIV/AIDS and those living with the virus. The first step, therefore, has to be working on the attitudes that serve as sources of such words. To agree upon what words to use first and then go to the underlying attitudes is fighting the manifestations without attending to the real causes of the manifestations. It would be more fruitful if

the attitudes are dealt with first and then words or sayings that go along with the attitudes are agreed upon later.

The manual in the introduction part says that it was prepared to guide community conversation at country level.

In order to strengthen the country's coordinated multi-sectoral anti HIV/AIDS response, preparation of different policies, programs, guidelines and plans are in progress; and Social Mobilization Implementation Manual is one of them. (Appendix 'J', p. 252)

In this statement, the manual claims that it is prepared as part of strengthening anti HIV/AIDS response at country level. This material, however, is being used for governing activities and reports related to HIV/AIDS in rural areas at kebele level. That is the reason why there are discrepancies in clearly stating the roles and identities of those who take part in the activities mentioned in the manual. The same manual that was prepared to train the trainers is being used to implement the training at the grassroots level. As a result, there are ambiguities that can have potential effect on the implementation of the messages.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

The current study attempted to analyse HIV/AIDS gender vulnerability messages in rural areas and their impact on discourse of HIV/AIDS and gender vulnerability. The research employed constructivist paradigm and under this paradigm, qualitative methodology because of the nature of data gathering and analysing approaches it followed. This preference was influenced by the fact that the researcher was interested in finding the meaning respondents give to HIV/AIDS and gender vulnerability from their own perspective. Qualitative methodology was found appropriate to attain this goal. The target population of the study were spouses living in rural areas and persons who have experience working on issues of HIV/AIDS. Data were gathered from these respondents through interviews and focus group discussions, which were part of the ethnographic approach. The data gathered were analysed using discourse analysis. Document analysis was also used in addition to information gathered from respondents. The data gathered from respondents through interviews and focus group discussions were intended to answer the following research questions.

1. What is the content of the messages in relation to representation of the audiences in the messages?
2. What are the assumptions behind the representation of the audiences and presentation of the messages?
3. What is the focus given to spouses?
4. What impact did the messages have on the discourse of HIV/AIDS and gender vulnerability?
5. What are the factors associated with the power and influences of the messages in effecting change?

Based on the analyses of the data presented in the preceding chapter, conclusions are given below under the five subheadings related to the five research questions restated above.

5.1 Conclusions

In the previous section, the data gathered through interview and focus group discussion and document were analyzed. The data gathered through interview and focus group discussion were analysed from the point of view of the six selected building tasks of language. These tasks are activities, identities, connections,

relations, politics and significance. The document selected for analysis was also analysed using theoretical tools developed by Gee (2011). The following conclusions are based on insights gained from these analyses.

A. Content of the messages in relation to representation of the audiences

Analysis of the document indicated that representation of the audience in the manual did not take into account factors that are related to the objective realities of the rural areas. This was indicated in:

- a. Activities presented in the manual are far beyond the capabilities of farmers. In some cases, for example, mapping the participants' surrounding, the activities are prepared for people who have expert knowledge in mapping.
- b. Examples presented are entirely based on life experiences of urban areas.

At times, it is difficult to identify individuals or groups of people mentioned in the manual. People are mentioned as having role in the implementation of the material but specific roles they play and why and how they are involved is not clear.

Women are represented in the manual as lacking the necessary knowledge and skills to emancipate themselves and rallying behind men, taking a second position themselves.

Men are represented as promiscuous, careless, stubborn, and sabotaging against the emancipation of women. They are also represented as active in and controlling sexual act. Women, on the other hand, are represented as faithful, caring, and oppressed. They are also represented as submissive in sexual acts.

The respondents also represented women as practicing extramarital and premarital relations just because they visit health clinics to seek abortion. This is so because there is no way to confirm men's practicing the same practice because they do not become pregnant.

Health extension workers are represented as conforming to social norms and lacking the courage to confront the norm. Consequently, they failed to discharge their responsibility for fear the society might condemn them. They, for example, failed to take decisive measure to defend a partner where one partner is known to be HIV-positive.

Health extension workers are also represented as using dishonest means to make the people suspect one another and avoid risky sexual relation. They tell the people lies about HIV test result to create suspicion and foster care.

Rural people are represented as resistant to change and often relapsing into behaviour after being taught about its impact. They are also represented as strongly condemning the use of condom in marital relations.

B. Assumptions behind the representation of the audiences and presentation of the messages

The manual makes different assumptions concerning activities and participants. These assumptions are presented in detail as follows.

One of the assumptions the manual makes is that the participants are educated. This is clear from the fact that the participants are asked to prepare ground rules in picture form, to wrap up activities of one day in twenty minutes, to draw maps of their surrounding areas and to document community conversation materials. The assumption behind all these activities is that the participants are educated and can do the activities.

The manual is based on the assumption that the participants have some rudimentary knowledge about the transmission and prevention of HIV/AIDS and community conversation can help to further develop this knowledge.

The manual is also based on the assumption that there is transgression on part of the community concerning desirable behaviours to prevent HIV/AIDS and this can be corrected by involving the community to reflect on their own behaviour and seek solutions.

The other assumption is that there is stigma and discrimination against those living with the virus and the best way to minimise this is by making the community discuss the issue and seek solutions.

The manual also makes the assumption that the community will be initiated to take part in the intervention if it is involved in the planning, implementation and evaluation of the intervention programs. It is believed that this develops the community's sense of ownership and motivates them for active participation.

C. Impact of the BCC messages on the discourse of HIV/AIDS and gender vulnerability

The material failed to include groups of people it pledges in the conversation. It was stated in the objective of the manual that the conversation would focus on the general population and youths in school. The content, however, does not have issues relating to youths at all. The material, therefore, was intended to have

impact on these population groups but failed to achieve this as a result of failure to include the people.

Analyses of the data in the preceding chapter indicated that the messages have had impact on women's behaviour. They began to ask their husbands to be tested for HIV/AIDS and otherwise not to have sexual relation with him.

People started to personify and address HIV/AIDS in their language as if it were a human being. In their address they represent the virus as someone who fights back only if provoked. This shows that they came to realise that HIV/AIDS is a preventable disease and can also be contracted through one's behaviour.

The fact that married youth started to say 'I am not faithful to my partner' and accept condom from health extension workers also shows that there is a change in frankly expressing one's behaviour. This also shows a positive change in taking care of one's own life and that of one's partner.

People condemn extramarital and premarital sexual relations though there are still some people practicing them. Nevertheless, there is a decrease in the number of people engaging in the practice and these practices are condemned at least in speech. They are considered as socially undesirable acts.

People's awareness of the transmission and prevention of HIV/AIDS in general has developed though there is still a problem concerning the use of condom. There is also a gap to fill concerning the role of gender in exacerbating the spread of the virus. None of the respondents mentioned gender as a contributing factor to the spread of the virus.

The messages did not develop mutual love and concern between couples in the face of contracting the virus. Husbands are intolerant towards and blame their wives when they themselves or the wives are found to be HIV-positive. Apprehensive of this blame, wives keep it secret the result of HIV test and their plan to be tested.

D. Factors contributing to either the acceptance or rejection of the messages

There are a number of factors that contributed to the acceptance or rejection of the messages. Some of these factors are presented below.

People living with HIV/AIDS are forced to hide their serostatus as a result people's use of discriminatory words such as 'the disease of the day' to address the disease. This made those living with the virus to hide themselves. It also led to these people denying themselves the advantages they would gain from the association of persons living with HIV/AIDS.

People still condemn the use of condom especially in marital relations. The major reasons for this hatred is people's representation of condom as:

- ✓ Nuisance to sexual pleasure,
- ✓ Sign of promiscuity between couples,
- ✓ Undermining the culture by encouraging girls to begin sex at an early age and thereby exposing them to unwanted pregnancy,
- ✓ Anti pregnancy,
- ✓ Carrying the virus itself,
- ✓ A false friend that encourages a person to take up a dangerous challenge but is not there for help.

In some cases, people say that they have accepted the intended behavioural change but practically stick to the old ways. This is true of circumcision, the use of condom, extra/premarital sexual relations and empowerment of women. The major driving reason behind this cheating was the interventionists' use of fear as a strategy to make the people accept the messages. The interventionists use the government as a tool to frighten the people to accept the messages. They also believe in the use of punishment against those who failed to change their behaviour. To avoid this punishment, the people verbally accept what is taught but practically stick to the old ways.

The interventionist's use of fear as a strategy in delivering the messages has had a backfiring effect on issues such as female circumcision and empowerment of women. People circumcise their daughters at an early age before others start to suspect them they would circumcise the girls. As a result, girls are exposed to unbearable pain before they mature. The idea of empowering women also has been the cause of conflict between some husbands and wives.

The strategies used by the health workers/interventionists in delivering the messages are based on discourse of blame and difference. Men are blamed for being unfaithful, suppressing their wives and sabotaging against empowerment of women. Health extension workers are blamed for their failure to demonstrate and teaching people about condom. The people are blamed for failure to favourably respond to intervention messages and show change, and stigmatising and segregating those living with HIV/AIDS.

Health workers also followed divisive strategy in segmenting audiences for the messages. They exclude men from the messages. In some cases, they even divide

the women on access to information. The training given to women in mid 2005 (Et. C.), for example, included only those women who were in reproductive age. Women outside reproductive age were excluded from the training though reproduction route is not the only way of transmission of the virus.

As a result of divisive attitude followed by the intervention, it has been possible to reach only half of the population with messages of gender vulnerability. The messages prepared for the training given in 2005, for instance, focused on reproductive health. The participant, nevertheless, were women only as if reproduction is the responsibility of only one sex. Because of this division and lack of interest to include men, messages did not focus on couples.

The health extension workers' use of falsehood as a strategy to make people respond to intervention messages are also factors that contribute to people rejecting the messages. The people receive two opposing view about their test result from the health workers. The nurses tell people that they are free from the virus, but health extension workers tell them that not all of them are free. These conflicting results lead the people to suspect the truthfulness of or to reject the messages altogether.

Failure of couples to use appropriate expressions to initiate discussion is also a factor in working against the existence of healthy and constructive discussion to create mutual understanding and fight the virus. Couples, especially wives, use emotional expressions such as 'I do not want to have sex with you' when they want to talk to their partners about issues of unfaithfulness. Such expressions make the other partner defensive and can block the road to discussion from the outset.

5.2 Recommendations

The analyses and conclusions in the preceding sections indicated that there are gaps in the delivery of BCC messages on gendered vulnerability to HIV/AIDS. Based on the analyses and the conclusions, the following recommendations have been forwarded so that they may help in the design and delivery of BCC gender vulnerability messages in the future.

1. The interview and focus group discussion as well as the document analysis indicated that the messages are not contextualised to the objective realities of rural areas. This is, in part, as a result of using materials developed for country level intervention at kebele level. Those whom the design of HIV/AIDS BCC messages concern, therefore, have to see to it that messages are designed appropriately for different localities and audiences.

2. The document analysis, interview, and focus group discussion data show that spouses have not been targeted by BCC intervention. They are simply included in the family. But spouses are the core of the family and their behaviour can shape either negatively or positively the behaviour of the rest of the family members. So spouses should be given emphasis in the design of BCC messages in the future, for they can change the whole family if they are changed first.

3. Findings from the data gathered indicate that men have not yet developed positive attitude towards the empowerment of women and do all they can to maintain their status quo in the family and in the society. This resistance is in part a result of discourse of blame that brought about excluding men from intervention messages. This in turn resulted in ignorance of men about the impact of gender on women and on men themselves. As the findings of this study indicate, there is a use of force to make men accept the messages. Though the use of force may not be ruled out under some circumstances, attempting to convince men only through legal force without raising their awareness about gender may cause more loss than gain. It should be noted that the best way to fight ignorance is through enlightenment but not punishment. Therefore, HAPCO as well as other concerned bodies have to make sure that men are given due attention in the design of BCC messages intended to empower women and thereby mitigate the spread of the virus. It is also important to make sure that those people who are politically influential at all levels are targeted and convinced about the importance of including men in empowering women.

4. Interventionists use fear as a strategy to make the people accept their messages. The people, as an opposition to this measure, are avoiding saying 'no' directly to the interventionists but violating practically what the interventionists are promoting. This is having drastic effect on the lives of those people who were intended to benefit from the interventions. A case in point is circumcision of girls at an early age to avoid legal consequence if the circumcision was done after the girls matured. Therefore, both political leaders and interventionists have to see to it that the use of fear as a strategy is minimised and the people are persuaded to change their behaviour based on reasoning.

5. People are using discriminatory words such as ‘disease of the day’ to address HIV/AIDS. The use of such words is making those who are living with the virus ashamed and hide themselves. As a result of hiding themselves, these people are denying themselves of some benefits they could get from association of persons living with the virus. This condition also forces those living with the virus to hide themselves and continue to infect others. This, added to the fact that married people condemn the use of condom but engage in premarital and extramarital sex, will fuel the spread of the virus and increase vulnerability of spouses. Therefore, health workers have to work on convincing the people that caring for and sympathising with the patients benefits not only the patients but also the carers and the sympathisers by making the patients act in like manner.

6. Analysis of the data indicated that people use of language that shows their hatred towards the use of condom in marital relations. Advocacy concerning the use of condom, however, focuses only on the unmarried and on urban areas. Therefore, those concerned have to see to it that future interventions focus on rural areas and work on changing public attitude towards condom in marital as well as extramarital relations. Especially, it has to be stressed that all the expressions used in relation to condom are baseless. It has also to be stressed that condom is not only used for extramarital sexual relations but it is also an effective means of birth control and family planning.

7. The document analysis shows that schools have not been targeted by HIV/AIDS interventions so far. The analyses and conclusions of interview and focus group discussion also indicate that schools teach their students only what condoms are used for without teaching how they are used. It has also been indicated that students engage in risky sexual relation beginning from lower levels to universities. Therefore, interventions have to focus on schools and in addition, schools and universities have to be committed to teaching to their students both the transmission and prevention of HIV/AIDS. They have also to encourage their teachers not to conform to backward beliefs concerning student-teacher relation and to speak freely about issues of sexuality and HIV/AIDS. Particularly universities have to devise ways of raising the awareness of female students coming from different areas as to the care they have to exercise concerning sexuality and

HIV issues. This has to be encouraged not only in government-owned universities and colleges but also in private ones.

8. Health workers use falsehood to make the people abstain from risky sexual behaviour. This may be advantageous for limited time. But if repeated and the people come to realise that the workers speak untruth, it may result in people rejecting the workers' teachings. It is, therefore, advantageous to devise effective mechanism to convince the people the negative consequences of relapsing into risky behaviour after blood test rather than using falsehood as its disadvantages may outweigh its advantages.

9. It was found out that the language wives use to invite their husbands for discussion makes the latter respond rather unfavourably. This can be the result of absence of counselling couples. Therefore, health extension workers and other health workers have to see to it that couples are counselled together and especially wives are oriented on how they can convince their husbands without causing conflict.

10. Spouses are not honest to each other concerning their HIV test-results especially if the result shows positive serostatus. The data also indicated that women are victims and take the blame whenever husbands find out that they have the virus in their blood irrespective of whether it is the husband or the wife who contracted the virus first. This is one manifestation of gendered discourse in which women are treated unjustly. Interventions, therefore, have to aim at creating favourable condition for healthy communication between the couples not only concerning HIV/AIDS test results but also other issues concerning the virus and its prevention. The interventions have to especially target men so as to convince them to be tested with their wives by at the same time reasoning with them that failure to do this will have negative consequences on men themselves.

11. One of the conclusions from the data is that women do not want to attend meetings because they believe that these meetings do not bring change on their ways of life. Women do not only dislike to attend meetings but also discourage those who go to meetings. The administration and other bodies concerned, therefore, have to see to it that issues to be raised on meetings

have a meaningful relation with issues that concern the immediate lives of those attending the meetings.

12. Data from interview and focus group discussion indicated that the respondents know the transmission routes and the three preventive methods of HIV/AIDS. It was also indicated that there are still misconceptions concerning asymptomatic transmission of the virus. So HAPCO has to see to it that interventions include messages which develop people's comprehensive knowledge about the virus and follow the delivery process.

13. Respondents indicated that political leaders do not take issues of health and HIV/AIDS seriously. But it is obvious that the involvement of political leaders is decisive for the effectiveness of the messages. Implementation of the HIV BCC messages at district and kebele levels seem not to have taken this fact into account. HIV/AIDS prevention and control efforts have been left to health workers and NGOs. Therefore, HAPCO and Health Offices operating at different levels have to devise ways of ensuring involvement of all sectors in the prevention and control of the virus. It should be emphasised that designing and dispatching messages to district and kebeles does not bring the changes the messages convey. There has to be proper way of following up the implementation of the designed messages.

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APPENDICES

Appendix A- INTERVIEW Wives

Name: Kumeshi Age: 25 Education: 6 Date: 09/07/04 Site: Garadie Started: 10:40 Ended: 11:20 Archival No: Du01

1. Gudeta: Have you ever heard of HIV/AIDS?
Kumeshi: I have heard of its name.
2. Gudeta: Where and when?
Kumeshi: I heard it on kebele meetings but I do not remember the time. They taught us about the disease. How it is transmitted and how it is prevented.
3. Gudeta: For how long did they teach you?
Kumeshi: They taught us for one day.
4. Gudeta: Do you think that there is a difference between how people understood HIV before and after they were taught?
Kumeshi: Yes.
5. Gudeta: What do you think is the difference?
Kumeshi: We learned that the disease is transmitted through sharp objects such as needles and razor blades. We also learned that it is transmitted through sexual contact from males to females and vice versa.
6. Gudeta: Did this change come as a result of the training you took for a day or are there other contributing factors too?
Kumeshi: We were also given lessons at kebele at different times though it did not last full day. Trained kebele leadership members and health extension workers teach us.
7. Gudeta: Can you tell me how HIV/AIDS can be prevented?
Kumeshi: People have to be faithful to one another. If not they have to use condom.
8. Gudeta: Do you and your friends or people you know discuss HIV/AIDS whenever there is a chance to be together?
Kumeshi: Yes, we discuss.
9. Gudeta: What do you say when you discuss?
Kumeshi: We say we can protect ourselves from HIV if we are faithful to our husbands.
Gudeta: Is it only you/the wives who should be faithful? What about the husbands?
Kumeshi: No use discussing the husbands. Whatever we discuss does not change them. They themselves discuss issues related to living [having sex] with women. But what they discuss is not how to be faithful because many of them are not faithful.

10. Gudeta: If a husband or a wife suspects his or her partner of promiscuity, can they freely discuss issues of using preventive methods?
Kumeshi: Yes, they can
Gudeta: What issues do they raise in such discussions?
Kumeshi: They give up having sexual relations....
11. Gudeta: Is that the only way of resolving promiscuity problems?
Kumeshi: They have to discuss testing their blood for HIV.
12. Gudeta: Who shows interest in such discussion?
Kumeshi: Women
Gudeta: Why?
Kumeshi: The virus affects them more.
13. Gudeta: Do you mean that it does not affect men?
Kumeshi: It affects both but women do not have resistance.
14. Gudeta: If one of the two (husband or wife) lacks interest in such discussion, what type of reason does he/she offer for the lack of interest?
Kumeshi: I have said that women show interest. But husbands, to show that they do not want the discussion, either scoff at the idea when the wives raise such issue or they quarrel or beat the woman.
15. Gudeta: Do you think it is ok for husbands to beat their wives?
Kumeshi: It is not right if you go to the law. But not all women go to the law.
Gudeta: Why?
Kumeshi: Because, if you run to the law whenever you are beaten, the neighbours or local people will give you bad names. Even if you succeed before the law your social relation will be affected.
16. Gudeta: What will be the consequence if a conflict that arose as a result of promiscuity is not resolved peacefully through discussion?
Kumeshi: They will divorce.
17. Gudeta: Who do you think will be affected more, husband or wife, as a result of a divorce?
Kumeshi: The wife will suffer more.
18. Gudeta: Why not the husband?
Kumeshi: It is the wife who suffers with the children because the husband does not care for them as she does.
19. Gudeta: If elders or relatives try to resolve such conflict through arbitration, whose idea will be accepted more (husband's or wife's)?
Kumeshi: That of husband.
20. Gudeta: Why?

- Kumeshi: A woman's case is often unacceptable.
21. Gudeta: Is it because they are not mistreated or it is just not acceptable?
Kumeshi: They are mistreated but what they say is not acceptable because this has been the practice.
22. Gudeta: Have you and your partner been given counselling on HIV/AIDS and sexuality issues as couples?
Kumeshi: No
23. Gudeta: How do you explain the current extramarital sexual relation practice of couples in your locality? (Is it practiced?)
Kumeshi: It is still practiced.
24. Gudeta: If so who practices it more?
Kumeshi: Men practice it more because this has been handed down from generation and men could not change this practice.
25. Gudeta: Has anyone ever taught you about condom?
Kumeshi: Yes, health extension workers taught us that it prevents diseases that are transmitted when men and women talk together [have sexual relation].
26. Gudeta: What do people say concerning its function? Do they say it is good or bad?
Kumeshi: They speak of its good sides.
Gudeta: What is your reaction?
Kumeshi: I also say what the government says is good. But I have not seen or used it and neither do I want to use it.
28. Gedeta: You said it is good but you also say you do not want to use it. Do not these two views contradict each other?
Kumeshi: I do not say it is bad for those who want to use it. I did not say it is bad for me too. But I do not want to use it.
29. Gudeta : What do people say when they speak about being faithful to ones' partner?
Kumeshi: They say nothing. They accept what is taught. But they may not be faithful to their partner as taught. This I have answered above.

**Name: Chaltu I. Age: 25 Education: 2 Date: 09/08/04 Site: Garadie Started: 11:19
Ended: 11:44 Archival No: Du002**

1. Gudeta: Have you heard about HIV/AIDS?
Chaltu: I have heard; my husband and I have also been tested.
Gudeta: When and where have you heard?
Chaltu: They gathered and taught us at kebele .We also hear it from radio.
2. Gudeta: Is there any change concerning the knowledge you have of HIV/AIDS after you have got information from the kebele or your radio?
Chaltu: Yes, there is a change because those who have the virus in their blood are getting help.
Gudeta: But is there a change in how people understand or talk about HIV?
Chaltu: Yes, there is because we [my partner and I] are protecting ourselves from the disease following what we have been taught.
3. Gudeta: How do you explain the change that was brought in how people understand HIV?
Chaltu: We now understand that HIV is transmitted through sharing sharp objects and having multiple partners for sexual relation. So to protect ourselves from the disease, we do not share sharp objects and we are also faithful to each other.
4. Gudeta: Do you and your friends or people you know discuss how HIV is prevented?
Chaltu: No we hear and raise the issue on meeting summoned or arranged for this purpose.
5. Gudeta: If a husband or a wife suspects his or her partner of risky sexual behaviour, can they freely discuss how to protect themselves from the disease?
Chaltu: I only know about my husband and myself. We discuss whenever we are tested, he tells me and I tell him about the result of the blood test.
6. Gudeta: Who do you think is more interested in this kind of discussion (husband or wife)?
Chaltu: Both are interested because the virus affects both of them.
7. Gudeta: If a husband or wife loses interest in this kind of discussion, does he/she say 'no' straight forward or does he/she offer pretexts?
Chaltu: I think they should be interested since this is a matter of life.
8. Gudeta: If a conflict that started as a result of the refusal of one of the couples would not be resolved, what do you think will be the consequence?
Chaltu: They will take the case to court. The court will decide according to the existing law. The decision may be in favour of divorce.
9. Gudeta: Who will suffer more if the end result is divorce?

Chaltu: I think the wife suffers more because it is the mother who has to look after the children whether she leaves or stays in the house.

Gudeta: Why should it be mothers who look after the children?

Chaltu: Because mothers do not like to leave their children behind since the woman whom the x-husband marries may mistreat the children.

Gudeta: Does not the woman also marry another man and does not that man mistreat the children?

Chaltu: Husbands mostly do not mistreat the children unless they hate the wife. It is children begotten from previous marriage, if there are any, who hate the stepchildren. Even in such circumstances, mothers prefer to keep their children unless forced by circumstances beyond their control.

10. Gudeta: Who do you think should leave the house? Should it not be the husband since the children remain with the mother and he is by himself?

Chaltu: In towns, this may be possible since the husband and the wife may have their own employment or private work. But this is impossible here in rural area where everybody depends on land for living. This is because husbands consider it as defeat sharing what belongs to them with a woman they divorced. They also do not want to leave their home. They are not also expected to leave. So the wife has to leave though she can share the house and the land and live there from legal point of view.

11. Gudeta: Have you ever been counselled as couples on HIV and sexuality issues?

Chaltu: No they teach all the dwellers together.

12. Gudeta: How do you explain the practice of extramarital sexual relation in your locality?

Chaltu: I do not practice it myself and I do not know about other people.

13. Gudeta: Have you heard of condom? What do people say about its advantage or disadvantage?

Chaltu: I only hear that it prevents diseases. We do not know about it because we live in rural area.

Gudeta: Do you mean rural people do not know about condom or they do not use condom?

Chaltu: They do not use it.

Gudeta: Why do not they use it as far as they know of its advantage?

Chaltu: They hear it as a rumour but they do not know how to use it.

Gudeta: Even if they hear it as a rumour, how do they react to that rumour?

Chaltu: I have not heard.

14. Gudeta: What do people say in their everyday talks about being faithful to one's marriage partner?

Name: Hirpe T. **Age:** 30 **Education:** 6 **Date:** 05/06/04 **Site:** Garadee
Started: 11:40 **Ended:** 12:18 **Archival No:** DU003

1. Gudeta: Have you heard of HIV/AIDS?

Hirpe: Yes.

Gudeta: When and where did you hear it?

Hirpe: We have been taught on kebele meetings and at health centre.

Gudeta: Who gave you the teachings?

Sisaay: Health workers teach us when we are pregnant and go to health centre for check-ups. They tell us to be tested with our partners and to be faithful to our partners after knowing our serostatus.

2. Gudeta: Is there a difference between the concept people have of HIV/AIDS before and after they have been taught about the disease?

Hirpe: Now they know that the disease is transmitted through using sharp objects.

3. Gudeta: Do people abide by what they have been taught?

Hirpe: My partner and I are living according to what they taught us. Others who have been taught are also living according to what they learned. Not all people got the teaching. Only those who attended prenatal clinics and those who attended kebele meetings have understandings about the disease.

Gudeta: Are there people who do not attend kebele meetings?

Hirpe: Yes, women generally do not attend meetings.

Gudeta: Why?

Hirpe: They think that what is taught at kebele meetings does not change the state of affairs. They say that those who teach do so just to get their per diem.

4. Gudeta: Is there any difference between males and females in their degree of vulnerability to HIV/AIDS?

Hirpe: Women are vulnerable because they are hot blooded.

5. Gudeta: Do people you know /your friends discuss HIV whenever they meet?

Hirpe: No, they do not.

6. Gudeta: If a husband and a wife suspect each other of promiscuity, how do they express their suspicion?

Hirpe: Yes, the person who suspected can say, "I cannot have sex with you because you have sexual relation with somebody else." Health workers are also telling us to be tested and know our status. So where there is suspicion couples can be tested and live with mutual trust.

7. Gudeta: Of husbands and wives, who do you think is more interested in this kind of discussion?

Hirpe: Women are interested more, because husbands, if they begin extramarital relation, they tend to forget their marriage. They find the new extramarital love more enjoyable and their marriage boring. Women do not want this to happen and, to avoid this they want discussion.

Gudeta: Why are men not interested in such discussion?

Hirpe: Men cannot stop seeking extramarital sexual relation .This makes them lack confidence and avoid discussion as much as possible.

8. Gudeta: If husband or wife loses interest in this kind of discussion, does she/he reject the discussion openly or offer false reasons?

Hirpe: It is impossible to have a healthy discussion where either the wife or the husband is promiscuous.

9. Gudeta: What do you think will be the consequence if they cannot resolve their misunderstandings through discussion and prefer to go their own ways?

Hirpe: They will divorce.

Gudeta: Who will be affected more as a result of this divorce?

Hirpe: Both will be affected because they will be scattered and the property they accumulated will be divided. They will also be forced to be accustomed to new partners and new life.

10. Gudeta: Have you been counselled as couples on HIV/AIDS and related issues?

Hirpe: No, we have been counselled as general public.

11. Gudeta: Do you think that married people in your locality practice extramarital sex?

Hirpe: It is impossible to say all married people practice extramarital sex. Some are loyal where others are not. Especially most of those people who have accepted the gospel [Christians] are more loyal. In the first place, they know that having sexual relation with someone outside marriage is adultery or sin. Secondly, they understand from health lesson that having multiple sexual partners exposes one to infection by HIV. For these reasons, they refrain from having sex except with their partners. But those who do not know the gospel usually have unchecked sexual relations even if they get health education.

Gudeta: Can we say that those who have accepted the gospel are less promiscuous and those who have not accepted are more so?

Hirpe: Yes, but this does not mean that some Christians do not commit adultery. There are some who are promiscuous. What I wanted to say was that the number of Christians engaging in extramarital relation is less than that of non-Christians. There are also some non-Christians who are loyal in their sexual life. Religious and health educations have made most of the married people not to have sexual partners outside marriage. But still we cannot say all have given up the practice.

12. Gudeta: Who (husbands or wives) engage in extramarital sexual relation more?

Hirpe: I do not know about this issue.

13. Gudeta: Have you heard of condoms as a means/method of preventing HIV/AIDS?

Hirpe: No

Gudeta: Has it not been taught or...?

Hirpe: I am sure it has been taught but I might have missed it.

Gudeta: How could you have missed it?

Hirpe: I do not often attend meetings. As I told you earlier, I learned about HIV/AIDS when I went to health centre for pregnancy test. But this might have been taught at kebele and that is the reason why I missed it.

Gudeta: Does that mean you do not attend kebele meetings?

Hirpe: Yes, I am always busy and have no time. Men attend meetings and bring us the information.

Gudeta: Is it because your husband forbids you to attend meetings?

Hirpe: I do not know. He has never said to me "You do not attend meeting" but he is not happy whenever I raise the issue of attending meetings. Since I have been accustomed to this, I do not say I will go to a meeting, when there is one. If the meeting concerns only women, I may not get information as to what is said on the meeting since he cannot attend it. But if it is for men and women, my husband gets the information and shares it with me.

14. Gudeta: Even if you have not learned about condoms yourself, what do people say about it?

Hirpe: I heard about the issue from no one.

Name: Jorge W. **Age:** 26 **Education:** 9 **Date:** 04/08/'04 **Site:**
Garadie **Started:** 12:50 **Ended:** 13:15 **Arch No:** Du004

1. Gudeta: Have you heard of HIV/AIDS?

 Jorge: Yes. I heard about it at school. They start teaching about it in grade2.

2. Gudeta: Is there any difference between how you understand HIV now and how you understood HIV before you were taught about it?

 Jorge: Yes. Before learning about HIV, I only heard its name mentioned and that it was a disease for which there was no cure. But after having been taught, I came to realize that, though it cannot be cured, it can be prevented. I learned how it is transmitted and prevented.

 Gudeta: Can you tell me how it can be transmitted and also prevented?

 Jorge: It [HIV] is transmitted through sharing sharp objects such as razor blades, needles and so on that can carry blood. It can also be transmitted through having sexual contact with a person having the virus in his blood. It can be prevented by using private instruments such as needles, being faithful to one's marriage partner or using condom.

3. Gudeta: Is there a difference between men and women concerning their degree of vulnerability to the virus?

 Jorge: There is no difference.

4. Gudeta: Do you or other people you know discuss HIV and related issues?

 Jorge: I do not think they do.

5. Gudeta: If a husband and a wife suspect each other of risky sexual behavior, can they freely discuss preventive methods?

 Jorge: Yes, they can. They can discuss issues such as using condom if they do not trust each other.

6. Gudeta: Who do you think is more interested in this kind of discussion?

 Jorge: Men are interested more.

 Gudeta: Why?

 Jorge: Because men have power over women and want to impose their interests on women through this discussion.

7. Gudeta: If a husband or a wife loses interest in such discussion, does he/she directly say "I do not want to discuss" or do they create pretexts?

 Jorge: There may arise a conflict between the two as a result of lack of interest to discuss.

 Gudeta: Who do you think starts the conflict or fight?

 Jorge: The wife.

 Gudeta: Why?

Jorge: Because she does not have interest in having multiple sexual partners. And when the husband raises promiscuity issues and wants to incriminate her for what she did not do through the discussion, she may be angry and start to fight.

Gudeta: What reason do they give for their refusal to discuss?

Jorge: They look for pretexts to initiate fight. They may even demand divorce. This is because they know that husbands want the discussion to impose their own needs and interest.

8. Gudeta: What do you think will be the consequence of such refusal to discuss?

Jorge: If the conflict is not resolved through local elders, it may lead to divorce.

Gudeta: Does this divorce affect one of the couples more than the other?

Jorge: No, because they will share whatever property they possess according to the existing law.

9. Gudeta: Have you ever been counselled as couples on HIV and related issues?

Jorge: No one gave us.

10. Gudeta: How do you explain the current extramarital sexual practice of married people in your locality?

Jorge: It is still practiced.

Gudeta: Of husbands and wives who do you think engages in such practice more?

Jorge: Men practice it more.

Gudeta: Why?

Jorge: Men naturally have stronger sexual urge than women. That is why they cannot restrict themselves to a woman.

11. Gudeta: You have said that one way of preventing HIV is by using condom. Do schools or health professionals teach why and how condom is used?

Jorge: I learned only at school but not at kebele or health centre. At school, they only teach us that condom prevents HIV and pregnancy. But they do not teach us how it is used.

Gudeta: What are people's views concerning condom?

Jorge: I have not heard from anyone.

Gudeta: Can you tell me your own view?

Jorge: I think it is good in extramarital relation, such as before marriage, to prevent pregnancy and the virus.

Gudeta: What about within marriage?

Jorge: I think it is not necessary where the husband and the wife are loyal to each other. Under circumstances where they are not loyal to each other, I think they have to use condom until they are tested.

12. Gudeta: How do people react to idea of being faithful to one another so as to prevent HIV?

Jorge: Even if they are not taught, people have at least heard that sexual faithfulness is necessary to prevent the virus. In spite of this teaching, not all people are faithful to their partner's. Even if they are not faithful, they do not express this in words. This is because by speaking against marital sexual faithfulness, they expose their promiscuity which diminishes their social value.

13. Gudeta: Do you and your husband discuss and use condom?

Jorge: We can discuss but do not use it because we trust each other.

Name: Gemene A. Age: 40 Education: ---- Date: 7/09/04 Site:
Garadie Started: 3:20 Ended: 3:45 Arch No: Du005

1. Gudeta: Have you heard about HIV/AIDS?

Gemene: Yes.

Gudeta: When and where did you hear?

Gemene: My husband and I divorced in the dergue regime. I was bringing up my children as a single parent after the divorce. I did not know that I had the virus in my blood. At first, I thought that it was TB. I first suffered from severe headache and dizziness. I took different medicines but they could not help. Finally, they tested my blood at Nekemte Hospital and told me that I had the virus in my blood. I did not have any sexual contact except with my husband. I used to buy things at one market and journey to another market in a day to sell what I had bought. Often there were rashes on different parts of my body. I used to sweat a lot when I walked and I thought the rashes were a result of the sweat. I think I contracted the disease through sharing razor blades and needles with other people. I was sharing these objects. I swear in the name of God who sustained my life up to this time that I was loyal to my husband. Some say that my husband divorced me because of my promiscuity. But that is false. I was not promiscuous and I did not suspect him of promiscuity. I do not know how the virus affected me. I think it is the wrath of God.

2. Gudeta: When they knew that you had the virus in your blood what was the reaction of your children?

Gemene: My children were shocked. First, they thought I was suffering from TB. Even after I tested HIV positive, I was not given the right medication immediately. It was after the third month that I started medication. Their father had already left them. I was the only person caring for them as a father and as a mother. Losing me was equivalent to losing everything to them. So they were shocked.

3. Gudeta: Was there any stigma or discrimination from the people when they knew your status?

Gemene: No, there was none. The children were disturbed and sorry because they thought I would die.

4. Gudeta: Have you received any education on HIV/AIDS either before or after knowing your serostatus?

Gemene: Yes. After I knew that I have the virus. They told us to care for those who do not have the virus in their blood. They told us to have our own needle and razor blade. Those who are sexually active also have to use condom if they cannot abstain.

5. Gudeta: Did they tell you whether there is a difference between men and women in their vulnerability to the virus?

Gemene: They did not say there is a difference. They told us all contract the virus equally if they do not care.

6. Gudeta: Do you and those who have the virus in their blood discuss how you came to contract the virus and how you can teach other people from falling victim to the virus?

Gemene: Nowadays I do not go to market. I do not see people. I am becoming weaker and weaker. People also do not come here. Even when they call us for trainings or for some help, I go there with difficulty and for that matter, they call us once in five or six months. So my chance of seeing and discussing with people is very low.

7. Gudeta: Do you think that married people in your locality now have extramarital sexual relation?

Gemene: No one has sexual contact outside marriage. Those intending to get married must have their blood tested for HIV before marriage.

8. Gudeta: What did you learn about condoms?

Gemene: When they teach us they said 'those of you who cannot abstain and cannot restrict yourselves to one partner must use condom'. That is what I heard.

Gudeta: What is people's reaction to using condom?

Gemene: I do not know. I told you that I have not gone even to market since one year. I even do not go to river to fetch water. I do not attend kebele meetings. People also do not come and talk to me. The only people I have contact with are my children and they do not raise such issues with me.

Gudeta: Why do not you discuss issues related to HIV with your children? Does not that help them to learn from you?

Gemene: We do not discuss. I think they can learn the impact of the disease by just living with me. It does not need telling them because they are experiencing it by living with me. As to telling them about the use of condom, condom protects us from contracting the disease through sexual contact. But as I told you earlier, I did not contract the virus through sexual contact. I was loyal to my husband. I still do not know how I got it. I do not think telling them to use condom can be the solution. I will pray that God protect them.

APPENDIX B

Interview Husbands

Name: Gari A. Age: 26 Educ. _- Date: 29/06/'04

Site: Garadie Started: 13:12 Ended: 13:40 Arch No: M005

1. Gudeta: Have you heard about HIV/AIDS?

Gari: Yes.

Gudeta: Where and when?

Gari: I was working as a day labourer in Nekemte four years back. They used to come and teach us every month. They told us people do [sex] with care to protect themselves from HIV. They took our blood and told us that most of us did not have the virus. They then told us not to share sharp objects with other people even with our mothers and fathers.

Gudeta: Did they tell you any other way by which HIV can be transmitted?

Gari: They also told us it can be transmitted through sexual contact. After they told us this, the workers avoided having sexual contact with those who have the virus in their blood.

Gudeta: How did you know? Did they tell you who had the virus and who did not have?

Gari: They told us publicly and reduced those who had the virus.

Gudeta: What care were those whose blood was free from the virus taking during sexual contact?

Gari: They did not take special care after being tested. What they did was just avoid those who had the virus in their blood. Some girls even got pregnant as a result of not taking care.

2. Gudeta: Where else did you learn about HIV/AIDS?

Gari: I did not have chance to learn about the virus at any other place.

3. Gudeta: Did those who taught you about HIV tell you whether there is a difference between men and women concerning vulnerability to the virus?

Gari: They did not tell us about this. They told us we were free and had to take care thereafter. They separated those who had the virus and recommended them for financial support.

4. Gudeta: What care did they tell you to take concerning sexual transmission of the virus?

Gari: I think we have to take care of ourselves. We have to “live” [have sexual contact] with someone we trust. For example, if women go away from home and they are forced to have sex unwillingly, they have to use condom.

Gudeta: They are forced to have sex means they are doing it against their will. How can they make the person use condom under such circumstance?

Gari: They will try to convince him. If he refuses to use, what can they do? They have to pray to God to make them free since they did not do it willingly.

Gudeta: When you started to answer my question above you said “If they go away”. Does that mean women are not forced into having sex while at home?

Gari: They are forced but the condition is not the same. At home, they are forced by the people whom they know and who know them. They know whether the people have the virus or not.

Gudeta: Do you mean that people of a given area know who has and who does not have the virus?

Gari: Most of the time we hear rumours. Besides, those who have the virus often become thin and cough. So you can suspect who has the virus.

5. Gudeta: Do you and your friends discuss HIV and related issues when you come together?

Gari: We do not discuss. Only the educated ones do.

Gudeta: Whom do you mean when you say the educated ones?

Gari: I mean those who have been to school and can read and write. They get information by reading on how people of other areas lead their life.

6. Gudeta: If a husband and a wife suspect each other of risky behaviour, can they discuss freely to use preventive methods?

Gari: Yes, they can discuss. They can discuss to be tested for HIV or to use condom.

7. Gudeta: Of husbands and wives, who do you think is interested in this kind of discussion?

Gari: Men are interested more.

Gudeta: Why?

Gari: Because men think broadly than women but women, even if they know that there is a risk, may not prefer to discuss and may resort to conflict. There is a difference in their mental capacity. So men have the capacity to settle problems peacefully and can achieve what they want through discussion.

8. Gudeta: If a husband or a wife loses interest in this kind of discussion, does he/she reject the discussion directly or does he/she use a pretext?

Gari: I do not think they should lose interest. If they do, they have to divorce.

9. Gudeta: If they somehow agree to discuss, whose opinion, that of the husband or the wife, do you think dominates in the discussion?

Gari: That of husband.

Gudeta: Why?

Gari: A woman, even if she has an opinion, cannot have it well expressed. But the husband can understand the consequence of their discussion on their life and make necessary amendments considering what they both need.

10. Gudeta: Have you been counselled as a husband and a wife on how to prevent HIV/AIDS?

Gari: No

11. Gudeta: Do married people in your locality perform extramarital sexual relation?

Gari: I have not seen this kind of act in this area. Everybody is loyal to his/her partner.

12. Gudeta: Do you think couples in this locality have been given lesson on condom?

Gari: I do not know whether it has been taught or not. But I am sure from what I hear that they do not know about condom. Most of the people, including me, do not know even what it looks like.

**Name: Tola D. Age: 36 Education: _____ Date: 24/06/'04 Site: Garadie
Started: 12:00 Ended: 12:36 Archival No: M001**

1. Gudeta: Have you heard of HIV/AIDS?

Tola: Yes.

Gudeta: When and where?

Tola: Are you asking about how we can protect ourselves from the virus?

Gudeta: Okay tell me about that too.

Debel a: We have been given training on how to protect ourselves from the virus.

They told us to avoid sharing sharp objects and sexual relation.

Gudeta: Should these things be avoided altogether?

Tola: We have to avoid sharing sharp objects with those we suspect. We have to give up sexual relation outside our marriage. I did not have any concept of HIV before health extension workers gave us training at kebele.

Gudeta: Can a person contract HIV if s/he shares a room with an HIV patient?

Tola: Yes, I think he can.

2. Gudeta: Is there any difference between men and women in their degree of vulnerability to HIV/AIDS?

Tola: No one told me about this and I do not know whether there is a difference or not.

3. Gudeta: Do you and your friends or people you know discuss HIV/AIDS and related issues?

Tola: Some people I know sometimes discuss.

Gudeta: When do they discuss?

Tola: When they see someone who is thin, an HIV/AIDS patient, children orphaned by HIV or other issues related to HIV.

4. Gudeta: If either a husband suspects his wife of promiscuity or a wife suspects her husband for the same reason, can they freely discuss the possibility of using preventive methods?

Tola: My partner and I do not discuss because we fear each other.

Gudeta: She is your marriage partner why should you fear each other?

Tola: I do not want to raise with her issues related to sex and neither does she. I think this is due to our lack of education.

5. Gudeta: Of husbands and wives who do you think is more interested in such discussion?

Tola: May be it is the wife.

Gudeta: Why?

Tola: Because she wants her husband not to have affair with another lady.

Gudeta: Does this mean that husbands do not care if their wives have an affair with another man?

Tola: No, they even care more. But what I mean is men usually visit other women outside marriage. So women know this issue and want to stop that. That is why they are interested in discussing issues related to sex but they do not discuss because their husbands do not let them do so.

6. Gudeta: If one of the two loses interest in such discussions, does he/she say 'no' to the other person's request or does he/she offer pretexts?

Tola: I think he does not say 'no'. He may complain being busy whenever the matter is raised or he may quarrel for no reason. If she persists in demanding discussion, he starts a serious fight groundlessly to cover up the issue of promiscuity. If she tries to bring the case to the law or to local elders, he confuses the second issue, for which there is no ground, with the issue of his promiscuity.

7. Gudeta: If the issue is brought before the law for legal action or to local elders for reconciliation, whose opinion (husband's or wife's) do you think dominates?

Tola: The degree of bias may be lessened before the law. But still the husband's ideas are dominant. If the case is brought to elders for arbitration, the husband's ideas dominate. Even if they find out that the wife is mistreated, they do not want to say the husband is the wrong doer. They blame both the husband and the wife and say "whoever is the wrong doer, do not remember the past. Get reconciled for the sake of God and your children". They advise the husband not to do the mistake again in the absence of the lady and tell the woman that he has been advised well. But nowadays this kind of bias is being challenged because the kebele started to assign a woman as a member of any arbitration process in cases involving a husband and a wife.

8. Gudeta: If both of them become stubborn and push up to divorce, who do you think suffers more as a consequence of the divorce?

Tola: The husband suffers more because he has to add responsibility of the wife on top of his when she leaves.

9. Gudeta: Have you ever been counselled as couples on HIV/AIDS?

Tola: No.

10. Gudeta: Do you think there is extramarital sexual relation in your locality?

Tola: I do not have knowledge about such things.

11. Gudeta: Have you heard of condom?

Tola: Yes we heard it from radio though I do not know how it is used.

Gudeta: But you know what it is used for?

Tola: Yes, it is used to prevent HIV/AIDS.

Gudeta: What do people say about it?

Tola: They say it is good. But I do not want to use it because I am loyal to my wife and also trust her. Those who are not loyal to one another can use it.

Name: Dhibara O. Age: 30 Education: 8 Date: 26/07/'04
Site: Garadie Started: 14:16 Ended: 14:51 Archival No: M002

1. Gudeta: Have you heard of HIV/AIDS?

Dhibara: Yes.

Gudeta: Where and when did you hear?

Dhibara: Wherever there is public gathering such as kebele meeting, church etc. Mostly health workers give lessons at these gatherings. Though I cannot say people are implementing what they have learned, there is a considerable change. Mostly we have been taught on kebele gatherings how the disease is transmitted and prevented.

Gudeta: What changes have been observed after you have been taught?

Dhibara: Previously people only heard about HIV/AIDS talked by men who do not know and share how to protect oneself from the virus. But after the teaching, people learned that HIV is transmitted by sharing sharp objects and failure to restrict oneself to one sexual partner. So there is a change. Now we have our own needle and razor blade in our family. My wife and I are tested for HIV every three months. We are loyal to each other.

Gudeta: Was the health lesson given only at kebele by health workers or other institutions also gave health lesson at other places?

Dhibara: It was mainly given at kebele gathering. It was also given at church.

Gudeta: Was the content of the lesson given at kebele gathering and at church the same?

Dhibara: Yes, they both focused on the transmission and prevention of the disease.

2. Gudeta: According to what you have been taught, do men and women show difference in their vulnerability to HIV/AIDS?

Dhibara: Yes, women are more vulnerable and also transmit the disease more. This is because if a lady is beautiful, many people target her for sex and may succeed. At least one or some of these people may have the virus in their blood and infect the lady. This lady in turn infects the other men who have contacted her attracted by her beauty. So as a result of her beauty this lady became vulnerable to the disease and again infected those who contacted her sexually.

3. Gudeta: Do you or people you know discuss HIV/AIDS and related issues?

Dhibara: Not all but some people discuss. In their discussion they raise their own or other people's sexual experiences and how vulnerable or not they or the other people they discuss are.

Gudeta: If a husband or a wife suspects his/her partner of risky behaviour, can they freely discuss the possibility of using preventive methods?

Dhibara: They can, as far as my partner and I are concerned. If I suspect her or if she suspects me, we can discuss how we can prevent the virus. I do not know whether this is true for other people. Educated people do this but the uneducated ones do not. The uneducated ones do not discuss at all.

4. Gudeta: Who do you think is more interested in having this kind of discussion, husbands or wives?

Dhibara: Wives are more interested.

Gudeta: Why?

Dhibara: Because men often take the initiative to ask for sex. Women do not go forward and ask even if they are interested in a person. If men do not force them, women are naturally careful. So they suspect and want to warn men from possible danger through discussion.

Gudeta: Why do you think are women more careful than men in sexual matters?

Dhibara: Men are addicted to a lot of things. They drink, they chew khat and they smoke. These things initiate them for sex. But women do not do this mostly because of the responsibility they have in the family. Men mostly force women into sex when they [men] are intoxicated.

5. Gudeta: If a husband or a wife loses interest in this kind of discussion, do they directly say 'no' or do they offer false reasons?

Dhibara: It is if he does not love the woman that a husband loses interest to discuss promiscuity issues with her. In such cases, he does not express his lack of interest in words. He avoids talking to her and avoids sexual contact with her satisfying his sexual lust through extramarital relation.

6. Gudeta: What do you think will happen if the husband persists in his risky behaviour and refusal to discuss the issue?

Dhibara: If the husband refuses to change his behaviour and to discuss with his wife, she will first call two elders and raise the issue in their presence. If he says 'no' in the presence of these people or if he continues with silently punishing the woman without verbally saying 'no', she can bring the case before the law. This actually depends on the woman's strength. If she is strong enough, she may go to court. If not, she continues with her suffering.

Gudeta: Why does the woman need to be strong to go to court?

Dhibara: First, she has to be able to resist social pressure from men. All the men try to dissuade her lest this serve as a lesson to their wives. So they do everything to discourage her. Second, she does not even know that the law will work in favour of her. This is because she does not have the chance to attend meetings and develop experiences.

7. Gudeta: Who will suffer more if the court decides in favour of divorce?

Dhibara: The husband suffers more because he was not accustomed to housework. So he will find himself in a difficult situation to get accustomed to both the loneliness and house chore which used to be accomplished by the woman. He will even have a problem marrying another woman because people know that he divorced his life.

8. Gudeta: Have you ever been counselled as couples on HIV/AIDS?

Dhibara: Yes, we have been counselled more than twice by health extension workers. My wife and I have been tested for HIV a month ago.

9. Gudeta: How do you explain the current extramarital sexual relation of couples in your locality?

Dhibara: There is the practice after all the teaching although the number of people engaging in such an act has been minimized. Some people could not change their behaviour.

10. Gudeta: Of husbands and wives, who do you think engages more in such act?

Dhibara: Women. There are women who drink more even than men. These women usually get intoxicated and lure men into sex.

11. Gudeta: Does it mean that men do not drink?

Dhibara: Men also drink but it is women who initiate men for sex after getting drunk themselves.

12. Gudeta: Have you been taught what condom is?

Dhibara: Yes. We have not been taught by health workers here. We heard that from the radio. We hear that it is used when couples suspect each other of promiscuity.

Gudeta: What is people's view toward condom?

Dhibara: I have said that condom is used to protect oneself from HIV/AIDS and other venereal diseases. But some people, even if they know its use, do sex without condom and risk their lives.

Gudeta: Why do they avoid condom?

Dhibara: They say condom is anti pregnancy. They also say it reduces sexual pleasure. So, married people do not use condom because they want to have children. Besides, they are loyal to each other and raising the issue of condom with one's partner is suspecting oneself and also one's partner.

Name: Morka B. **Age:** 40 **Education:** 8 **Date:** 28/08/04 **Site:** Garadie
Started: 13:43 **Ended:** 14:19 **Arch No:** M003

1. Gudeta: Have ever heard of HIV/AIDS?
Morka: Yes
Gudeta: When and where have heard?
Morka: I heard it from health workers when they taught us on kebele meetings.
2. Gudeta: Is there a difference between how people understood HIV/AIDS before they had been taught about it and how they understand it now?
Morka: Yes, there is. Before the teaching, we did not know how it was transmitted but now we know how it is transmitted and prevented.
Gudeta: Would you explain how it is transmitted and prevented?
Morka: It is transmitted through using sharp objects used by another person.
Gudeta: Is there any other way of transmission of the virus?
Morka: They also told us that it is transmitted through sexual contact. So to prevent the disease, they told us that we should not share sharp objects even among family members. Each person should have his/her own object. We also should not have sex except with our marriage partners.
3. Gudeta: Do you and your friends discuss HIV/AIDS and related issues?
Morka: I gained what I know about the disease from health workers. I do not discuss it and have not heard other people discuss the issue.
4. Gudeta: If a husband and a wife suspect each other of risky sexual behaviour, can they freely discuss the possibility of using preventive methods?
Morka: Yes, they are equal concerning care though I have not heard the issue of promiscuity discussed. I think both [husband and wife] can raise the issue freely.
5. Gudeta: Who do you think is more interested in this kind of discussion, husbands or wives?
Morka: The wife is interested more.
Gudeta: Why?
Morka: This may be because men are suspected of promiscuity. So women need the discussion to convince men to be loyal.
6. Gudeta: If a husband or a wife loses interest in this kind of discussion, does he or she say “I do not want to discuss” or give false reason?
Morka: He may say, “I do not want to live with you” or may request divorce.
Gudeta: Does he do that just to avoid discussion?
Morka: Yes, because he does not want his secret to be exposed through discussion. This happens especially if he is disloyal.

Gudeta: Do you mean he prefers putting an end to the marriage to resolving conflict through discussion?

Morka: Yes, especially men do not accept defeat in front of those they know. They may even prefer death rather than welcome defeat by a woman.

Gudeta: Can it be concluded from your answer that it is men who are interested in discussing promiscuity issues?

Morka: No. Men resist discussion when they know that they are promiscuous. They do not want to say, "I am mistaken or I apologize". But if it is the wife who is suspected of promiscuity, she does not resist discussion. The wife is not like the husband as far as this discussion is concerned. Even nowadays, when they have legal backing where they are mistreated, they do not find it difficult to say "forgive me, I am mistaken ". This they do even when they know the husband is disloyal.

Gudeta: But why should they accept it as their mistake when they know the husband is mistaken?

Morka: They want to keep the family intact at the expense of their own pride. What matters to a woman above all things is her home and family.

7. Gudeta: In such conflicts where promiscuity is an issue, whose opinion [that of husband or wife] do you think is more acceptable?

Morka: That of the husband is more acceptable. If it is elders trying to resolve the conflict, the husband's opinion clearly dominates. But if the case is taken to court, the dominance is minimized. The problem is that only few women go beyond traditional arbitration.

8. Gudeta: Have you and your wife been counselled together on HIV/AIDS and sexual matters?

Morka: They teach us all the time.

Gudeta: As couples?

Morka: No, no, not as couples but as a whole the whole society.

9. Gudeta: Do you think that married couples in your area engage in extramarital sexual relation?

Morka: They are loyal to each other. But previously when there was marital disloyalty, it was husbands who show disloyalty. They want multiple sexual partners.

10. Gudeta: Have you been given teachings about condom?

Morka: No one taught us but I heard it when people talk. But for myself I have not even seen it with my eyes. I do not know why and how it is used. I do not want to use it because I am not young and do not talk [have sexual contact] with other people's wives. People say they find it on the road and in farms.

Gudeta: You said that no one taught about condoms. Who do you think uses and throws the condoms?

Morka: I think the unmarried people use it. They learn about it at school. I do not think married people use it.

Gudeta: Why do not married people use it?

Morka: Why should they use it with their wives? They do not visit other women than their wives.

11. Gudeta: What do people say about being faithful to one's marriage partner?

Morka: No one speaks against it. But men are practically disloyal though they do not openly object to being faithful. That is against religious teaching. It also exposes to HIV.

Name: Ibsa D. **Age:** 20 **Education:** 7 **Date:** 29/06/04 **started:** 12:38
Ended: 01:09 **Archival No:** M004

1. Gudeta: Have you heard of HIV/AIDS?

Ibsa: Yes.

Gudeta: When and where have you heard?

Ibsa: I first heard at school. I learnt that it is transmitted through sharp objects and sexual contact. It is transmitted through unchecked and unprotected sex.

Gudeta: Where else have you heard?

Ibsa: I heard from people discussing. Others are taught at kebele meetings. I do not go to meetings because I am not a member of farmers association. So I did not receive lesson given at kebele.

2. Gudeta: Why have you not become a member?

Ibsa: We [my wife and I] have been married recently. We were learning together. I was in grade seven while she was in grade nine. We fell in love and then eloped together.

3. Gudeta: Have you got your blood tested before you were married?

Ibsa: We did not. We know each other because we had been in love for two years by the time we were married. Even if we wanted to be tested together, we were afraid of her parents. They would find out that we were in love. If they found out that we were in love, they would take her somewhere else. Now we have been married for almost a year and are healthy so far.

Gudeta: Why have you not been tested after getting married?

Ibsa: We did not find it important because we are healthy. We are now planning to be tested.

4. Gudeta: Is there a difference between how people understood HIV /AIDS before getting the lesson and how they understand it now?

Ibsa: Yes, there is. Previously they do not know how the virus is transmitted and prevented. But now they know how it is transmitted and how it is prevented.

5. Gudeta: Is there any other source of information that helped you understand about HIV?

Ibsa: Yes, we also get information from the radio.

6. Gudeta: Is there any difference between males and females concerning their degree of vulnerability to HIV/AIDS?

Ibsa: There is no difference.

7. Gudeta: Do you and your friends or people you know discuss HIV/AIDS and related issues?

Ibsa: Yes, we do.

Gudeta: What do you say in your discussion?

Ibsa: We say that there is no cure for HIV/AIDS and the remedy is protecting oneself from the disease.

8. Gudeta: If a husband or a wife suspects his/her partner of risky sexual behaviour, can they freely discuss the use of preventive methods?

Ibsa: Yes, they can say “let us have our blood tested” without fear because this is a matter of life.

9. Gudeta: Who do you think is more interested in discussing issues related to risky sexual behavior?

Ibsa: Both are and must be interested as absence of discussion affects their lives.

10. Gudeta: If a husband or a wife loses interest in such discussion, does he/she say “I do not want to discuss” or offer false reason?

Ibsa: I do not think they lose interest. They should be interested because it is a matter of life.

11. Gudeta: Have you ever been counselled as couples on matters related to HIV/AIDS?

Ibsa: No.

12. Gudeta: Do you think married people currently engage in extramarital sexual relation?

Ibsa: Yes, some people still practice it.

Gudeta: Of husbands and wives, who do you think practices it more?

Ibsa: I cannot say either husbands or wives engage more because members of both sexes take part in the act.

13. Gudeta: Have you heard about condom?

Ibsa: They say it can prevent HIV. They also say it does not prevent it.

14. Gudeta: How do people express their view concerning being faithful to one’s partner?

Ibsa: They say it is good.

APPENDIX C

FGD Wives

	Name	Age	Education
1.	Lelo T.	31	--
2.	Fayo W.	27	--
3.	Dilale B.	24	4
4.	Jifare W.	28	2
5.	Ragdu A.	40	--
6.	Argine A.	36	4

Date: 02/09/04 **Started:** 11:00 **Ended:** 12:40 **Arch-No:** -- FGW001

1. Gudeta: When and where have you heard of HIV?

Dilale: Previously we heard rumours about the disease. We did not know anything clearly. It was last month that they gathered us, women, and told us everything about HIV/AIDS.

Gudeta: Do you remember specific points they told you?

Dilale: Yes. They told us how it is transmitted and prevented. They gathered and told us at kebele.

2. Gudeta: Is there a difference between how you understand HIV/AIDS before and after you have received this training?

Jifare: Before the training, we heard that it was a disease for which there was no cure and it was transmitted through sexual contact. After the training, we understood that it can be transmitted through sharing sharp objects like needles and razor blades in addition to sexual contact. Previously people used to call it TB.

Gudeta: In what ways can sharp objects carry the virus from person to person?

Fayo: One can get the virus if he uses a needle or a razor blade that is used by a person having the virus.

Dilale: It can also be transmitted if a husband lives [has sex] with a woman that has the virus. He will contract the virus from the woman and transmit it to his wife.

3. Gudeta: Is there a way in which a husband or a wife is more vulnerable to HIV/AIDS?

Fayo: Circumcision also puts a woman in a difficult condition during labour or delivery. It also exposes her to the virus.

Ragdu: I have a daughter who is living with the virus. Her children and the other people living in the house with her do not drink from a cup or glass she drank from, they do

not eat from the same dish, and they do not share eating or drinking utensils. She has her own materials separated from the family. Those who have the knowledge teach all people living in the kebele to take care of themselves like this family. But I am telling you what I saw and heard. For myself I do not mess up with such risky behaviours as they were telling you. Why should I? How does it get me if I am careful? They told us at kebele that AIDS said “touch me not and I will not touch you, once I mount you, I will not get off you”. I am beyond the age at which women look to other men beside their husbands.

Gudeta: Why do you think do they not eat and drink with your daughter? Haven't you said that the virus is transmitted through sharing sharp instruments and through sexual contact?

Ragdu: No, no. I do not blame them. It is life. Those who teach may say that so that people may not exclude those who have the disease. They cannot be trusted. After all, why should they suffer with her? Even though she is my daughter, she brought the disease to herself. It did not catch her, she caught it.

Gudeta: You have said that you have been taught circumcision is harmful to the woman and also exposes her to the virus. Have people now given up circumcision altogether?

Lelo: Yes, that is prohibited by the law.

Gudeta: Let me put my question in a different way. Do you think that circumcision should be stopped?

Argene: We learned last month that it has dangerous effects on the woman and hence, should be stopped.

Lelo: Previously people said that not to be circumcised has an effect on the woman during delivery. They also said an uncircumcised woman would break utensils and would be disobedient to both the parents and her husband. She would not be restricted to her husband for life [sex].

Ragdu: Let me tell you my childhood experience. When I was 10 or 11 years old, there was an uncircumcised girl, the same age as I was. This girl was not circumcised because she was an orphan. Whenever we went to river to fetch water, she used to beat two or three of us at a time including those who were older than she was. Because we knew that we could not fight back and retaliate, we used to insult her saying “you uncircumcised whore”.

Gudeta: If it is believed that uncircumcised women break utensils, are disobedient and disloyal, if not to be circumcised also results in complicated labour and has an impact on delivery, do not you think that it should continue?

Ragdu: No, no it should not continue. That would be working against what the time demands. It is a government directive. It is obligatory to do what the government wants to be done. Even if it is obligatory to do what the government wants us to do, insulting the

uncircumcised one's could not be stopped. Girls are still insulting those who have not been circumcised in spite of the legal enforcement.

4. Gudeta: Where were you given teachings about HIV/AIDS?

Argine: It is given everywhere. It is given mostly at church and kebele gatherings.

Gudeta: What do they say when teaching at church?

Ragdu: They say the same thing we have been telling you. They say, "do not touch it unless you touch it, it won't touch you".

Gudeta: Do not touch what?

Ragdu: The things that make you contract HIV, especially talking to people outside marriage [having sex].

Gudeta: What about if people have sex with other people outside marriage?

Ragdu: In that case, they have to go [die]. Hereafter I think even teaching about the disease has become boring except to children. The adults and the youngsters have been taught more than enough. If they want to change, what has been taught is enough. If they do not want to change, it is their preference to die. I wonder why we should worry to save those who preferred to die.

Gudeta: Is there any difference between what the church teaches and what the kebele teaches about HIV?

Fayo: Yes, there is. There is a difference in that the church focuses on being faithful to one's marriage partner to stop the virus. They do not teach the use of condom as it encourages adultery. The church focuses on faithfulness but not on other ways of preventing the disease.

5. Gudeta: You have said that HIV/AIDS can be transmitted through sharing sharp objects and having multiple sexual partners. In these ways of transmission, is there a possibility that either men or women are more vulnerable to the virus?

Fayo: Women are more vulnerable because they bleed during delivery. This loss of blood affects them.

6. Gudeta: Do you think that people exchange views on HIV/AIDS?

Lelo: Yes, they do.

Gudeta: What do they say when they talk about the virus?

Ragdu: It has almost become a proverb that AIDS said, "do not touch me so that I may not touch you. Once I mount you, I won't dismount you." ["Nattihinbu'insittihinbu'uu, siyaabbannaansirraahinbu'uu"]. Those who have the virus in their blood themselves do not want to mention it. They say they are TB patients though they know that it is HIV.

7. Gudeta: If a husband or a wife suspects his/her partner of risky behaviour, can they freely discuss the possibility of using preventive methods?

Ragdu: Yes, they can. If a husband has the habit of looking to other women for sex, if he stays out for a night for no tangible reason, for example, the wife can say, "I won't sleep with you unless you are tested". That is what the time demands.

Fayo: If we find out that they [husbands] idle out and spend their time at places where they are not expected to be, we can ask them. The government has also given us the right to ask them if we suspect them. But our husbands are now careful and do not idle around. Even if our husbands try to misbehave, we have government representatives in our locality who we can appeal to.

8. Gudeta: Of husbands and wives, who do you think is more interested in such discussion?

Fayo: The wife is interested more.

Gudeta: Why not the husband?

Fayo: Because she wants a peaceful family life.

Gudeta: Does not the husband need peace?

Fayo: Men usually like to visit other women outside marriage and this disturbs the family. Once men start love affair outside marriage, they start to consider themselves as a stranger who is in the house for only a night or so.

Gudeta: Does this indicate that men are still disloyal to their wives?

Jifare: Yes, not all are loyal. There are some to be suspected. Once a husband starts extramarital relation, it is not only by contracting the virus that he affects the family. He begins to consider himself a stranger in the family. He ceases to care for the family. So, wives want the discussion more than husbands do because they do not want this to happen.

9. Gudeta: If a husband or a wife loses interest in such discussion, does he/she say "I do not want discussion" or does he/she offer false reasons?

Ragdu: Usually the husband loses interest when he is not loyal. Even so he does not say "I do not want". He ignores her when he comes in and goes out. He may even go to the point of dispersing the family and clinging to his new love. He criticizes the wife for whatever she does including the food she prepares. He quarrels day and night. But if someone approaches and asks him what is wrong, he says everything is okay.

Dilale: The food she prepares tastes bitter to him. Whatever she says also sounds insult to him. This is because he wants to block the way to discussion from the outset. If he discusses, he fears that his promiscuity will be exposed and his new relation will be in danger.

10. Gudeta: What do you think will be the result of this conflict if it is not resolved in time?

Lelo: It will result in divorce and scattering the family.

Gudeta: Whom do you think is affected more when they divorce?

Fayo: The woman will be affected more because the husband is prepared beforehand for the situation. The wife will also be affected because she has to go with the children.

Gudeta: What do you mean by 'she has to go'?

Fayo: She has to go back to her relatives since he hated her. What else can she do? He shouldn't go away because he is in his relatives; may be in his father's house. But the woman came from another area and has to go back to where she came from.

11. Gudeta: If the case is to be settled through traditional reconciliation, do you think, of husband and wife, one is favoured over the other?

Dilale: The elders always consider the woman as a wrong doer. The husband covers up his fault through the use of words. But the woman, even if she is wronged, is shy to express that in words. And again, even if she decides to explain her case, refrains from doing so because of her concern for her house and family. But the husband, if he wants to leave the woman, thank God, we do not have such husbands in this area, uses every means to win the case or even if he cannot win and they divorce, to make people give the woman tarnished name.

Lelo: Women always toil around the home. Most of the things that sustain the family are done by women. But when men are called upon to judge a woman, no one praises her. Women, even if when they are sick, rest only physically but not mentally. It is only the government that speaks the truth about women. Men never speak the truth about women. Men never speak that women are good though their mind tells them so.

Gudeta: Why do you think is it so?

Lelo: I think it is because they have been brought up that way. They say women should not be praised because if they are praised, they will stop working. So instead of praising, they insult and degrade her even when she does good.

12. Gudeta: Have you been counselled as couples on HIV/AIDS and related issues?

Dilale: They taught us women only last month. They taught us about the disease and how we can be organized to get our rights respected. They taught us about HIV/AIDS, everything. How it is transmitted and prevented.

Gudeta: But has anyone counselled you as couples?

Lelo: Men do not want women to attend meetings or either with men or alone. Women also do not consider attending meetings as their right. They do not care whatever men say about women. So, women do not go to meetings when they are called. They themselves [women] give bad names to those few women who go to meetings. They call them uncontrollable or disobedient. The government often passes directives to make women speak for themselves. That did not change the state of affairs here. It was only last month, when one week health training was given, that women attended public gathering. Men were using

different reasons so that women may not attend the training itself. They were saying “My wife is busy, she is sick “. They were speaking on behalf of the women. Almost all women attended the training because the administration interfered. Men still suppress women though they do not admit this verbally. Women also accept their low position. When the kebele orders women to take part in development activities, the husbands say, “My wife cannot do this kind of work. I have to come instead of her”. They do not want women to attend public gatherings or meet people outside their immediate neighbours. Ragdu said that people have got enough education on HIV/AIDS. I think the issue is not whether they have learned or not. It is whether people live according to what they have learned. At the same time, she was objecting to the use of condom. So can we say people know enough or have accepted what has been taught? Condom is not used only to prevent HIV. It can also prevent other sexually transmitted diseases and also pregnancy.

Gudeta: Can we conclude that there has not been couple counselling so far?

Fayo: Yes, we have not been counselled as couples.

13. Gudeta: How do you explain extramarital sexual relation of couples in your locality?

Lelo: We do not engage in such an act and we do not know about other people.

Gudeta: I am not asking you to tell me about yourselves because you have already told me that. What I am asking you is whether all the people have given up the practice.

Fayo: People do not practice this in our area because they have been taught about its effects. Even if we practiced it, the men would get angry and punish us severely. But women may be forced for sex by men if they go away from their area. Men who know the women and their husbands do not rape them. The use of condom may be recommended at such times [when women are away from home]. Women cannot resist men when alone. They cannot even accuse them and get justice before the law because the court asks for witness. But men do not rape women in the presence of witnesses. Raped women cannot even tell their husbands that they have been raped. This is because if a husband hears that his wife has been raped by another man, he would get into physical confrontation with the person who raped the woman. In the confrontation, the husband may be injured or, even if he hurts the other person, he may be arrested. The woman also gets tarnished names as prostitute and incontinent for causing the conflict. The husband also does not stop by fighting the man. He will punish the wife too. He may say to the woman “You exposed the matter because someone saw you. You would not have exposed it if you were not seen.” So if she speaks that she has been raped, the consequence may be serious.

Gudeta: What would you say if you see condom in your husband’s pocket?

Fayo: I would be upset. I would ask him why he carries it around. I would ask him whether he suspected himself or me of promiscuity.

Dilale: I do not even know what it looked like and I do not want to know. One day we went to a forest to collect firewood accompanied by small children. While we were gathering firewood, the children who were with us found something that was wrapped in a sachet and showed it to us. We thought that it was so valuable and hurried home with it. Upon reaching home, we met my husband and gave him the thing, eager to know what it was. As soon as he saw it, he laughed loudly. We waited eagerly to hear what he had to say. Finally, he said, "Go from my sight. You started carrying condom around?" We were ashamed though we knew that he was joking. We told him that we saw a boy and a girl leaving hurriedly the site where we found the thing.

Ragdu: I do not accept what you are saying about rape. I do not think that men force women into sex especially considering my locality. Let me ask you a question, does your husband himself dare to sleep with you if you frown at him? I do not think. Men do not simply force women to sleep with them where the woman is not totally interested. They must get some sign from the woman. Even if men take the initiative to ask for sex, they do not proceed if the woman discourages their move. There must be the woman's consent in rape.

Lelo: I do not think what Ragdu is saying is right. Men do not always wait for women's consent to rape them. They may use force even where the woman tries to resist. In fact, there may be cases where the woman indirectly agrees to a man's move. Even if they want the man, they verbally say 'no' not really meaning that, and at the same time showing signs of agreement. This is where the two have acquaintance. But even if they know each other, men feel defeated where they want a woman for sex and the woman resists them. They become aggressive and follow her purposely. Even if they cannot find her alone to rape her, they spread rumour to defame her and create discord between the woman and her husband. Once their need is aroused, they do not care about your feelings. What they want most is to satisfy their need. They do not even give you time to think let alone to read your reaction. If the woman resists them to the end, they will follow her wherever she goes. Though they cannot have sexual relation with her, they want other people to suspect or think they have relation with the woman. This way they defame the woman and spoil her relation with her husband. It is clear that husbands always suspect that their wives have secret relation with other men. They do not think and believe that women are loyal; rather they believe that they hide their relations. So when they see someone following their wives, they conclude that there is a secret relation and suspect the wife. I do not think that all women under all circumstances allow men to rape them. Of course, it has to be known that there are some women who do not only accept men's move for sex but also those who tempt men into having sex with them. This, however, does not lead to the conclusion that all women are raped or have sex with men only when and where they want.

Fayo: Nowadays I do not think that men rape women especially in the women's locality unless they [men] are drunk. Of course, men do not know what they do when they are under the influence of alcohol. When they are drunk, they do rape women. They forget all the risks involved in having sex with a woman though they know that when they are not drunk. So they expose the woman and themselves to a lot of damages.

Gudeta: What are the damages involved in such relation?

Fayo: The woman may contract the virus. As a result of contracting the virus, she may be hated by her husband and her friends. She may eventually die and no one wants to die. Even if she does not contract the virus, the husband may know of her relation with the person. He does not want to believe that she is forced. He thinks that she did it willingly. In this case, there may arise a conflict between the two. She may also face social condemnation. A woman's problems are many. Older women may not face all these problems because only older men look at them for sex and they also need older people. But we, who are in middle age have many problems. Older men themselves and the youth want us for sex. We also sometimes fail to control our emotions and are inclined to have sex with these people. We are tempted all the time. But the fact that we are married makes us feel ashamed to use condom. So we are at a high risk of being affected by the virus.

14. Gudeta: What do people say in their speech about couples being loyal to each other for sexual relation?

Ragdu: Living one-to-one for sex is living a life free of conflict. Though this is true, there are some people who are not loyal to each other for sexual affair. Especially women married to older people engage in extramarital sex. There are also some husbands who are not satisfied with their wives and look for women outside their marriage. Extramarital sexual relation is not practiced here in our area. But in other places, we hear that people quarrel over such issues and are reconciled by elders. Such issues are not talked about publicly because both the couples and the elders who reconcile them keep the thing secret lest the couple become objects of laugh and ridicule. We often hear these kinds of issue as a rumour. This shows us that even if people oppose extramarital relation in words, they are not true to their words.

APPENDIX D

FGD Husbands

	Name	Age	Education
1.	Daka W.	35	2
2.	Regasa D.	30	7
3.	Wahima M.	42	-
4.	Dureso B.	30	-
5.	Abdeta G.	40	11
6.	Dhaba G.	26	6

Date: 14/09/04 (Et. C). **Site:** Garadie **Started:** 12:05 **Ended:** 1:35 **Archival No:** FGH002

1. Gudeta: Have you heard of HIV/AIDS?

Wahima: Yes, we have. They gathered us at kebele and taught us about the disease. Those living with the virus told us about the virus and that they do not want others to be victimized. They told us that the virus can be transmitted from person to person through having multiple sexual partners. They also said that it can be transmitted through sharing sharp objects such as needles. They said to prevent the disease people should use their own objects. We should also be tested for HIV and if we are free from the virus, should be faithful to each other. Since the youth are in a sexually active age and may have more than one sexual partner, they said that they should use condom. But, from what I observe, I do not think they use it.

Gudeta: How did you know this?

Wahima: We hear that many girls become pregnant and abort. Those who do not know how to abort give birth to children.

Gudeta: How do you explain people's understanding of HIV/AIDS after the teaching?

Daka: There is a change. We do not hear people dying of and contracting the disease. People are also not lending or borrowing needles and razor blades and not having multiple sexual partners as before. The government is helping those living with the virus and they do not hide themselves as they used to.

Dhaba: Health workers have taught us about HIV/AIDS. Those who have the virus in their blood also have taught us. They both stressed adultery as the cause of HIV. I have not been adulterous from my birth. I saw condom for the first time when they demonstrated it on training. Then also I did not like even to look at it.

Gudeta: Why?

Dhaba: Because I do not like to have multiple sexual partners and condom encourages that. I do not lend or borrow, for example, needle. It is proper for the youth to use condom since they are not married and they may have multiple sexual partners.

Abdeta: HIV/AIDS education is given at churches and kebele gatherings. As a result, the number of people engaging in behaviours that expose them to the virus is also minimized. I share the idea that condom is not necessary here in our locality because we do not have commercial sex workers. I accept that condom should be used in towns where there are commercial sex workers. These women [commercial sex workers] earn their living through sex work and cannot avoid multiple sexual partners.

Dhaba: I have been taught and, in return, am teaching about HIV/AIDS. I am a church member. The disease is a result of the wrath of God because of men's transgressing His law. The disease has no cure means the remedy is only with God. No human work can reverse God's plan and work. God created a man and a woman to live together as a husband and a wife. But human beings broke this law-a man seeking another woman and a woman seeking another man for their lust. Consequently, God sent this disease into the world to punish those who disobey Him. Since then, many parents died leaving orphans behind and many children died before they matured. But through the understanding God gave them, people realized that the disease can be prevented by being faithful. This is going back to what God had planned at creation. Men also included the use of condom for those who cannot be faithful. It is obvious that condom can prevent the disease to some extent but at the same time, it encourages people for adultery. So I think that condom should not be used at all. Those who support the use of condom to prevent the disease raise the issue of discordant couples. In such situations, they maintain, they should continue in their relation using condom. But according to what the church taught us, these couples should not be separated but should separate their bed. They should not have any sexual relation using condom because that will open the way to adultery for both of them. They should not be separated because that will have a serious impact on the children.

Gudeta: What happens if these people are young and cannot abstain from sexual intercourse?

Dhaba: In that case the decision rests with the individual. The church cannot tell a person to commit adultery. But the person can do that against what the church teaches. The same is true for using condom. Allowing a person to use a condom is equivalent to giving him or her license to be adulterous. A person may prefer to use or not to use condom. But the church has nothing to do with that.

2. Gudeta: Is there a difference between men and women in their degree of vulnerability to the disease?

Dureso: We hear that women are more vulnerable. Women are not only more vulnerable; they also transmit the disease to more men than men do to women. We can take female sex workers as an example. A single woman can be visited by many people in a day and transmit to all these people who visit her. Women also outnumber men with regards to the number of people dying of HIV/AIDS.

Gudeta: But if we take the rural areas which one is more likely, a woman visiting more men or a man visiting more women, if she/he is promiscuous?

Wahima: There is more possibility for a woman to see a lot of men.

Dhaba: I do not agree with the idea that women have multiple sexual partners and are more vulnerable. Let me support my idea with a story I know. There was my friend who lived in the kebele next to ours. He was sick for a long time and when tested, was found HIV-positive. After suffering for over two years, he passed away. But his wife, who was also found to be HIV-positive before he died, has lived for more than three years now. He died soon whereas she is still living. So how can you say that women are more vulnerable than men are. It is men who are vulnerable.

Gudeta: What I mean by 'vulnerable' is having more possibility of contracting the disease. Now, of men and women, who do you think has a more likelihood to be affected by the virus?

Regasa: Let me say something here. Women do not move around looking for men for sex. It is men who look for women. Some uneducated people even take this as a heroic deed. It is men who move from place to place to find women who can voluntarily accept their request. If they are not lucky to find women who are ready to satisfy their lust, they do not refrain from using power where the condition allows them to do so. What reason can we give to say that women are more promiscuous than men? Women do not ask or force men for sex. They are often forced or at least persuaded to have sex. So it is men who are more responsible for transmitting the disease and in turn more vulnerable to the virus.

Dhaba: People say that women have stronger sexual feeling than men. Whether this is true or not, women do not ask men for sex. Even if they want a man for sex, women never take the initiative and say, "I love you." Women keep to themselves whatever they think about the person. But men express their feeling without fear. So I think that men are more vulnerable to the disease due to their own deed. They are also more responsible for transmitting the virus than women.

Gudeta: What we have been discussing is sexual transmission of HIV/AIDS. Do you think that there are other ways of transmission of the virus that increase vulnerability of one of the sexes?

Daka: There are traditional practices that expose women to infection by the virus as we have been taught. We can mention traditional midwives as an example. These women

render delivery services without any scientific training or modern equipment to protect themselves from the disease. In cases where the woman in labour has the virus in her blood, the midwife becomes vulnerable since she is not protected. It can also be transmitted through using razor blade that is contaminated with the virus for circumcising different girls. In this case, the girls who are circumcised are vulnerable to the disease. So we can say that women are more vulnerable than men.

3. Gudeta: How far do you think has the lesson they learned helped people to give up these traditional practices?

Dureso: Previously, there were no health centres for pregnancy test and it was a must to call for traditional midwives. At that time, people did not know the negative effect of traditional midwives and even if they knew, they did not have access to modern medical care and treatment. Now they have learned the advantage of getting prenatal care and they have access to health institutes which give this service. So women now visit health centres beginning from the first or second month of her pregnancy. When the time for delivery arrives, the woman goes to health institute and gives birth there with the help of qualified health workers. So we can say that transmission of the virus during childbirth has been minimized.

Wahima: Concerning the circumcision of girls we can say it is not practiced now. But some people are still circumcising girls in secret. The reason why they circumcise girls is not because they do not know the negative impact of the practice. They have been taught about its impact on the woman during childbirth and increasing her vulnerability to HIV.

4. Gudeta: Do you think that the teaching by health workers has succeeded in changing the existing beliefs in relation to circumcision of girls?

Daka: Previously, uncircumcised girls or women were insulted by and ashamed in front of those who were circumcised. People were circumcising their daughters to avoid this insult or shame. Circumcision was public and even a source of income for the family. But today its negative impact has been taught to the people and the practice is legally forbidden. Today, it is a crime to insult a girl as uncircumcised.

Gudeta: Is it because the government banned it or because they realized its negative impact that people gave up circumcision of girls?

Daka: It cannot be said that all people have given up circumcising their daughters. There are people who are circumcising girls even today. These people have not changed their attitude towards circumcision. They still believe that circumcising girls makes them act modestly. They are torn between two opposing situations. On one hand, the government has banned circumcision and circumcising girls results in legal action. On the other hand, they do not accept reasons given for banning circumcision but they cannot openly say they do not accept the reasons. They fear that opposing what has been decreed by the government will

bring bad consequences. Circumcising the girls is acting contrary to the law whereas not to circumcise the girls is acting against their conscience. As a compromise between these two contradictory views, they resort to circumcising the girls in secret. That way, they will be able to practice what they believe in without facing legal consequence. So, most people have not so far changed their beliefs towards circumcision as a result of the teaching. They simply fear the law. But it should also be known that there are some people who have changed their beliefs and oppose circumcision.

Dhaba: The old belief concerning circumcision was that girls, if not circumcised, would be sexy and immodest. But now this belief has been challenged and people have given up circumcision though unwillingly. I think that we have to wait and see whether what health workers say or what was publicly believed is true. Let those girls who have not been circumcised grow up and let us see if they really acted modestly or not. If they act modestly, it is a proof that not to be circumcised does not make girls act immodestly. But if they acted immodestly and are sexy, I think the traditional belief is right and we have to continue with circumcising our girls.

Dureso: Let me tell you a true story. It was in 2000 [E. C]. It happened in this district itself. A family, after receiving health education, decides not to circumcise its daughter. The girl reached school age and went to school. One day, as they were walking to school, all her friends who were walking with her blocked their nose as if there were something stinking. One of them knowingly asks why they blocked their nose. Another answered saying “There is a bad smell like the one produced by an uncircumcised girl. Is there an uncircumcised girl amongst us?” The girl who was not circumcised did not respond at that time though she knew they were trying to humiliate her. She silently finished school time and went home. After going home, she immediately picked a rope and ran to the nearby bush to hang herself. The parents shouted for help and with the help of the neighbours saved the girl from taking her own life. When asked why she decided to kill herself, the girl told them that she had been insulted by her friends. The family regretted its decision not to circumcise the girl and soon circumcised her. We know girls who are 14 or 15 years old who have not been circumcised. Of course, they are few in number. It is also true that people are circumcising girls up to this time. There is something worse in how they circumcise the girls nowadays. Previously, girls were circumcised at 14 or 15 years of age. Delaying the circumcision up to this age had its own reason. That is, if the girl had a sexual intercourse before she was circumcised, the woman who performed the circumcision would know that the girl was not virgin and sometimes refused to circumcise ‘a woman’ [a girl without virginity]. She had to be paid extra payment in order to circumcise the girl and keep the secret. What mattered then was not the amount of money paid to the woman to circumcise the girl. It was the act of the girl in defaming the family. So the family hates and severely punishes the girl

for her act. The girl at that time avoided any sexual intercourse at least before she was circumcised. This is one advantage of circumcision as it was practiced previously. But nowadays people know that circumcision is an illegal act. To avoid legal action people started to circumcise girls at an earlier age-two or three years. They do this to circumcise the girls before anyone suspects that they planned to circumcise or before the girls know or hear of its bad effects and resist the act. Imagine the agony these girls have to undergo at such an early age. When the report, mostly as a rumour, reaches government organs such as the kebele leadership, the child has been circumcised two or three years earlier and the wound has already healed. This makes it difficult to take legal action against the offenders. Here, we see that the situation is worsening for the girls as a result of banning circumcision. When it was not prohibited, girls used to be circumcised at a relatively mature age. But after it was prohibited, people started to circumcise girls at younger age than before.

Gudeta: Why was it not possible to bring the offenders before the law after two or three years after the circumcision was performed? Is it not possible to verify that the girl has been circumcised through medical examination?

Regasa: The police or the court asks for evidence to consider any case as crime. These people circumcise the girls in the presence of those whom they trust and may be who have performed similar act on their own daughters before. So it is difficult to find evidence for such act. On top of that, there are few committed people to take the case to court. There is a problem to find people who push harder on such issues. In my opinion, it is better if the government lifts the ban and allows circumcision because banning it only worsened the situation. It did not bring any improvement.

Abdeta: Older women themselves do not accept that circumcision has negative effect on child delivery. They say that it did not have negative effect on women when they were giving birth to six or seven babies without any medical assistance. I myself share the view that girls should be circumcised at the age of 14 and above because it forces the girls to delay sexual debut. This is a government directive imposed from above and not something which the people debated on, voted for or against and accepted. People are considering it as something attempted against their culture. They are preserving it as part of their culture by performing it in secret. That is mainly why they are not exposing those who perform it. To stop this practice, if it has to be stopped, the government has to work on changing people's attitude towards the practice rather than simply banning it legally. This is not the first time that the government tried to stop circumcision through banning it legally. The Dergue also attempted once but it did not work. I doubt that it will work this time unless the approach used is changed.

5. Gudeta: If a husband or a wife suspects his/her partner of risky sexual behaviour, can they freely discuss the possibility of using preventive methods to protect themselves from HIV?

Regasa: The spread of HIV has forced people to at least minimize their sexual partners or to control their sexual feelings. Previously, it was a fashion and a sign of manhood to marry more than one wife and have many children. But this has now become outdated and ridiculous. Now the time requires maximum care because carelessness exposes one to infection by HIV for which there is no cure. So couples are loyal to each other for sexual contact than before though there are some who are still disloyal to their partners. I think, therefore, that they have the right to discuss how to protect themselves from the virus where there is no mutual trust. I think they discuss other preventive methods except the use of condom. As to me, the issue of condom should not be raised between couples. They should not discuss condom. They have to be loyal to each other. If the one suspects the other partner of promiscuity, they have to be tested for HIV. Resorting to using condom as a result of suspicion is equivalent to giving license to each other for promiscuity in the future. Couples in our locality always stay together. So why do they need condom unless they want to have sex here and there? In other areas, for example the towns, husbands or wives may be away from home for business purposes for weeks. Even these people should not use condom as far as they are married. They have to be able to control their emotions.

Gudeta: Which one is more harmful, to use condom and save one's life if one cannot control one's emotion, or to have sex without condom and contract the virus in case one cannot control one's emotion?

Abdeta: It may be preferable for a person to use condom than to die if he cannot control his emotion. But I think he should be able to control his emotion when he is at other places if he is loyal when he is at home. He will be tempted to engage in sex outside marriage when away from home only if he is accustomed to doing this when he was at home. He does not stay for months or for a year. It is only for weeks that he stays and he has to control his emotion during this time and should never use condom.

6. Gudeta: Of the husband and wife, who do you think is more interested in discussing issues of promiscuity with a partner?

Regasa: Mostly women are interested. They suspect their husbands of promiscuity. This is because men often go away from home. They drink and engage in sex when they are drunk. Even if they do not drink, men are not loyal to their wives. Due to these reasons, women like to discuss promiscuity issues with their husbands. They want to alert their husbands about the danger engaging in extramarital sex may bring.

7. Gudeta: How do you explain extramarital sexual relation of couples in your locality?

Daka: It is true that there has been some change in people's sexual behaviour after they got health education. But still we cannot say that all people are practicing what they have been taught. For example, we have said that people still circumcise their daughters though they have been taught against doing that. Concerning extramarital sexual relation too there are some people who do not practice what they have been taught.

Gudeta: Of husbands and wives, who do you think engages more in extramarital sexual relation?

Abdeta: I think we cannot say either husbands or wives engage more. This is because having multiple sexual partners is behaviour and behaviour differs from person to person. There are husbands who do not love much sex even with their own wives. The same is true for wives. A wife may be loyal to her husband whereas the husband has multiple sexual partners. A husband may be loyal while the wife is not. So it is difficult to generalize and say this sex is loyal and this sex is not loyal. Previously people said that the disease existed only in towns. But now we hear that it exists everywhere. That means there is fear of the disease here too. This forces both the husband and the wife to be careful in their sexual relation. We heard that truck drivers, soldiers and commercial sex workers are affected by and transmit this disease more than other section of the population. Some people say that men are more promiscuous than women because they drink. I do not think that this is true because there are also women who drink and get intoxicated like men.

8. Gudeta: What is people's reaction to the use of condom?

Abdeta: People object to the use of condom either in premarital marital or extramarital relations. I, personally, think that condom gives freedom to people to commit adultery. When people are accustomed to using condom, they will develop a sense of security to engage in sex with anybody they want. It will make them feel that they are protected from the virus and there is nothing to fear. Besides, although condom protects people from the virus, it is making the youth undermine our culture and at the same time spreading the disease. Before the introduction of condom, the youth refrain from having sex before they are married because, if they have sex, they may become pregnant and be exposed. After the introduction of condom, however, girls became free from the fear of becoming pregnant and started to engage in sex at an early age. The use of condom only emboldened them to begin sex at an earlier age than before and to have multiple sexual partners. But they do not use it consistently. You can see that they are not using condom consistently from the fact that a number of girls become pregnant and give birth to fatherless children or face health problems while trying to abort. Now if you go to a bush you will find used as well as unused condoms thrown away by someone. Did these condoms fall down from the sky? No, they are thrown by people. They throw them where children can find and use them as play materials. So it has more disadvantages than advantages.

APPENDIX E

Interview, Hawi Chairperson

Name: Tura A. Age: 40 Education: 12 Date: 11/07/'04

Site: Garadie Started:11:17 Ended: 11:51 Archival No: HC001

1. Gudeta: How are dwellers of rural area represented in your association?

Tura: Our members come from both urban and rural areas of the district. Most of them are from rural areas as the district has only two small towns.

2. Gudeta: What type of language do people use to refer to those living with the virus?

Tura: They use such terms as 'disease of the time' 'disease of curse', and other derogatory terms I do not want to mention. They also discriminate them. As a result, people were not willing to join our association. I took the initiative to form the association but I did not agitate the other members for membership. We knew each other even before we formed the association and they accepted my idea as soon as I proposed. They were weak, helpless and hopeless and I suggested that we could do something to help these people if we organize ourselves. Others joined us after a few of us founded the association. Others were informed about the association by health centres when they were tested and knew their serostatus. That is how people became our members. But still not all people living with the virus in both urban and rural areas are our members. Only those who are weak and need help joined us. Others, though they may be weak and need help, hide themselves for fear of discrimination by their neighbours or those who know them. We have been trying to help them to overcome the fear and become members. But we have not succeeded as expected because most of the people living with the virus in rural areas have not yet become members.

3. Gudeta: Have you encountered any social stigma or discrimination as a result of your serostatus?

Tura: Yes, though it did not happen to me, people often discriminate those living with the virus and have acknowledged their serostatus.

4. Gudeta: Do you think that family members discriminate a member if they find out that she/he has the virus in her/his blood?

Tura: We know cases where only one partner has the virus and the other is free but the couple living peacefully. There is also a case where a husband, after knowing that his wife had the virus, requested divorce and left her.

Gudeta: Was the husband tested and free from the virus?

Tura: He was tested and he knew that he was positive even before they divorced. But still he refused to live with the woman. But I heard recently that they were remarried after living separately for some time.

Gudeta: Is it the husband or the wife who blames and resents the other more after knowing that his/her partner has the virus in his/her blood?

Tura: I observed that husbands blame and resent their wives more though I do not know why.

5. Gudeta: Of the members you have in rural areas, who is more in number-men or women?

Tura: Women are more in number. This is true for both urban and rural areas. But if you ask me why, I cannot give you the reason.

Gudeta: Do these women come along with their husbands or do they come alone?

Tura: Most of the time women come alone to be tested for HIV without consulting their husbands. They do not also consult their friends or relatives. So when they come for membership too, they come alone. This, I think, is because they fear their husbands would condemn them saying "You harlot, you lived with whoever you liked and infected me with AIDS". There is a woman who visited our office just this morning. She was enrolled as a member and then disappeared after some time. We looked for her for months and eventually contacted her again. When she came this morning, she told us that she intentionally hid from us because, if people of her area, especially her family and her neighbours, find out that she has the virus in her blood, they would condemn and exclude her from social life. But now, considering that this association will stand by her in time of difficulty, she finally decided to continue with her membership. Here, it has to be known that there are also some women who come along with their husbands for membership though they are not many in number.

6. Gudeta: What is your worry concerning the spread of HIV into rural areas?

Tura: My worry is concerning the reaction of the people towards those who have the virus in their blood but who are hiding their status fearing social discrimination and condemnation that follow. People use discriminatory words such as 'those with disease of the time' against them. As a result, these people do not acknowledge that they have the virus and our rural people do not take the necessary protective measures. I think this will contribute to spreading the virus into the rural areas.

7. Gudeta: Who do you think should play major role in averting the current situation in relation to the spread of HIV in rural areas?

Tura: I think it is the government because it has the resource and the power to make people change risky behaviour. We see that different government organs work day and night for political success. The same effort has to be exerted to create a healthy society. A lot has to be done to raise people's awareness about the virus. It should not be left to NGOs and charity organizations as it is now. For example, people sometimes refuse to show up for meetings when we call them. Those in power also do not show concern whether people come for meetings or not. But if the meeting has a political purpose, the administrators would take

severe action on those people who miss the meeting. Health issues, especially those relating to HIV, have not been given due attention. People do not know how HIV is threatening rural areas. If they do not know that it is a real threat, they would continue with risky behaviours and help the spread of the virus. If it is necessary to control or stop the virus, the government has to play its role.

8. Gudeta: Some people say that HIV is stabilizing in towns. This is because towns' people took the necessary precautionary measures to protect themselves from the virus. Inversely, there is a fear that the disease is spreading into rural areas. Do you also share this fear?

Tura: Yes, I do. If we take our schools, for example, we do a lot of things to raise students' awareness of the disease. When we tell them, they do not care about what we tell them. This may be because they are in a sexually active age and do not want to hear anything that may affect their sexual pleasure. In spite of what we teach them, we find them in the bush moving in pairs possibly for sexual contact. I do not think these youngsters use condom. Some of them even get married without the consent of their parents and without being tested for HIV though we have told them not to be married before being tested. We have also told the parents on different occasions that no marriage should be approved by parents without the girl and the boy being tested for HIV. Neither the parents nor the youth seemed to care about what we told them. The fact that these people are married without HIV test shows that the future couples and the future families are at risk. I think they avoid the test because they fear that one of them would be HIV-positive in which case their love would be in danger. They risk their lives instead of losing someone they love. The other fear I have concerning the spread of HIV in rural areas is that NGOs are not willing to go and work in rural areas. Government organs are also not doing enough to mobilize the people to stop the virus. The existing stigma is also what worries me concerning how to stop the spread of HIV in rural areas. The degree of stigma and discrimination against HIV/AIDS patients is low when the patients can normally carry out their duties. But once the patients become bedridden, people start to avoid them. This condition discourages and makes hopeless those who are living with the virus and observe how people treat their sick brothers or sisters. It may trigger them for revenge against those who do not have the virus in their blood. This may result in many people contracting the virus.

9. Gudeta: People say that the church does not focus as health institutions do on teaching about condoms. How far is this true as far as you are concerned?

Tura: Previously, not only the church but also the public in general used to oppose the use of condom. They were saying that condom itself carries the virus. Things, however, have changed nowadays. The church does not directly condemn the use of condom though it does not support it. Other people also do not condemn the use of condom as they used to. The problem is that they do not use it practically.

APPENDIX F

Interview, OSSA (Organization for Social Support of AIDS) Representative

Name: Yadeta S. Age: 60 Education: 12+4 Date: 18/09/04 Started: 12:00
Ended: 12:40 Archival No: OS001

1. Gudeta: How do you explain the number of people coming from rural and urban areas to seek help from your organization?

Yadeta: More people come to our organization from urban areas because it is located in Nekemte, which is an urban area itself. But we are trying now to reach rural areas. Not only reaching the rural areas but we are intending to focus on rural areas in the future.

2. Gudeta: Has lack of cooperation from marriage partner or other family members ever hindered you from reaching HIV patients?

Yadeta: Yes, there were cases where a family denied us access and kept us away from the patient. There were also big problems to counsel a husband and a wife together where the wife was HIV positive but the husband was not. The husbands were abandoning their wives immediately after finding out that the wives were HIV-positive. They refused to come back to their wives even after being tested and knowing that they also have the virus in their blood. But the situation has changed recently in towns. Wives started to come along with their husbands and other family members. One undeniable fact is that people have information about HIV whether they live in urban or rural areas. This information, however, did not result in the necessary behavioural change. We have now prepared a new strategy to bring this behavioural change and are working on that. We have eight sites including this district. In this strategy, we have included both urban and rural areas. The training we are conducting now is part of the strategy. Our major focus in this strategy will be on stigma, discrimination, denial, mode of transmission, methods of prevention and opportunistic infections. Besides, we will focus on bringing attitudinal change towards being HIV patient. That is, there was a misconception that people who have HIV in their blood should always be supported. There was a feeling of dependence. This has been deep-rooted in people's mind and it is not simple to remove. The attitudinal change we are intending to bring is that it is not a must for those having the virus in their blood to be supported. The government is supplying medicine free of charge. If they take this medicine as prescribed and follow physician's advice strictly, they can work and live just like any other person. Nowadays to die of HIV/AIDS has become either foolishness or ignorance. The government has formed different structures that can enhance the fight against HIV/AIDS. The problem is that the structures are not functional. They are simply there. There are structures at district level and at kebele level. As I have said, they are not functional. On top of that, there is high turnover of workers. You contact and give briefing on what you intend to do and be acquainted with someone as a head

of an office today. When you come back to the same office after a month or so, you find him/her replaced by someone else. You have to go over the briefing and planning again. That is what we face in almost all the districts.

3. Gudeta: From what you know, how do you explain the spread of HIV/AIDS in rural areas currently?

Yadeta: People say that the disease has stabilized in urban areas. I think there is something that made us think like that. That is people having the virus in their blood are on ART [anti retroviral treatment]. This helped them live longer. The absence of many deaths as a result of HIV makes people think the disease has been controlled. This may make people undermine the disease and forget precautionary measures. What I have said so far may be true for urban areas. But if we take the rural areas, I do not think that the status of the disease has been researched well. Most of those who have known that they have the virus are hiding themselves fearing stigma and discrimination. Only few people know their serostatus though there is an encouraging attempt to convince the people for VCT [voluntary counselling and testing]. Even those who are tested are tested once and go away never to come back. They think that once free from the virus, they have nothing to worry about thereafter. When you put these points together, you can see how dangerously HIV is spreading in rural areas. I have also another worry though this may not be part of your question. There are, for example, people on first line drug and who have to move on to second line drug. The virus has already begun to show resistance to first line drug and the fate of those people taking the drug is not known. The sexual practice of people in reproductive age is another point that worries me. If you go to clinics and ask now, you will find that there are lots of abortions. Those practicing abortion include both married and unmarried people from urban and rural areas. This can be taken as evidence that both married and unmarried people engage in unprotected sex. Take our universities and colleges, for example. There is what they call 'contract marriage'. I think the term shows that the relation lasts only a short period of time. Universities and colleges have become places where the students practice 'free sex'. These students are from both urban and rural areas. Especially girls from rural areas were under strict control before coming to the universities or colleges. When they come to the universities they begin enjoying life free from parental control and cultural influence. I do not think these students even use condoms for some of them visit different clinics to seek abortion. These students go back to their parents who live in rural areas either after they graduate or for vacation before they graduate. During their stay at the universities, they have had sexual contact, most probably unprotected, with students from urban and rural areas of different regions of the country. Do not you think that these students have friends in the areas where they were born and brought up? I believe they do. So the cycle goes on. My fear is that universities and colleges have become places where students share not only knowledge and skill but also the

virus. Given that our people living in rural areas do not like or use condom, and they are not often tested for the virus, it is not difficult to imagine how severely the virus is affecting them.

[Added to this, economic conditions are worsening from time to time and people are doing their best to cope with the situation. Due to this worsening of economic conditions, parents find it difficult to meet the needs of students. This also forces the students to look for other means of income. This is true especially for girl students. They are more fashion-conscious than boys. You know that somebody with less than 300 birr cannot buy a shirt and the parents cannot provide this. To fill this gap the girls turn to somebody who can provide money in exchange for sex and that somebody who has the money may also have the virus. Through such contact, the girls do not get only the money but also the virus. It is again girls coming from rural areas that experience severe economic problems. I think our youth are in a very alarming condition currently. I do not know what the future holds for us. University and college students are expected to shoulder the responsibility of protecting and constructing the country from you and me. But they fell short of even protecting themselves. We often hear that newborn babies are thrown and found around university campuses. If this happens only once or twice, you may say that it is done by people living around the campuses. But this happens repeatedly. The information from different clinics also shows that university students engage in risky sexual relation. If you stroll around campuses especially in the evenings, you see students disappearing into nearby bushes in pairs. If you visit clinics such as Marie-Stopes or other clinics in Nekemte itself, you will be surprised at the number of university students going there for treatments related to abortion.

[Those people who are living with the virus are getting the right care and treatment. This has helped to minimize the number of deaths due to HIV/AIDS. But this does not mean that people are not being infected from day to day, especially given the current sexual practice of our youth. The government has extended different structures down to teams that embrace not more than 20 or 30 households. There are also two health extension workers assigned to each rural kebele. The problem, however, is not with the existence or nonexistence of the structures but the functionality of the existing structures. The structures are already there but enough has not been done especially concerning HIV/AIDS. Trainings are given at different times and at different levels. But still there is a problem on implementation. We do not often see people changing their behaviour as I tried to indicate above. This may have different causes. One of the causes may be lack of incentives. Those working in the structures are not paid for what they do. This may weaken their initiation for work. Besides, they are working among people who know them and whom they know previously. They might have been engaged before in behaviours they are now teaching people to denounce. They may be practicing the behaviours even now. There is a possibility that even those paid, such as health extension workers, do not show much interest in what they do. People have become business

mindful nowadays. They derive more satisfaction from what they personally gain than from their success in what they do. Especially, people have started to consider health care service as commodity. Therefore, the government should have a controlling mechanism as to what the reports say is really what is done.

Gudeta: What is the purpose of the training you are giving now?

Yadeta: It is capacity building. These people [those living with the virus] have been out of plan as a result of HIV/AIDS. They have been affected by stigma, discrimination and denial. It is only recently that they acknowledged their serostatus, are organized and initiating others to join them. We are rehabilitating these people and developing their self-reliance. We believe that persons living with HIV should not always look to other people to help them. We want to free them attitudinally. We give them basic lesson in relation to antiretroviral treatment. We want them to know that, taking the medicine, they can still work and live like any other person. We also teach them to acknowledge their status without fear. We want to initiate them to start their own micro-businesses that will bring them to self-reliance. We give them life-skill training assisted by experts. We give them initial capital for the business. We do not give them the capital on credit basis-it is just an aid. But we want them to open a bank account from the very beginning. We will follow their progress and give them any professional assistance they need. We will discuss how this can better be achieved with different sectors in the district. Especially we want women's and children's affairs and youth and sports sectors to actively participate in the program.

Gudeta: Does this scheme work equally for urban and rural areas?

Yadeta: Our main focus, about 60 percent of our activity, has been in Nekemte town. We are trying to reach rural areas with the remaining 40 percent. We are trying to shift our focus from towns to rural areas. We now have only four clubs in Nekemte town. As part of shifting our focus, we are forming centres in eight rural districts.

4. Gudeta: What do you think should be the role of men in stopping the spread of the virus?

Yadeta: I think you are speaking from the point of view of the discourse that existed before; the time when men were forcing women into sex. But now I think the two [men and women] have exchanged roles as far as sex is concerned particularly in towns. I think it is the girls who take the lead in initiating men for sex though they have not so far used force. But in rural areas, men still dominate issues related to sexuality. Therefore, it is important to devise mechanisms that focus on participation of men. A lot remains to be done here. No one tried so far to convince men that they are part of the problem and part of the solution too. Interventions focusing on gender issues always take women into consideration. Still men dominate women to the extent of refusing them permission to attend these meetings. I think this is natural. They are defending their position. I do not think that it is wise to use only force to make them relinquish their power. They should be convinced to sympathize with women. They should not be targeted as enemies. That way they will put up resistance which will at least delay the process of empowering women.

Gudeta: Thank you for your time.

APPENDIX G

Interview, District Health Office

Name: Hunduma B. Age: 26 Education: BSc Date: 21/08/04 Site: Garadie
Started: 10:04 Ended: 11:30 Archival No: DHO: 001

1. Gudeta: Have there been any interventions in your district that focus on the impact of gender in spreading HIV/AIDS?

Hunduma: Yes, we have given lessons to the people at different times concerning gender. These lessons are given formally and informally by extension workers. They are given formally at public gatherings held at farmers' association level. They are also given informally when the workers move from house to house talking to people they find at home. The lessons are also given by our health staff working at health centre level when people come to the centres for treatment.

2. Gudeta: Would you please explain what the content of the lesson given was?

Hunduma: It mainly focuses on the fact that women are more vulnerable to the virus. The reason for this vulnerability mainly lies in backward traditional practices like female genital mutilation, abduction, polygamy and so on. The other reason is women's lack of information. This begins at family level. It has not been the custom for families living in rural areas to discuss sex-related issues with their children, especially with girls. As a result of this custom families do not discuss how HIV/AIDS is transmitted and prevented even if they know it themselves. So the lessons focus on making the public aware of the impact of these traditional practices in spreading the virus. They also focus on prevention of other STDs [sexually transmitted diseases] such as gonorrhoea and how these diseases are related to HIV. After teaching them the transmission and prevention of the virus, we teach and encourage them to be tested for HIV. We also teach them the advantage of testing and counselling especially to prevent mother-to-child-transmission of the disease. We also teach women the advantage of prenatal care. We also advise mothers to go to health centres at the onset of labour.

3. Gudeta: Are these intervention messages prepared here at district level or are they prepared somewhere else and sent to you?

Hunduma: There are no special messages prepared for teaching about gender and HIV/AIDS. It is subsumed under health extension package which has 16 major components. 'Communicable diseases' is one component of health extension package and HIV/AIDS is one part of communicable diseases. This health extension package is designed at the level of the ministry of health and contains issues related to farmers' health in general. The messages in the package focus on how farmers can keep their personal and environmental sanitation. The package that is prepared at the ministry of health is then sent to districts. We select

messages out of the package based on what we want to teach. Then we train selected farmers on the issue to be learned and implemented. Then we facilitate conditions and encourage the other farmers to learn from the trained ones.

Gudeta: Do you train both sexes?

Hunduma: We used to train the public in general without focusing on any single group. But this year we trained women separately on issues related to gender and HIV. The training was prepared at bureau level and focused on women in reproductive age. We gave the training in all kebeles for one week. The major contents of the training were problems related to backward traditional practices, reproductive health and HIV/AIDS. Over 4,000 women were trained at district level. All these women were tested voluntarily for HIV at the end of the training and those who tested HIV-positive were given appropriate counselling.

4. Gudeta: You said that health package was prepared by ministry of health. Do you make any changes to the message?

Hunduma: It was prepared at ministerial level in Amharic. It was then sent to Oromia Regional Health Bureau and translated into Afan Oromo. The regional health bureau then sends the translated version to all districts found in Oromia. We do not make changes to this package. But we try to make the message understandable to the farmers when we teach.

5. Gudeta: What type of changes do you think have been brought as a result of the message?

Hunduma: There is low HIV incidence. Though we cannot say there are no new HIV cases, the number has stagnated relative to what it was before year 2000 [E.C]. Those who have the virus are on medication. There is a change in how people understood HIV/AIDS too. Previously people thought that contracting HIV means immediate death. But now they understand that HIV is an incurable disease but it is possible to live and work by taking life-prolonging medicine and taking care of one's actions as advised by physicians. There is improvement concerning stigma and discrimination against those who are living with the virus. Previously people refused to eat and drink with these people. But now they are taking the necessary precaution and living with those having the virus. People have also overcome their fear concerning VCT [voluntary counselling and testing]. They are having their blood tested voluntarily. Hence, majority of the people in the district have been tested since the past four years. In the year 2004 only around 7000 people have been tested. Some of those tested are being tested every year. We are not waiting for people to come to health centres. We have outreach program to each kebele for VCT. We have organized those who have the virus in their blood, both from urban and rural areas, into different micro-businesses so that they may become self-supporting.

6. Gudeta: How much have you succeeded in minimizing backward cultural practices?

Hunduma: Abduction has been minimized significantly. We have two kebeles in the district that are not easily accessible from here. These kebeles have not been given enough education especially before 2000 [E.C]. The people living in these kebeles were also educationally backward. We could not, for example, find even one person who had completed grade 10 by the year 2000. Hence, we could not employ health extension workers to work in these kebeles since they have to be recruited from kebeles where they were born. From this you can understand how educationally backward they were. But recently we have hired two girls from each kebele and assigned them as health extension workers. Since then there has been a relative improvement especially concerning backward traditional practices. But abduction is still practiced though it has been minimized. Most of the time, however, it is not abduction in a real sense. When the girl's parents refuse to allow a girl to marry the boy she wants, the girl elopes with the boy but falsely complains that she is abducted. But this is not to say that there is no abduction at all. There are cases, again mostly in these two kebeles, where girls are abducted against their will though this has been discouraged and minimized now.

Gudeta: What about circumcision of girls?

Hunduma: We get feedback on workshops and trainings that it is still practiced in secret. But no one is circumcising girls in public in all kebeles found in the district. The fact that people circumcise their daughters in secret shows they are forced by the law to give up the practice without their accepting the negative consequences of the practice on the girl. They want to avoid legal consequence without giving up the practice. We can understand from this that people's attitude towards the practice has not been changed. What has been changed is how circumcision is viewed before the law.

7. Gudeta: Have there been interventions that focus on couples in your district?

Hunduma: We did not have interventions that specifically focus on couples. What we have started recently is to request the presence of husbands when the wife is oriented about contraceptive. We are also encouraging husbands to be tested with their wives when the latter are tested when they come to health centres for pregnancy test. We are also encouraging indirect involvement of husbands in family planning. Family planning so far focused exclusively on women since it was they who take pills or injections. But now we are initiating men to be involved by caring for their wives at home and accompanying them to health centres when the need arises. We are also trying to encourage the husbands to use condom as part of family planning. But still there is a strong resistance to using condoms between married couples especially in rural areas.

Gudeta: What is being done to change that attitude?

Hunduma: We are giving education. We are also distributing condoms freely to those who need it.

Gudeta: Do married people accept them from you?

Hunduma: Only few of them, there is still a gap. I can say that there is no attitudinal change towards condom. As I have said earlier, so far we have focused only on women for family planning. We have been giving women two types of contraceptives: short-term and long-term contraceptives. But now we are trying to concentrate on long term ones-those that are given for three months and above. We are trying to do this by consulting husbands and wives together. The experience in rural areas before now was that husbands attend meetings and get information even on issues that concern women. It does not seem that women object to this at least verbally.

Gudeta: Do you think that these beliefs have been changed on part of both the husbands and the wives?

Hunduma: We can say that over 80 percent of the health package has been prepared by taking women into consideration. This is not without reason. In the first place, women constitute more than half of the population. Second, children are under the care of women for their sanitation, care and feeding. Thirdly, half of the care given to husbands themselves rests with women. That is why women are given emphasis in the health extension package. It is also women who were affected as a result of the absence of health care services so far. I think it is of no use if we teach men about prenatal care. It is not that important if we teach men about family planning. If we take the importance of toilet, it is more important to women and children because men spend most of their time away from home and do not care whether there are toilets at home or not. Taking these points into consideration, we have given one-week health training exclusively to women. The training included TB and HIV, family planning and prenatal care. They were taught problems that relate to each of the above points and how these problems can be solved. After the training, we organized women so that they may take part in all structures from district to kebele and team. Women did not have any share in these structures before. According to the current scheme, women are required to prepare their own health plan supported by health extension workers, such as plan to get prenatal care. All existing government structures are expected to give these women any assistance they need to overcome obstacles they may encounter in implementing what they plan.

8. Gudeta: From what you know, how do you explain the current extramarital sexual relation of couples?

Hunduma: Though I cannot say confidently that people have given up the practice, as a result of what has been taught, it is not supported as a culturally accepted practice, especially wife sharing among blood relatives has been stopped. Wife inheritance is also no more practiced. But it is clear that people still practice extramarital sexual relation though it is not as widespread as it was before. Some men seek other women for sex though they have

wives. Some women also look for sexual partners in addition to their husbands. There are even some women who marry other men leaving their husbands. That shows they had relation with the new husbands even when they were in relation with the previous ones. Some people could not change the old ways although they are taught to change that.

9. Gudeta: Who do you think engages more in this type of relation-husbands or wives?

Hunduma: I think men engage in extramarital relation more because women are almost all the time occupied by house chores. Women, even if they have the need for extramarital sex, do not have the time and freedom to go around and look for possible sexual partners as men do. The youth, especially the ones at school, have multiple sexual partners and engage in risky sexual relation. They learn about HIV/AIDS as part of school subject. Health workers also give lessons concerning the virus to the whole school community at different times. In spite of all these efforts, our students do not show the expected behavioural change. I think one of the reasons why our youth do not show expected behavioural change is absence of discussion of sex-related issues between the parents and their children at home. Families do not advise their children what is good and what is bad about sex before the children are mature enough to begin sex. They simply tell them that sex is bad. When the children mature to begin sex, everything initiates them to have sex. Their inner emotions, their young and grown up friends all tell them that sex is something enjoyable. Even if parents try to intervene and stop the youth at this time, it is of no use because they were not accustomed to discussing sex-related issues before.

10. Gudeta: How do you explain the cooperation of husbands when you try to mobilize women to protect themselves from infection by the virus, for example when you call the women for meetings?

Hunduma: Women could not control their emotion when we told them their life experiences. They sobbed when we told them the bitter experiences they had during circumcision and its negative impact on child delivery. But when we called them for the training, the training we have had with all women in all kebeles recently, they were reluctant to come. After attending the meeting, however, they regretted their reluctance. That is to say, not only men but also women themselves do not know the advantage of attending meetings or trainings. When we come to men, I think men resist any move that is made to empower women-especially they do not want women to be aware of their status and that this status is not naturally given and has to be resisted. But they do not openly speak this. They do not say women should not be made to know their status. They do not say women should not learn or assume power. They do not say women should not go to meetings because they are inferior. But they speak through their actions. Let me tell you what happened during the training of women I mentioned above. We received a report that a husband beat his wife for attending the training. We asked the woman who was beaten and she told us that it was true. She told us

that he beat her because she refused to accept his order not to go to the training. We called the husband to office and asked him about what happened. He did not deny that he beat her. But when we asked him why he said that because the woman refused to go the training. That is what men do nowadays. They try to cover up their reasons for doing something when they know that what they did has legal consequences. The problem, however, is that women themselves are not strong enough to bring such cases to the law. But we observed after the training that they started to stand together for their rights. We heard that in one kebele a woman was in labour. Men refused to take her to a nearby clinic because they did not find it important. But women in the neighbourhood were gathered and after discussing, carried the woman to the health centre. Here we can see that the teaching started to take effect.

11. Gudeta: What do you think is the attitude of rural people towards condom?

Hunduma: Rural people express their disliking for condom in different ways. The main reason they offer for this disliking is that it paves the way for adultery.

12. Gudeta: What did your office do to bring attitudinal change towards condom?

Hunduma: I think we have not done enough to change people's attitude towards condom. In the first place, condoms are meant to be used by men but our health extension workers, who have to teach about condom, are women. The problem here is that these female health extension workers do not have boldness to teach to men about condom. They are ashamed. They especially cannot demonstrate condom on penile models in front of men. They of course teach what a condom is and what it is used for. But they do not have the courage even to show a condom where there are men. This may be because these workers are working where they were born and brought up. There are elderly men and women whom they fear. They are also products of a culture where women are expected to be ignorant about sex-related issues. I think this is what contributed to our inability to change the existing negative attitude towards condom in rural areas. This is also what we have to work on in the future.

13. Gudeta: How do people express this disliking in what they say?

Hunduma: They say they feel burning sensation when they use condom; it weakens the woman's sexual feelings; and it carries the virus itself. They say all these without trying it for themselves. As I have tried to tell you, we have not done enough on this issue. But I know that it is not because they do not know that condom saves life that these people object to its use. They once conceived that it is a sign of promiscuity and we failed to help them get rid of that misconception. We proved that people want to use condom but are ashamed to express this need in words because if they express it, they will be labelled as promiscuous. We carried out a simple experiment on this issue when people refused to accept condom from health workers. What we did was that we left condoms, at night, where people can see them and we left the spot unnoticed. When we came back in the morning, all the condoms had been taken away. We found out that this was an effective way of distributing condoms but we soon gave

up because we feared that children would have access to condom and begin practicing with it at an early age. People know the advantage and use of condom, want to use it but avoid it because of the negative social value attached to it.

APPENDIX H

Interview, Health Extension Worker

Name: Bontu K. Age: 22 Education: 10+1 Date: 11/10/04 Site: Garadie
Started: 10:04 Ended: 10:48 Archival No: HF001

1. Gudeta: As a health worker, have you taught the impact of gender on spreading HIV/AIDS?

Bontu: Yes, I have but our people do not show change. They understand and accept what we teach them. When we teach them and immediately ask them to be tested for HIV, they become very eager to know their health status. They line up to give their blood to the point that there were no kits for all of them. After a month or so after the teaching, however, you find them indulging in the same risky behaviour which they were taught to abandon. They know that the behaviour is risky but they persist in doing that.

Gudeta: Why do you think do they cling to the behaviour?

Bontu: I think they find it difficult to give up what they have been accustomed to from birth.

2. Gudeta: What was the content of the lesson you taught?

Bontu: We focus on how the virus is transmitted. Most of the time, after VCT, the nurses who carried out the counselling and testing congratulate them for being free from the virus. But we tell them after the nurses have left that not all of them are free. We say that there are some people who have the virus. We [the nurses and health extension workers] have a code to communicate who is free and who is not. Some of you have the virus and some are free. So you have to be careful in your relations. We do this to create mistrust among them so that they may not indulge in unprotected sex thinking that they are free from the virus. We tell them preventive methods they have to follow.

Gudeta: But why should you tell them something that you know is not true?

Bontu: We know from experience that once they know that they are free from the virus, they start to engage in unprotected sex with those they know have been tested and are free from the virus. They convince themselves that once free from the virus, they are free forever. So it is if you make them suspect one another that they take care fearing the disease. They do not think that one who is free from the virus today can contract the virus through unprotected sex.

3. Gudeta: Do you teach what backward traditional practices are and how they are related to HIV/AIDS?

Bontu: Not all traditional practices transmit the disease. What we teach the people in general is not to share sharp instruments with anyone. We stress that each family member

should have his/her own instruments and should not lend or borrow them from other family members. We teach them this in addition to teaching them the impacts of female genital mutilation, abduction, wife inheritance and the like. As a result of the teaching, practices such as abduction and wife inheritance are no more practiced in our area. Circumcision, however, though not practiced publicly, is done in secret. They take the girl to a neighbouring house or a relative far away and circumcise her there. The reason they take the girl to another place is to avoid the rumour leaking out and reaching the ears of suspecting neighbours or government bodies such as the kebele leadership. We hear that so and so has circumcised his daughter after the circumcision is long past. It is long past and on top of that we do not have any evidence to bring the offenders before the law. Courts always require evidence and no one performs such acts as circumcision in the presence of other people who would testify against them. Offenders are escaping unpunished and the practice is hidden but not stopped. Due to these conditions, those who gave up circumcising their daughters are now regretting their decision. They fear that their daughters may become objects of laugh as most of the girls are circumcised. Those who did not circumcise their daughters still stick to the belief that uncircumcised girls break utensils and are sexually uncontrollable. We taught them that circumcising girls does not make the girls modest and sexually calm. To the contrary, it has negative effects on the girl's health. It complicates delivery and has resulted in the death of many mothers. When they learned about the negative effects of circumcision, women were moved to tears associating what we had said with their own experiences. But after going home, you find them practicing the same thing that they were taught affected their life. They do this so that their daughter may not be insulted by her friends and lest she become sexually active. The value people attach to circumcision is still there. Those girls who have not been circumcised do not feel free in the presence of those who are circumcised. This is because they know that they are few in number and they would be looked down upon by others. So what is really happening is the opposite of what we expected would happen-those who obeyed the law are regretting their deeds whereas those who offended the law are feeling proud and encouraged. Even we ourselves are being discouraged because we are labouring for nothing.

Gudeta: You have said that the court is asking you for evidence whenever you try to level a charge against those who circumcise their daughters. Is it not possible to verify through medical examination the fact that the girls were circumcised?

Bontu: It can be verified but the punishment is not as educative as it should be. Let me give you an example. A certain family circumcised its daughter and this was exposed after sometime after the circumcision was performed. District women and children's affair office levelled a charge against the family. The court ordered the health centre to verify whether the girl was circumcised and the centre ascertained that she was really circumcised. The court

then sentenced the parents though the sentence was not serious enough to give lesson to other parents performing the same act. The parents were sentenced to six months prison term. It seems that the police also defend circumcision. Whenever women bring an issue of circumcision to their office, they ridicule the women saying, “Were you not circumcised yourself and would you not circumcise your own daughter? Why do you try to put others in trouble for doing something that you would do?” They do not consider it as a crime. I sometimes think to myself that we, health workers, are teaching the people to stop something that is not forbidden by the law.

4. Gudeta: How do you explain the practice of rape in your locality?

Bontu: I have never heard of rape in the kebele where I am working now. I heard that one or two men were sentenced for raping women in other kebeles. What I often hear practiced in remote kebeles of the district is abduction. When we have meetings at district level, we hear reports from our friends working in these remote kebeles that there are girls stabbed to death when they tried to resist the abductors.

5. Gudeta: Where do you get HIV gendered vulnerability messages from?

Bontu: I think some of the messages are prepared at bureau level. Some are prepared at zonal level and sent to districts. Then the districts distribute the messages to their kebeles. We use these materials as well as a book we were given at the end of our training. This book has the 16 health packages.

Gudeta: Does the district health office or do you make any amendments or changes to the messages before delivering them the target people?

Bontu: We make no changes at all to the messages but we face resistance from the people when we teach about condom. They blame us assuming that we are encouraging adultery.

6. Gudeta: Do you prepare your messages for specific group of people such as husbands, wives, etc. or for the public in general?

Bontu: The messages were not prepared for any specific group of people. There are 16 health packages and none of the packages focus on any specific group of people. It is we ourselves who prepare our messages according to the age and interests of the group we are going to teach. We prepare messages differently for the old and the youth, for example.

7. Gudeta: How do you explain the changes these messages brought in the behaviour of couples?

Bontu: The behaviour change brought is less than what is expected. There are only two health extension workers in the kebele and when compared to the magnitude of work they have to accomplish, this number is much less. But this does not mean that there is no change. There are changes. As a result of what they have been taught, people do not get married unless both of them are tested for HIV. This is one result of the teaching. On the contrary,

there are youth who are married without getting their blood tested for the virus and without the consent of their parents. If they were married with the consent of the parents, the parents would not accept the marriage without the boy and the girl getting tested their blood for the virus. This is because the local community and local churches have agreed that a boy and a girl should be allowed to get married only after they have been tested for HIV. All churches in our locality have been implementing this for three years now.

8. Gudeta: How do you explain the extramarital sexual relation of couples in your area?

Bontu: It is not practiced now as we heard it was before. People started to consider it as a shame and culturally unacceptable. You hear no one speaking in favour of the practice. We do not hear rumours that men have sexual relation with other people's wives. Nevertheless, we cannot say that people have given up the practice altogether. There are some evidences that lead us to the conclusion that extramarital relation is still practiced. We often see that girls or widows become pregnant in this kebele. Though there is no tangible evidence since the thing is done in secret, there are rumours that married men have sexual relation with other people's wives or with girls. From this, we can understand that both husbands and wives practice extramarital sexual relation. We sometimes hear a husband and a wife quarrelling over issues of promiscuity. Therefore, we can say that though the practice is not encouraged by the society, it is still practiced.

9. Gudeta: Who do you think is more promiscuous- husbands or wives?

Bontu: I think men are more promiscuous. Wives sometimes come to me complaining about the promiscuity of their husbands. Especially some strong women I have been working with in this kebele say, "I suspect that my husband has had an affair with another woman. Therefore, I cannot sleep with him unless we are tested together for the virus." We bring them together and try to convince the husband to be tested. In some two or three cases, the husbands accepted us and were tested for the virus. None of them were found HIV-positive. We did this just to calm down the women and bring peace to the family for we know that the virus cannot be detected in the person's blood before three months from infection. Still some men say 'I am loyal to my wife; why shoul I be tested'? When the husbands become stubborn, the wives drop the issue and resume their normal life as before. We also keep quite because we do not want to incite disagreement in the family. So it is women who always complain the promiscuity of their husbands which shows husbands are more promiscuous.

10. Gudeta: How do people express their reaction to promiscuity or loyalty in their daily language?

Bontu: As I told you earlier, promiscuity has now become discouraged. It is punishable from legal point of view too if it is done with someone else's wife or husband. So even if they do not want to be loyal to their partners, people do not say it is better to be

promiscuous. Let me give you one example. There was a man who married a second wife while living with the first one. After sometime, the first wife found out that her husband married another wife and accused him of polygamy. The court, after hearing the case, passed its verdict that the second marriage was illegal and should be dissolved. The man accepted the court's verdict without saying anything to defend his act. But even after the court's decision, he continued with his relation with the second wife. So, people do not say it is good to be promiscuous even if they are promiscuous themselves. They remain silent or verbally accept what is supported by the existing political system and practically do what they believe in, if possible, in secret. The reason why extramarital sexual relation has been minimized is not because all people changed their belief but the practice is discouraged by the administration. When people suspect that their opposing something results in legal action, they speak against their belief just to escape the punishment.

11. Gudeta: How do you explain people's reaction when you teach about condom?

Bontu: Let alone other people, members of kebele leadership who have attended different trainings and are expected to speak in favour of its use tell us face to face that we should not even mention the name of condom. They say, "You teach that the youth should not begin sex before marriage and the married should be loyal to each other. And again, you say that we should use condom. That is, you are telling us not to be loyal. Why is it necessary to use condom if people delay sex until married and are loyal to each other once married? This is confusing. Telling people to use condom is giving them license to begin sex anytime they need and to have extramarital sexual relation after marriage." They also relate condom to religion and say, 'encouraging people to use condom is preaching adultery.' We always tell them that we are not advising them to use condom with someone else's wife or another woman outside marriage. We say that a husband and a wife can use condom as an alternative way of contraception especially in cases where the wife is allergic to pills or other contraceptives. But still many of them say that condom should not be accepted under any circumstance. Some of them, however, especially the married youth, directly tell us that they are not loyal to their wives and accept condom from us.

12. Gudeta: What are the rumours that circulate around in favour of or against the use of condom?

Bontu: Men often tell us that women do not like it. They only tell us that women hate it without telling us the reason. Men say they do not like it themselves because they fear it would be torn. They also say condom itself carries and passes the virus. They say 'it is a false friend' because it gives them confidence to have risky sexual relation but does not really protect them from the virus.

Gudeta: What do women themselves say?

Bontu: They do not tell us because they are ashamed. So I do not know whether women hate it or not. What I know is that married people generally hate it. The major reason they give for their hatred is that it promotes adultery.

13. Gudeta: Do women attend meetings you call to teach HIV and related issues?

Bontu: Most of the time they like to be represented by their husbands. I think they do this to please the husbands who do not want their wives to be present at public gatherings. But this trend is changing now. They [women] started to attend meetings irrespective of whether the husbands like or dislike it. We also do not want to gather them at kebele level whenever we want to teach them. We always go from house to house. When we do this, it is women that we find at home for men are often away from home. We also find women when they bring their children for vaccination.

14. Gudeta: Do you know cases where only a husband or a wife has the virus and the other does not have it?

Bontu: Yes, there are many such cases in our kebele.

Gudeta: What impact did their serostatus have on their relation as a husband and a wife?

Bontu: Let me tell you about a couple where the wife has the virus but the husband does not. When he first heard that she was HIV-positive, he sent her away complaining she infected him. But through the counselling given to both of them, they are living together now. We told him to use condom and he accepted that because he is educated. But even after that, they often quarrel, the husband blaming the wife for her act in contracting the virus. He often blamed her of promiscuity because he was tested and was free from the virus.

15. Gudeta: What is people's attitude towards the woman who was found to be HIV-positive?

Bontu: This is not new in our kebele. There are some 15 people living with the virus now. People reacted differently to these people. I know a woman, who, after suffering for a long time, finally knew that she was HIV-positive. She and her husband divorced long time ago. It was rumoured that the reason for their divorce was the woman's disloyalty to her husband. They also said that the husband requested a divorce because he knew that she was having an affair with someone who had the virus. After knowing of her serostatus, the woman's children all avoided her. They refused to eat and drink with her. They refused to touch anything she touched. They refused to accompany her to hospital. It was after a lot of persuasion that we convinced them to accompany her to hospital. We told them that she would get financial support from different organizations because of her health status and would no more be a burden to them. Even then, they could not forgive her; they just tolerated her. They still blame her for disgracing them. Unfortunately, this woman has not been given support of any kind. This has been another reason of complaint for the children. They

tolerated her hoping they would get support to care for her. The absence of this help renewed or even aggravated their hatred. There are also cases where the husband or the wife, after knowing that he or she has the virus, keeps it secret from the partner. In such cases, we tell the other partner to be tested and know his/her serostatus. We simply stress that he/she has to be tested. If we tell them that one of them has the virus but is hiding it, this might be the cause for dispute and we might be blamed by the society for doing this. What we want is to save their lives. What is surprising is, men always blame their wives for contracting the virus even where it is they themselves [husbands] who were tested and knew their serostatus first. They do not blame their wives openly. They nag them and make them feel guilty. Women, even if they know that the husbands were tested and knew their serostatus first, do not answer their husbands back for fear that this may worsen the matter.

16. Gudeta: Is it only you, health workers, or are there other persons or organizations teaching about the relation between gender and HIV?

Bontu: The church and other NGOs also teach. It is not only the health workers.

Gudeta: Do both of you, for example, the church and health workers, equally emphasize all preventive methods?

Bontu: No, we do not. For example, we differ on the emphasis we give to the use of condom. The church says that condom should not be used since it is encouraging adultery and adultery is unbiblical. But we have evidence that even those who publicly oppose the use of condom, including church people, use condom. When we ask them to use condom they oppose that and even blame us for saying so. But when we put condoms away from the reach of other people and where it is accessible to these people, they take the condoms without even leaving one. They also know how to use it for it is often found used and thrown away. These people condemn condom only in their speeches. They do not want other people to know that they use it.

APPENDIX I

Interview, District HAPCO

Name: Diriba Worku Age: 39 Education: 12+3 Date: 26/09/ '04 Site: Garadie
Started: 11:05 Ended: 11:55 Archival No: WF002

1. Gudeta: Have you ever participated in teaching the impact of gender on the spread of HIV/AIDS?

Diriba: Yes, six weeks ago, we were teaching women alone about female genital mutilation, abduction, polygamy and the impact of these practices on spreading HIV/AIDS. This type of teaching was not common before.

Gudeta: What do you mean when you say it was not common?

Diriba: Previously, we were teaching the public in general. But this time the focus was only on women. Although the content of what we taught was meant for the public in general, it was only men who attended meetings and got the lessons. Women did not have the chance because they were busy attending to house chores.

2. Gudeta: What was the content of the teaching?

Diriba: It mainly focused on backward traditional practices such as polygamy, abduction and rape. We taught that these practices are associated with gender and gender relations have their role in spreading HIV/AIDS. We also taught the women that they have to be organized to fight against such practices.

3. Gudeta: Where was the lesson prepared?

Diriba: It was prepared at health bureau level. The bureau prepared and distributed it to districts.

4. Gudeta: What changes did you make to such messages before delivering them to the target audience?

Diriba: We simplify the language so that the people can understand it easily. We also improve the content by making it focus on major problems prevalent in our district. For example, circumcision and extramarital sexual relation are our main concern at this time whereas abduction is not as serious as the two. So we reshape the messages so that they may emphasize problem areas.

5. Gudeta: Have there been interventions that aim at changing people's behaviour in this district?

Diriba: Yes, we have been teaching the public in general either to abstain from sex or to be faithful to their partners or use condom. Before coming to telling them the behaviours to be changed, we taught them how the disease is transmitted. Then we told them how it can be prevented. That is the behaviour change they have to bring.

6. Gudeta: Was the content of the intervention prepared for husbands and for wives separately?

Diriba: We have started to focus on women. But we have not prepared lessons separately for husbands. It was the practice that whenever we called meeting of any kind, it was only men who attended. So there is no need to teach husbands separately.

7. Gudeta: What changes have been brought on people's behaviour as a result of the intervention?

Diriba: Circumcision, abduction and polygamy have been abolished. But these practices still linger in remote kebeles of the district. In these kebeles, the practices are still there though they are not practiced as before.

Gudeta: What is the reason for this discrepancy?

Diriba: It is not convenient to go to these kebeles as often as to the nearer ones mainly due to transportation problems. They do not get information as kebeles nearer to roads. There is a low probability of bringing offenders to law when these acts are performed. Offenders will have time to silence victims through arbitration because of the distance of the place from the district town. The social tie is strong there that the kebele leadership cannot go beyond local elders. Other kebeles, however, do not have these problems.

8. Gudeta: How do you explain the current extramarital sexual practice of couples in your locality?

Diriba: We advise people to abstain from sex before marriage and to be tested before getting married. In spite of this, people still engage in premarital sex. This is evident from the fact that some girls become pregnant and risk their life while attempting abortion.

Gudeta: What about married people?

Diriba: It is difficult to support what we hear with evidence like that of girls. But it is rumoured that married people also engage in such practices with those married and with the unmarried ones. Besides, some married women who have been tested were diagnosed HIV-positive. Though we cannot say that women contracted the virus through their promiscuity, this can be evidence that couples practice extramarital sexual relation.

Gudeta: Why did you say women were tested? Does that mean the husbands were not tested?

Diriba: Not as many of them are tested as women. Women are tested when they come for prenatal test or to get their children vaccinated. Even when they are tested, they make us promise we do not expose the secret to the husbands in case they have the virus in their blood. When we ask them why, they say that if the husband finds out the truth, the whole family will be dispersed. So they keep the secret to themselves.

Gudeta: Do you tell the husbands to be tested or you simply keep quiet just like the wives?

Diriba: We cannot tell the husbands that the wife has HIV because we promised not to do so. If we expose the secret, in the first place, the relation of the couples will be in danger. Second, other women will refuse to be tested fearing what would follow if they become HIV-positive. So we teach the people to be tested and know their status. We also tell the wife to initiate her husband to use condom giving him different reasons. But the women tell us that this is impossible because it will make the husbands suspect them of promiscuity.

9. Gudeta: What do you think do the people know about the transmission and prevention of the virus?

Diriba: We have taught them about the three preventive methods-abstain from sex at least until married, be faithful to a marriage partner or use condom if unable to be faithful.

10. Gudeta: What do people say concerning what they have been taught?

Diriba: What I know is what they say on the stage. There, they say that it is better to be faithful to one's partner.

11. Gudeta: According to what has been taught, who is more responsible for transmitting HIV/AIDS, men or women?

Diriba: We have not taught whether men or women are more responsible. But those polygamous men may transmit the virus more since they have sexual relation with two or more women.

12. Gudeta: Who do you think should play greater role in preventing the spread of the virus?

Diriba: Both should be taught and participate in the prevention process equally. Both have equal role in sexual relation. Therefore, they should also have equal role in the prevention.

13. Gudeta: What do people in the rural areas say concerning the use of condom to prevent HIV/AIDS?

Diriba: We have not focused on rural areas in teaching about condom.

Gudeta: Would you explain why you focused on urban areas only?

Diriba: Rural people are not interested when we teach them about condom. In the first place, they say they hate condom because it minimizes sexual pleasure. Second, they say teaching about condom is encouraging people for adultery.

Gudeta: How do they relate condom to adultery?

Diriba: They say that people may refrain from sex fearing the virus and unwanted pregnancy. But if they are taught or allowed to use condom, they feel secure from both the virus and pregnancy and engage in extramarital and premarital sex. So they prefer to be taught about faithfulness than about condom so that people may refrain from extramarital and premarital sex.

14. Gudeta: How do people express their attitude towards being faithful to one's partner?

Diriba: They say faithfulness, besides protecting people from the virus, solves other social problems too.

Gudeta: What social problems does it solve?

Diriba: As a result of lack of faithfulness husbands and wives quarrel or even divorce, families are dispersed, all family members suffer psychological problem or sometimes people even kill each other. But where there is faithfulness, there are no such problems.

Gudeta: Thank you for your time!

APPENDIX J

Material for Document Analysis

**Social Mobilization
For Prevention and Control of
HIV/AIDS Community Conversation
Training Manual**

HIV/AIDS Prevention and Control Office

Ministry of Health

July 2007

1. INTRODUCTION

According to the 2007 surveillance survey conducted in Ethiopia, the estimated number of people infected by HIV is 978,000, out of which 258,264 need anti HIV/Aids treatment. The average prevalence rate of HIV is 2.1% (2.6% female and 1.79 male). Urban and rural prevalence rates are 7.7% and 0.9% respectively. It is estimated that there are 898,350 HIV/AIDS orphans that need care and support. (Source: Single point estimate Annual Report.)

In order to strengthen the country's coordinated multi-sectoral anti HIV/AIDS response, preparation of different policies, programs, guidelines and plans are in progress; and Social Mobilization Implementation Manual is one of them. This implementation manual is developed based on the previously prepared Social Mobilization Intensifying Strategic document. The main programs included in this manual are the community conversations in the general population as well as youths in schools.

Recently, HIV/AIDS-related community dialogues have been initiated in many of the regional states. Through these endeavours, there has been success in coordinating and utilizing community resources, raising public awareness on HIV/AIDS, reducing harmful traditional practices and enhancing care and support activities among the community. The development of this manual has been initiated by the need to establish nationwide effective planning and evaluation system concerning HIV/AIDS endeavours. Besides, it is believed that the community conversation-training manual will serve as a pre-requisite for the implementation of social mobilization manual.

This manual is centrally prepared to enable all stakeholders, from federal to community levels to follow the same pattern in the process of implementation. Coordinators, implementers and those who support community conversation program are among others that this manual is intended for.

2. Community Conversation Concepts, Objectives, Principles and Expected Outcome

2.1 Concepts

Community conversation is a process in which representatives of different members of the community come together, hold discussions on their concerns and by using own values and capacity, pass resolutions that can bring about changes, and implement them accordingly.

From the perspective of HIV/AIDS response, community conversation is a process in which the community uses the material wealth, social knowledge and positive norms to prevent and control HIV/AIDS epidemics, and curb the social crises imposed as a result of the epidemic. It also encourages the community to use the available health and related services and build sustainable capacity to manage the social challenges as the owner of the problem.

Community conversation is a means of involving the community for social change and building its capacity. Both Latin American and African countries have been practicing this approach since the 1970s and brought about positive outcomes.

Anti HIV/AIDS community conversation concepts got wider recognition because they followed information dissemination education and development practices which were based on personalities, failed to involve the community and to take their capacity into account. The result was that they could not bring the intended change, as indicated in different surveys done previously.

There is a conviction that the community conversation would help in preventing and controlling HIV/AIDS epidemics and enable the community to provide care and support services, and mobilise the society to make a difference. For their success, HIV/AIDS community conversation messages depend on the existing social practices and relationships as well as community concerns. Community conversations use group discussions as a means of imparting information and since these discussion groups are led by the facilitators, the knowledge of the facilitators in moderating discussions has a significant role. Group discussions are preferable because they provide equal opportunity to the participants to air their views freely.

2.2 Objectives

2.2.1 Venture for rapid, quality and comprehensive contributions for social mobilization through building the capacity of individual, community and organizations.

2.2.2 Coordinate and utilize the capacity and resources of individuals and that of the community and properly respond to HIV/AIDS epidemic, thereby increasing the awareness to analyse, develop and initiate change.

2.2.3 Encourage and enhance the involvement of people living with HIV/AIDS, by analysing the attitude of the community and creating a condition where the two parties can cooperate and live together.

2.2.4 Initiate individuals and the community to utilize properly the existing health facilities and related services.

2.2.5 Build individual, family, community and organizational capacities to enhance coordinated social response and care activities and alleviate HIV/AIDS impact through community participation.

2.2.6 Establish a system, which will assist individuals and organizations to work with the community.

2.2.7 Facilitate the transfer of knowledge and skills amongst individuals, organizations and the community at large.

2.3 Principles of Community Conversation

2.3.1 Recognize Community Capacity

Community conversation should identify and utilize capacity of community for the anticipated changes and help transfer the experience to other communities

2.3.2 Encourage Participation

Community conversation should encourage participation through listening and respecting other participants' point of view and openly discuss concerns to create mutual understanding.

2.3.3 Respecting Community Values

It is advisable to understand and respect the life style of the surrounding, families and the community to be the core factor in initiating their own decisions rather than imposing.

2.3.4 Partnership/Joint forum for Learning

The joint learning forums have to be organized and discussions between facilitators and the community, amongst communities, individuals and also among organizations have to be carried out to reach practical solutions.

2.3.5 Gender issues

Cognizant of the fact that social, economic and cultural suppressions have highly exposed women to HIV/AIDS, they should be encouraged to fully participate and contribute to community conversation along with men.

2.4 Expected Outcomes of Community Conversation

2.4.1 The community will be able to develop wider and comprehensive view on harmful traditional practices that fuel the spread of HIV/AIDS in the community and bring about behavioural and social changes to avoid them.

2.4.2 Encourages the community to solve the problems by applying its values and the practices recommended.

2.4.3 The community's ownership attitude to HIV/AIDS prevention and control activities shall be enhanced.

2.4.4 The community's capacity to plan, implement and follow-up HIV/AIDS interventions will be strengthened.

2.4.5 The community's health and related services utilization will be improved.

2.4.6 Stigma and discrimination of people living with HIV/AIDS among the community shall be minimized.

2.4.7 The positive response of people living with HIV/AIDS to the pandemic will be enhanced.

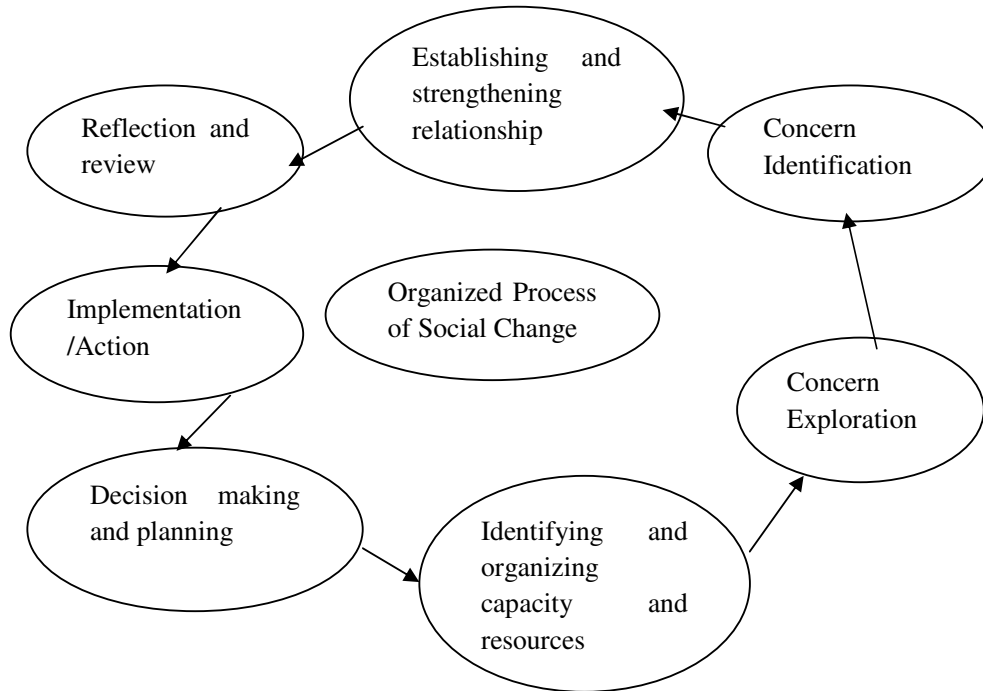
2.4.8 The contribution of the community towards providing care and support will be increased.

2.4.9 The willingness and capacity of joint efforts among the community, partners and government bodies shall be strengthened.

Part One – For Participants, trainers and facilitators

3. Methodological Framework of Community Conversation

As community conversation is a continuous process, the implementation follows the following steps.



4. Discussion Topics for Community Conversation

4.1 Establishing and strengthening Relationship

4.1.1 Introducing Participants

Introducing participants and facilitators will help to know and trust each other, build mutual respect and create sound relationships among the participants.

Objective

The purpose of introducing community members and facilitators is to create strong relationship during the discussion process.

Methodology

The facilitators will tell participants to get into pairs with the person whom they do not know and ask them to introduce themselves to each other:

- o Name
- o Community of origin
- o Favourite hobbies
- o Strengths/what they most like about themselves
- o Name by which one wishes to be called

After sharing this information, each person presents his/her partner using the information collected during the discussion. At community level introduction will take place on the stage.

4.1.2 Governing Rules during Conversations

Every community has its own rules and regulations. These rules and regulations are established by the participants and govern all the activities and interactions of the community during the workshop.

Objectives

1. Give enough time to the participants to formulate the rules and regulations
2. Agree on additional ground rules required during the facilitation of the workshop.
3. Agree on the accountability of the members to the rules they have set.

Methodology

- o Discuss and agree on the importance of mutual respect, approach and behaviours that should exist among members during the workshop.
- o Ask groups to explain the ground rules in picture form. For example, the rule 'No smoking in the meeting room!' could be shown by putting 'X' on a cigarette picture.
- o Form a group comprising 4 to 5 members.
- o Distribute papers and markers to each group.
- o Ask each group to present their picture to the larger group and also ask them to explain the rules they would like to be adhered to.
- o If two groups have drawn similar pictures, decide with participants as to which picture is better.
- o In the plenary session, if participants agree on each proposed rule, post the picture on the wall.
- o Ask participants to select 'minister of justice', who serves for a week time, to remind when rules are not respected. Assigning timekeepers in rotation bases may be helpful.
- o At the end of the session, briefly highlight the importance of respecting common codes of conduct in order to exist in harmony.
- o This process is to be emphasized in the training of facilitators, but the community conversation sessions shall have general rules and guidance to follow for the sake of time saving.

4.1.3 Group Formation

In any community, working in a group is more successful than working on individual basis. Accordingly, it is important to facilitate conditions for participants of

community conversation to work in groups and share individual knowledge and skills. The participants have to reach consensus on this and be able to implement it in the future as well.

Objectives

- o Make the individuals aware of their roles in a group.
- o Enable group members to notice and recognize individual contribution in a group.
- o Explain the importance of other members' role in successfully completing group tasks.

Topics

- o Divide the participants into groups.
- o Distribute flip charts and markers to each group.
- o Ask participants to individually think of an animal that he/she can draw in 3 minutes.
- o Tell participants to be quiet and relay the markers and start drawing the picture.
- o Inform group members to complete drawing the picture of the animal they have in mind by extending lines (10-15 minutes).
- o Ask participants to name the picture and then post it on the wall.
- o Finally, ask them to present the group work in the plenary session.

Discussion questions

- o What did you feel?
- o What did you learn?

4.2 Identification of Concerns

4.2.1 Basic Facts of HIV/AIDS

A) HIV/AIDS Basic Facts

As a matter of fact, comprehensive knowledge and skill development programs were conducted regarding HIV/AIDS. However, there is still a gap to be filled and it is this gap that community conversation is expected to fill by equipping the participants with basic knowledge and skills about the epidemic.

Objectives

After the session, participants will be able to know and explain:

- o The different ways of HIV/AIDS transmission,
- o Methods of HIV/AIDS prevention,
- o The different stages of HIV/AIDS,
- o All about HIV/AIDS,
- o Sexually transmitted diseases and their linkage to HIV/AIDS.

Methodology

- o Explain the objectives of each topic.

- o Arrange participants in groups and introduce group enquiries.
- o Discuss the group enquiries.
- o Substantiate discussions with emphasis on the basic facts about HIV/AIDS.
- o Provide additional reading materials or flyers as much as possible.

Group discussion Questions

1. What are HIV and AIDS?
2. What are the ways of HIV transmission?
3. What are the methods of HIV Prevention?
4. Explain HIV stages.
5. How do sexually transmitted diseases transmit? Explain their nature of manifestation.
6. Discuss the relationship of HIV/AIDS and other sexually transmitted diseases.

Time

B) HIV/AIDS Programs and Services

Interventions to prevent and control HIV/AIDS include:

- o Information Education and Communication/Behavioural Change Communication program,
- o Counselling and testing services,
- o Antiretroviral treatment services,
- o Prevention of mother to child transmission,
- o Care and Support services,

Despite the widely expanded application of these services, people are not utilizing them as expected due to lack of awareness, accessibility problem and fear of stigma and discrimination.

In community conversation, further expanding services and improving accessibility have been given due attention. Simultaneously, raising community awareness, minimizing stigma and discrimination, increasing the demand in services, and providing care and support have to be strengthened.

Objectives

After the discussion, participants will be able to:

- ✓ increase their basic knowledge concerning services,
- ✓ widen their knowledge concerning benefits and locations of services,
- ✓ utilize services without fear, and
- ✓ get involved in care and support activities.

Methodology

- o Facilitators will explain the objective of the topics and mention group discussion points and questions.

- o Facilitators will give enough time to participants so that they can discuss the questions with their families, neighbours and friends.
- o Next day, participants will further discuss in-groupsthe points they gatheredfrom family members, neighbours or friends.
- o Every group will present its findings in the plenary session.
- o Facilitators will provide information, knowledge and skills on the basis of the findings presented by discussion groups.

Issues for Group Discussion

1. Where do we find IEC/ BCC materials around our community?
2. What are the benefits of HIV/AIDS counselling and testing services?
3. What are the benefits to be gained and precautions to be taken in taking ART?
4. What are the services provided to prevent mother-to-child transmission? And what are the advantages?
5. What is the true picture of care and support activities in our area?
What about the extent of community participation?
6. Where do we find the above-mentioned services?

4.2.2 Myths and Misconceptions

Home Work

Since the emergence of HIV/AIDS in Ethiopia, intervention programs have been using IEC/BCC approach to enhance people’s knowledge and skill and raise their awareness concerning the epidemic. Yet, there are still misconceptions and misbeliefs among the community about HIV/AIDS.

Example

- o Getting a mosquito bite transmits the virus.
 - o The virus can be transmitted by sharing food and drink.
- Participants will discuss misconceptions and misbeliefs with their families, neighbours and friends. The following day, participants will present their findings.

Methodology

- o In the next discussion session, participants will clearly explain points of misconceptions and misbeliefs.
- o If there are issues upon which participants could not agree, facilitators will elaborate more or invite professionals for clarifications.
- o Facilitators will record in detail the misconceptions and misbeliefs raised including responses given by members of the community. They submit and distribute to the concerned bodies and reflect it in all community meetings.

4.2.3 Reviewing and Analysing Prevailing Work processes

This is a process of reviewing the efforts made to prevent, control and reduce the impact of HIV/AIDS in the community.

Objective

The objective here is to enable participants identify the strength, successes, weaknesses and challenges encountered in preventing and controlling HIV/AIDS and alleviate its impact at individual, community and organizational levels, and then, design better strategy for the forthcoming intervention.

Methodology

- Facilitators will explain the objectives of the topic and discussion questions.
- Form discussion groups.
- Begin the session by asking participants to analyze the questions individually.
- The discussion has to focus on the objective realities and practices of the community.
- Group members will exchange individual viewpoints related to the questions.
- Group discussion points will be documented and presented to the larger group.
- Record lessons learned and weak points mentioned in order to build on and expand experiences that worked well and improve those that did not work well, after facilitating conditions for the group to reach an agreement. Finally, they will distribute the documents to the concerned bodies, discuss the information on different forums and collect responses thereof.

Issues for Group Discussion

1. What are the successful achievements regarding HIV/AIDS? Why? (At individual, community and organizational levels)
2. What are those practices that did not work well? Why? (At individual, community and organizational level)
3. What approaches are used at individual, community and organizational levels to combat HIV/AIDS?

4.2.4 Socio-cultural Facts and HIV/AIDS

HIV/AIDS is highly interconnected with the social norms and values of the community. The way people live and their relationship among families, the community and others is interrelated with the spread of HIV/AIDS and play significant role.

Social and cultural relationships, values, beliefs, norms, gender and power relationships are all based on misconceptions and beliefs on the pandemic.

The socio cultural dynamics that cause the rapid spread of the epidemic are called “arid grassland”. If you strike a match and lit it in dry grasses, the fire will spread quickly. On the other hand, there are also factors within community cultures that mitigate the spread of HIV/AIDS and minimize the impact. These factors are referred to as “green grassland”.

Objectives

The participants will be able to carefully analyse the conditions of the epidemic and identify its causes at an individual, community, and organizational levels and arrest its spread.

Methodology

- Explain the topics and group questions in detail
- Form discussion groups.
- Pay visit to each group, attend the discussions and create conducive environment.
- After the first question is well addressed, facilitators will initiate the second question
- Facilitators will ensure that the identified community concerns are discussed exhaustively and reach consent; and distribute the consolidated report of the meeting to the concerned bodies.

Issues for Group Discussion

1. What is the level of AIDS epidemic in our community? /State the impact and the most affected age group and mention 8 key issues in this regard.
 2. A wise man in/mention the name of the community/ went to the community to know about the underlying causes behind the spread of HIV/AIDS and listened to what people had to say and identified the following issues:
 - o Taking into account that women are inferior,
 - o Excessive alcoholic drink,
 - o Hypocrisy,
 - o The spread of sexually transmitted diseases,
 - o Inadequate supply and utilization of condoms,
 - o Less number of people to get HIV counselling and testing,
 - o Incrimination and stigmatization of people living with HIV/AIDS,
- Note: The causes of these situations can vary depending on the objective situations of a given environment.

Group Discussion

1. Do you agree with the viewpoints and conclusions of the wise man? Why? Give your reason.
2. List additional causes not identified by the clever man and present them in the plenary session.

4.2.5 Change and Language

Language has major role in the process of social change processes. The applications of certain words, their implications or the feelings they create have to be considered cautiously to avoid negative impressions among people. For example, the number of participants may decrease; it may create despondency and encourage retaliation.

On the other hand, proper language use could promote individuals and the community work together, minimize hierarchical disparity and take the initiative to support others.

Objective

To enable participants to avoid using words that humiliate or embarrass individuals and the community while discussing HIV/AIDS.

To enable them to be sensitive in choosing words that respect human rights, encourage participation, avoid stigma, discrimination and minimize hierarchical disparity.

Methodology

- o Facilitators enlighten the objective of the topic in detail,
- o Form discussion groups,
- o Describe the meaning of words or sayings in the discussion question by giving examples like /Orphan, Victim, Carrier of or affected by AIDS/
- o Facilitators will identify words or sayings that have negative connotations and the reasons behind. List the words agreed upon by the discussants to replace them and submit the topics discussed to the concerned bodies.

Issues for Group Discussion

1. List words and sayings that can have negative impact while communicating.
2. Why not we use the above words and sayings?
3. State or replace the above words and sayings with words that have positive impacts.

4.2.6 Assessment and Mapping

A. Surveillance Mapping

Mapping could be used to visualize, investigate and understand the surrounding of the community; such a move mainly focuses on some factors, which are given less attention by people. This situation will lead to give the neglected issues social attention and concerns. Participants will investigate the capacity and strengths of the community including the causes for the spread of HIV/AIDS.

It is to enable participants identify the strengths and concerns and build deep insight about their community.

Methodology

- o Make marked lines in areas where the trip will take place.
- o Participants will make the trip in groups.
- o The trip focuses on careful observation and insight about the community rather than asking questions or conducting discussion.

- o The trip could be avoided if the facilitators realize its contribution as insignificant for community conversation.

During the trip, carefully consider the following points:

- o Strengths of the community,
- o Meeting places,
- o Analyse how the “dry grass” affects the community in fuelling the spread of HIV/AIDS.
- o Identify the “green grass” or factors that support the prevention and control of HIV/AIDS.

B. Mapping

Following the trip, mapping could be used to visualize community strengths, concerns and other issues. Mapping will deepen the understanding of the current reality of the surrounding. It is also a way of documenting one current community reality and can be used again at a later stage to illustrate and measure changes that have taken place.

Objectives

- o Describe that mapping is used to identify community concerns.
- o Help participants map their own surroundings.
- o Use strategic questions to draw out community concerns using the map.
- o Emphasize that mapping is a tool that can be used throughout the process to identify and explore community concerns and make decisions.

Methodology

- o Explain that mapping is prepared based on the information gathered during the trip.
- o Describe that facilitators use mapping to help the community members to identify their concerns including HIV/AIDS.
- o Explain how mapping is carried out, and tell community members to select areas where they can exercise mapping. Individual members of the community should contribute their share in the mapping process. Location of schools, business areas, residential houses and other detailed places should be included in the map.
- o Group maps drawn during the trip will be ready.
- o The maps will be presented and explained at the plenary session.
- o Facilitators should use the maps to ask strategic questions to find out concerns of the community.

For Example

- o What health and other development related activities are carried out in your community?
- o Where does this activity take place?

- o What are the concerns of your community regarding HIV/AIDS?
- o How and in which area of your community is HIV/AIDS spreading?

4.2.7 Gender and HIV/AIDS

Gender issues have wider role to play in the spread or arrest of HIV/AIDS, and participants are expected to discuss the two issues deeply, examine their relationships and make decisions.

Before discussing the relationship of the two, participants have to be clear with sex and gender relationships and how they are manifested. Sex indicates the state of being male or female and as a natural phenomenon, is inevitable. This natural phenomenon shows the physical and reproductive differences of the two sexes.

Example

- Females get pregnant and breast feed.
- Male has moustache.

On the other hand, gender refers to the division of labour between male and female and the way it is conceived. This situation could be changed due to social, cultural, political, technological and economic situations.

Example

- Considering in-house activities as the domain of women,
- Families prioritization in giving educational opportunities to males,
- Organizations assign women on secretarial work and males in responsibility positions.

Objective

- To make participants well aware of gender issues and clarify their relationship and differences with sex.
- Participants will understand and explain the relationship between gender and HIV/AIDS, specially identify which sex group is more vulnerable to the epidemic.

Methodology

- Form groups and explain the topics in detail.
- Present the findings of the group to the plenary.
- The facilitators will present with additional information on top of the points discussed in the plenary and exhaust the issue.

Issues for Group discussion

- Explain the relationship between gender and HIV/AIDS.
- Which sex is more vulnerable to the virus and why?
- Discuss the causes for the spread of HIV/AIDS as a result of sex relationship.

4.3 In-depth Assessment of concerns

4.3.1 Story telling (Narration)

Stories could be told about people and what they do. They are ways of understanding social life, its dynamics, influences and impact. Stories touch listeners more than theories or statistics do. Stories and proverbs are the ways that traditionally helped people to understand their own actions and their impact on others.

Objectives

- Enable participants to explore values and attitudes influencing individual and collective behaviour.
- Demonstrate the use of stories as a tool to create conducive atmosphere to instigate self-expression.
- Mobilize the community to anticipate changes.
- Enable participants to discuss HIV/AIDS and related issues in detail.

Methodology

- Prepare stories based on the objective situation of the community.
- Invite participants to be in a circle to enable them listen attentively.
- Begin to narrate a story and invites community members to involve themselves and take part.
- Assist facilitators document individual views and responses forwarded after community story presentation.
- Facilitators analyse the views of the community responses.
- Facilitators share the findings from their analysis with participants.
- Explain how to prepare, analyse and present stories.
- Ask participants to be in groups and practice the creation of stories, document viewpoints, respond and analyse them.
- Facilitators conclude the session after discussing and commenting on the report presented by each group.

Story Creation

Stories could be created from the concerns of the community that require in-depth discussions to bring about positive results after community conversation.

The following points should be considered in order to create stories

- Ensure that the story focuses on identified community concerns.
- Underscore the possible outcome /direction/ of the identified community concern.
- Assure individual names, places and other matters are commonly used and avoid misunderstanding in all manners. Besides, the names of individual that took part in the story creation should not be mentioned.
- The story should be short and precise and inclusion of basic facts to clarify the story is helpful, as also deemed necessary.

- Ensure that the story touches the day-to-day real life of the community, and draws the participant's attention. This in turn will have significant role in the process and success of the discussion.

There are different ways of creating stories. The following story is presented as an example:

Abebe Kebede and Masresha Tesema are couples residing in Addis Ababa. They are faithful and love each other, and also exemplary to others. They have two children and Masresha is 3 months pregnant. Her husband Abebe is an engineer and works for a private company. Due to the nature of his work, he frequently travels out of Addis Ababa. Masresha is a civil servant working as a secretary in one of the government agencies.

As usual, Abebe went to Bahir Dar for a two-week mission. He has planned to make his return trip next day and wanted to watch television news in the hotel bar. He started drinking beer and continued taking more while attending the television programs and it happened that he passed the night with one of the bar ladies. The next morning he realized that he had sex with a young lady without condom and was highly depressed.

As he noticed that return to Addis Ababa is approaching, he picked his luggage and went to the airport and checked in. In the mean time he started recalling the events of the night, which were unique and unusual practices of his life. The situation bothered him so much and started thinking by asking himself the following questions:

- The situation might have exposed me to HIV/AIDS.
- What am I supposed to do?
- How can I inform my beloved wife?
- Can the situation create problems in my relationship with my partner and beloved family?
- Whom should I first inform about the situation?

Finally, ask all the participants to put themselves in Abebe's shoes and narrate the story.

Facilitating story telling

After carefully creating the story and determining the time for community presentation, facilitators should consider the following points:

- One of the facilitators will tell the story taking position in an appropriate place that will ease the audience to be attentive. The second facilitator will document the viewpoints and responses of the individual community members. This facilitator will sit with the community and collect the information without obstructing the attention and feelings of the community.
- The facilitator narrating the story has to face all participants and give equal opportunity during the discussion.

- He/She has to allow participants to see the story in different angles in relation to community concerns arising from the discussion.
- The facilitator has to know when to stop the discussion. The story has to be discontinued at some point to make participant more eager about what next. This way the discussion could be extended with their families and friends. However, it is not advisable to stop the discussion without letting the community exhaust the issues.
- Finally the facilitators with participants will make analysis of the story narration and present the findings for a broader discussion.

Analysis of Narration

After the story, it is important for the community to conduct discussion, which has great advantage and the facilitators have to prepare steps of analysis to start the discussion. The analysis includes the following points:

Analysis of story narration

Community Perception	Concerns	Neglected and overlooked issues	Misconception/misunderstanding	Issues that require action
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The above points are described in detail below.

Community Perception

It is an individual opinion; it includes the views and responses that were created on the basis of the story that participants listened to.

Concerns

Concerns are issues reflected by participants repeatedly and created mixed passions like happiness, initiation, anger, disappointment, dialogue and other feelings among participants during the discussion.

Neglected and overlooked issues

These are issues not raised or reflected by participants during the narration because of different reasons or reluctance to react. Even though participants overlooked some of the issues due to diverse reasons, the facilitators can raise them and give emphasis in the discussion.

Misconceptions/misinterpretations

These issues are points raised during the discussion but are far from reality and lack scientific evidences. It is necessary to document these misconceptions because they could contribute to the spread of HIV/AIDS. Hence, these issues will enable facilitators to develop

strategic questions and ideas when they start the discussion and formulate strategy to equip the community with such information.

Issues that entail Intervention

Story telling is a key to instate an in-depth discussion of community concerns, and in addition it assists and prompts the community to intervene.

Hence, facilitators should identify issues that require action on the basis of the content and process of the discussion and present the same for more discussions and suggestions.

4.3.2 Analysis of the Four Windows

The community should have in-depth awareness about the identified community concerns and their causes in order to make valid and acceptable decisions. To this effect, the analyses of the four windows enable one to see things in different perspectives. That means one can look at individual and community levels in light of internal and external factors in order to grasp the real picture.

Objectives

- Create awareness on the causes that fuel the spread of HIV/AIDS at an individual and community levels.
- Have insight and analyse the view and conceptual differences among individuals and the community, and understand the correlation between behaviour and real action.

Methodology

1. General concepts and objectives of the analysis of the four windows.
2. Divide participants into groups and make them analyse the identified concerns by using the four windows.
3. Discuss the findings of the groups in plenary session.
4. Highlight the findings including decisions made or solutions recommended.

Description: Analysis of the four windows

	Internal	External
	Subjective invisible and unsuccessful	Objective/tangible/ visible and successful
Individual/individualistic	B)•Observation • Feelings • Assumptions • Approach	A)• Behaviour • Action
Common/communal	C)•Culture/habit/norm • Value • Common outlook	D)• Regime/system • Structure • Policy • Service delivery • Governing rules

In the analysis of the four windows, the issues stated in the four different quadrants could be discussed as follows:

- The issues included in /A/ (the individual and external quadrant) are community concerns pointed out during the discussion. These are the starting points of the discussion.

- Issues included in /B/ (individual and internal quadrant) are the causes that prompt individuals to behave or act on matters stated in /A/.

Example: Statement like “sex with condoms reduces satisfaction” could lead individuals to abandon using condoms.

- Issues included in /C/ or (common and internal quadrant) are factors that create behaviour or actions related to culture, habit, norm and value that create community concerns, which are stated in ‘A’.

Example: If the community believes that uncircumcised girl is out of the social norm, then girls are apt to be circumcised.

- Issues included in /D/ or (common and external quadrant) are factors that create favourable situation or behaviour by using system, structure governing rules, service delivery and the like, which are stated in ‘A’.

Gaps:

Example: In a community, where there is no HIV counselling and testing service, it could be a cause not to get tested.

Note: Matters mentioned in /A/ need to be carefully analyzed, because behaviour and action are quite different both in content and quality.

4.4 Resource and Capacity Identification & consolidation

After building relationship and identifying community concerns, participants should recognize and consolidate individual and group capacity and resources in the community before they arrive at decisions and launch intervention.

Objectives

- Be able to identify and know individual and group ability, skills and strengths.
- Become aware and know the resources available in the community.
- Understand how to utilize the recognized individual, group and community capacity and resources to solve their problems.

4.4.1 Analysing Social Asset

Social asset are the societal, cultural makeup and communal relationships, customs and community based organization shared by a given society that interconnects each other.

Social asset

- Strengthen mutual respect and trust and build strong social bondages, and as a result minimize economic, social and gender differences.
- People will be reconstituted from the devastating impact of the epidemic and know themselves as part of their community and the culture. The good experiences they have could also be strengthened.

Objectives

1. Enable participants to identify the social assets in their communities
2. Assist participants to collect, coordinate and control social asset in the community to fight the spread of HIV/AIDS and associated impacts.

Methodology

- Arrange participants in groups and ask them to discuss the under listed questions and present their findings in the plenary.
- Not only help them identify social assets, but also ascertain through discussion the practicality of the identified assets.

Issues for Group Discussion

- Translate social asset in the local language.
- How is social asset manifested in their community? Explain the ways in detail.
- How can the above-mentioned social assets assist in preventing and controlling HIV/AIDS, provide care and support, reduce its impact and bring about behavioural change?

4.4.2 Appreciative Inquiry

Appreciative inquiry is a process in which people evoke their capacity and success stories and exchange experiences.

Objectives

1. Enable participants reflect their ability, strengths and skills.
2. Facilitate mutual learning from the experiences and successes of each individual in the group.
3. Remind them to use past experiences and skill in preventing and controlling HIV/AIDS and address community concerns.

Methodology

- Arrange participants into groups and ask them to discuss on appreciative inquiries.
- Present the points of discussion to the plenary and finally the facilitator summarizes the discussion points.

Issues for Group Discussion

- Discuss the initiative taken by the community to solve its problems or concerns using its own capacity, resources and skills.
- What are the resources, capacity and skills, currently used to minimize the problem or impact on HIV/AIDS?
- Discuss on the possibilities to arrest the spread of HIV/AIDS and reduce the impact by applying past experiences and successes.

4.5 Decision Making and Planning

This is the stage where the community prioritizes the identified concerns and decides possible solution and prepares plan of action.

4.5.1 Decision Making on Identified Concerns

This section has the following main processes:

Facilitators present the major concerns of the community and create a situation where they can discuss thoroughly and prioritize. The recommended possible interventions need to consider the capacity, resources and skills of the community.

B) Prioritization:

It is not possible to implement all the recommended interventions at the same time. It is necessary to prioritize the interventions by using some of the following criteria:

- **Urgency**

From among the recommended interventions, the relatively urgent and the most pressing ones deserve priority.

- **Accessibility and simplicity**

This refers to the evaluation of the community's capacity and resources, as well as simplicity of implementation.

- The attribute of the intervention to address more concerns from among the recommended interventions, some may best contribute to address multiple concerns or pave the way to handle others.

Objective

- To enable facilitators and the community to prioritize the recommended intervention on the basis of the above criteria.

Methodology

- Assist participants to be well aware and comprehend the criteria.
- Use rating points to prioritize interventions.

Facilitators could apply the criteria and the methods used by the participants to identify community concerns and prioritize the interventions to prepare plan of action.

4.5.2 Preparing Plan of Action

Planning is a key building block in the capacity enhancement process. The action plan has to respond to questions like what, how, who, when and where. It has to include budget or inputs expected from the community and its partners.

Objectives

- Discuss and realize that planning is important in the process of implementing the agreed interventions that address community concerns.
- Draw sound plan and program.

Methodology

- Exchange views on the importance of the plan of action for sustainable intervention and outcome.
- Draw the palm of your hand with five fingers and relate the five key words that represent the pillars of planning.

What

How

Who

When

Where

These key elements refer to the following:

- What – what activities should we execute?
- How – How are we going to work it out? What are the specific steps we need to take to accomplish our goals? What are the inputs required?
- Who – Who will be responsible for each action?
- When – When is the appropriate time to take the action?
- Where – where does the action take place?

Note: The facilitator with the representatives of the community will prepare the plan and program by using the following annex and then present to the general assembly for endorsement.

Community Conversation Decisions and Action Plan Form

- 1) Region _____
- Zone _____
- Woreda _____
- Kebele _____
- CC station/Sub kebele _____

2) Concern identified by the community

Ser. No	Decision reached to avoid the Concern	Major interventions to put the decision into action	Community		Patterns		Time-frame	Expected outcome
			Capacity	Role	Name	Role		

Completed by (facilitator) _____ Community's Representative) _____
 Name: _____ Name: _____
 Date: _____ Date: _____
 Signature: _____ Signature: _____

Note: This form is filled at the CC station while minority and comprehensive plan is prepared at kebele levels.

4.6 Interventions

At this stage, community conversation participants, community leaders and other community members implement jointly those interventions stated in the action plan form, in accordance with the timeframe.

Involving all community members in the implementation process develops a sense of concern and ensures success and sustainability. Furthermore, the kebele administration, cultural and religious leaders and other members of the community have a broad role to play in coordinating and advocating the decision to be more acceptable if they attended the kebele conferences and other meetings.

4.7 Monitoring

It is a process in which the community observes the achievements made in the behavioral and social changes of the community, problems encountered in the course of implementation and learn from the experiences; take remedial actions and ensure sustainability.

At this stage, evaluation takes place to ensure that the decisions of the community, plans and programs drawn are implemented urgently with wide coverage by maintaining quality services. These processes could be carried out in regular discussion sessions, consultative meetings and field visits.

Methodology

- Facilitators will report to the community about the implementation of the plan of action.
- Participants will exchange views regarding the activities carried out to implement the plan of action and discuss behavioural and other changes observed in the community.
- Agree on the next step based on the information in the report.
- Facilitators should complete and pass the evaluation form regarding results of the meeting to concerned bodies.

Community Conversation Action Plan and Evaluation Form

Date:_____ Location of the CC:_____ Woreda:_____ Kebele:_____ Sub-kebele/Village:_____

Ser. No	Planned Activities	Activities Performed & Changes Noticed	Discrepancy between implemented and planned actions	Reasons for the discrepancy	Future action Required

Part Two: For Trainers and Facilitators

5. Supportive Techniques to Strengthen Community Conversation

A Community conversation facilitator is expected to look for and have adequate understanding of supporting the techniques that could be applied by participants to strengthen and make the dialogue fruitful. Supportive techniques are the following:

5.1 Reflection

It is a process of looking for an idea from within the participants and having more time to critically question and listen to answers on a given topic. Any community conversation begins with a reflection session. The process helps participants to go deep into one's internal feelings with an opportunity to forward ideas of concern.

Objectives

- Enable participants realize the behavioural changes they gain.
- Encourage the community to develop the process of reflection to generate new ideas.

Methodology

- Ensure the discussion environment is tranquil and conducive.
- Leave the participants on their own for two minutes discussion after providing enough descriptions and clear instruction,
- Inform participants to make deep thoughts about HIV/AIDS individually and encourage them to reflect about what is expected of them.

Example:

- What am I doing?
- Why am I doing this?
- What initiates me for transgression?
- Do I have any behaviour that exposes me to HIV/AIDS?
- Which of my behaviours/attitudes contribute to the spread of AIDS?
- What can I contribute with respect to anti- HIV/AIDS movement?

After five minutes of silence, ask participants to voluntarily share with members what they individually came up with.

5.2 Wrap-up

It is a process of orderly and clearly summarizing the important points perceived during the daily discussions. Wrapping-up helps to connect issues discussed at different sessions. The presentation could be carried out by one or two participants or by the facilitator when necessary.

Objectives

- Evaluate whether key issues discussed during the day were conveyed properly.
- Assist in connecting the different discussion sessions.

Methodology

- Tell the group to nominate one or two participants to wrap- up the daily discussion points.
- The selected reporters will organize their notes and sequentially summarize the activities and ideas discussed during the day.

- The same individual(s) will present the wrap-up, in fifteen minutes at most at the beginning of the next session.

5.3 Advocating Community Conversation

Participants transmit awareness, ideas and decisions that invigorate change to other members of the community. The process of transmitting them is further extended in a form of relaying the information and then causes a multiplying effect among community members.

Methodology

The advocacy process of community conversation could be carried out in the following style.

- Making individuals to disseminate knowledge, ideas and the like gained from the discussion to at least five people.
- Pass the same information to family members, neighbours and colleagues.
- Use social gathering places like Idir, religious, marriage and mourning services etc.
- Convey resolutions of the discussion to administrators, partners, stakeholders, pastoralists, farmers and other members when they get together.

5.4 Documentation

Documentation is a process of organizing and compiling community conversation information in writing, photographs, pictures, films, drama and using other methods.

Facilitators document resolutions reached during the discussion, changes observed, problems encountered, facial expression and the discussion time including even the negative reactions manifested in the conversation.

Documentation does not focus on information contained in the action plan, but has to include any registered information about natural and social phenomenon or happenings.

Furthermore, facilitators should have complete information before they are involved in a given activity. Besides while developing action plan, facilitators should have information that will respond to the five key questions: what? How? Who? Where? and When? and help the implementation of the plan.

Objectives

- To enable the participants agree on the definition of documentation.
- To discuss different means of documentation with facilitators and the community.
- To be well aware the benefits of documentation in community capacity building.

Methodology

- The facilitator will give brief description on documentation.
- The facilitator will lead community meetings by posing the following questions as deemed.

Questions for Discussion

- Ask participants to write the replies for questions on a flip chart
- Why do we need to document community conversation process?
- Where shall we place the documents?
- Who should be in custody?
- Who are the users?
- What means can we use to document? (Mapping, current events, video and audio system and photographs)

5.5 Collecting Baseline Data

Before the discussion begins, the facilitators should collect basic information in order to evaluate the realized changes after community conversation sessions. The content of the information includes the following points.

- General information about the environment/ population census, economic, cultural and social situations/
- Social factors that could be causes for the spread of HIV/AIDS
- Misconceptions
- Harmful habitual practices in the community and etc.

Objectives

- To enable participants to list out interventions to be carried out with regard to combating HIV/AIDS
- To enable facilitators acquire ample information about the values, culture, norms and living conditions of the community before they start community conversation.
- To see the differences brought about during and after the conversation on the basis of the prior information collected.

Methodology

- Talk to and discuss with kebele agriculture extension workers, teachers, and religious leaders, prominent figures of the community as an individual and in a group.
- If the discussion is to be carried out by health extension workers, unaddressed issues have to be addressed and the information has to be included.

Note: If the information is going to be collected by facilitators with the help of health extension workers, then the document need to be kept in the kebele.

Community Conversation Report Form

Part One: Basic Information

A. Region: _____ zone: _____ Woreda: _____ Kebele: _____ subkebele: _____ B.

Date of Conversation: _____.

C. Previously conducted CC sessions: _____.

D. Duration of the conversation from _____ to _____

E. Number of participants, male: _____ female: _____ total: _____.

Facilitators full name: _____ .

Part Two

A. Level of the process: _____

B. Discussion topics of the day: _____

C. Important issues raised: _____

D. Misconceptions revealed and inclination that are far from the reality:

E. Problems encountered and recommended solutions: _____

F. Observed changes in the community: _____

G. Community metaphors (proverbs) and quotes: _____

H. Community Decisions or agreements reached _____

I. Other issues: _____

Note: Community changes recognized within fifteen days will be prepared briefly and the form community conversation will be completed and be sent to the Woreda.

6. Skills and Behaviour of Community Trainers and Facilitators

6.1 Process Facilitation

Community conversation facilitation process creates good learning environment where participants' freedom and equality is maintained, without being said "right or wrong" about the idea they raise. Facilitators are also expected to know community norms and culture.

Methodology

Show the two pictures and ask participants to answer the following questions.

Picture 1

Picture 2

- What is taking place in picture one? How about in picture two?
- What do you think about the feelings of people in the two pictures?
- How do you define the relationship of people in picture one and two?
- Which picture indicates the habitual practices while dealing with community?
- How can you put in plain words the situation in picture one and two?

- Summarize the discussion and finalize it.

6.2 Facilitators' Role

First of all, facilitators should understand that there are differences in opinion both at the start and all the way through community conversation. They are expected to make the process simple and fast until changes occur. They are supposed to coordinate, lead and encourage participation in the process of discussion and do other related activities.

A. Coordination of the discussion process

- Ensure that the discussion is clear and every participant understands and accepts.
- Encourage participants to respect workshop rules and regulations.
- Select and use tactical means to interlink activities.
- Support and coordinate group and the community during the intervention

B. Leading the Process

- Lead the discussion in line with the identified discussion topic.
- Ensure participants are attending attentively.
- Find solutions to contradictory ideas.
- Create common understanding to clearly prompt awareness.
- Mediate contradicting views of the participants of community conversation.

C. Encouraging Participation

- Encourage full participation of the whole participants and encourage learning from each other until ideas are exhausted.
- Initiate participants to forward different suggestions, contribute, ask questions and participate in the discussion.
- Be exemplary by respecting the viewpoints of participants.
- Explain that making unnecessary fun, laughter, humiliation, and incrimination, disregarding and underestimating of others is not allowed.
- Give priority to participants to answer questions.
- Appreciate and motivate aged participants that respond to questions in order to encourage others.

6.3 Strategic Questioning

It is an enabling way of soliciting information and perspective that opens up several options for answers. It is a special skill in the identification and exploration of community concerns.

Distinguishing Features of Strategic Questions

- Create options/several possibilities
- Emanate from facts and practical experiences.
- Go deeper into matters.
- Reinforce and give value to speaker.

- Not elicit simple ‘yes’ or ‘no’ answers
- Exclude the word ‘why’ and its accompanying value judgments and tendency to put people on the defensive.
- Help touch the untouchable and tickle taboos.

Example

“Demeku! Do you want to go and reside in Addis Ababa?” This question requires one of the two answers, i.e. ‘yes I will’ or ‘No I will not’ and limits the number of options. On the other hand strategic questioning has to provide several options.

Example

By extending the first question, we can ask Demeku in different ways.

“Where do you want to live?” Or “where do you wish to live?” These questions provide different options or alternatives.

6.4 Active Listening

Active listening is a skill in which a participant in a conversation follows closely what is being said. Facilitators are expected to develop this skill and carefully listen to participants to achieve positive results.

In most situations, people tend to remember the ideas that they enjoy and agree upon. Anyway if a person is expected to listen actively, he must have a free mind. However, if a person agrees or disagrees with someone’s idea, he must actively listen and remember the idea.

Active listening has the following attributes.

- Maintaining eye contact with the speaker.
- Not showing signs of disagreement or being frustrated with the speaker’s opinion.
- Observing and acknowledging non-verbal expression
- Paraphrasing to confirm that you understand what has been said.

Objectives

- Develop active listening capacity of participants.
- Enable participants to listen to ideas that are different from their own.

Methodology

- Divide participants into small groups
- Prepare question that can provoke discussion

Example

- Talking about HIV/AIDS and the idea of using of condoms in faith-based organizations should be encouraged.
- Parents should talk with their children about sex.
- People living with the virus should be allowed to marry and have children.

- Ask participants in groups to reflect individually and write down their responses and perspectives.
- Ask participants to read their perspective and share the same with other group members.
- Facilitators clarify as participants to listen actively and not interrupt the person who is sharing his perspective.
- Ask people to be attentive to retain only what they agree with, but also remember what they do not agree with.
- After all group members expressed their perspectives, ask each group member to remember what they heard from others.
- Encourage a group to reach to common perspective and consensus if possible, if not possible tell them, as diversity is a reality of their group.
- Ask participants to give a detailed description of how to show respect for and take in to account everyone's perspective during conversation.
- Ask each group to identify three key elements of active listening and respect for diverse perspectives.
- Finally, the highlights of the group discussion will be presented in the plenary.

6.5 Power Relations

In a community, power relations exist between male and female, families, social life and in places of work. Hence, our every day environment is highly influenced by power relations.

In the process of prevention and control of HIV and minimizing its negative impact, power relation plays significant role.

Objectives

- Aware participants about certain attitudes of dominance or submission and its impact.
- To be aware of the impact and consequences of positions in individual relations.

Methodology

- Make sure that there are enough chairs for all participants.
- Ask participants to sit in pairs.
- Choose one person who will dominate and another person who will be dominated.
- Use a topic chosen by participants for the discussion.
- Ask the dominant person to take his chair.
- Simultaneously, ask the dominated person to sit on his chair and the dominant individual to sit on the floor.
- Ask the dominated person to play the role of the dominant person.

- Ask participants to share their feelings, resentment, reflections and ideas that they have discussed in their group.
- Finally, the facilitator can make a brief presentation on different types of power in individual relations. The examples include:
 - o Relations among teenagers
 - o Between husband and wife
 - o Parent and child
 - o Boss and subordinate and others.

6.6 Emotional Intelligence

Among the major issues that should be taken into account by an individual are about oneself and the surroundings social and economic situations. Accordingly, an individual is expected to have a skill related to self-emotions and behaviour, which in turn assist to know oneself and the community properly in order to determine and lead sustainable social life.

In the current situation, knowledge acquired by individuals will not be the only means to get results, but enhancing emotional skills wisely, equally contributes to be successful. Among the emotional skills, the following major ones are included.

A. Knowing and Understanding Oneself

Knowing oneself could be described by the following three behaviours

- Proper self-assessment

Facilitators' knowledge about their special skills and the identification of their strengths and weaknesses has significant importance.

- Self-respecting and valuing

A person that respects himself will give proper respect to others; this in turn could provide him a better place.

- Self-confidence

Building self-confidence emanates from identifying one's strengths, weakness and giving due respect to others.

B. Self Control Skills

An individual has self-emotions, strengths, limitations, concerns and favourable opportunities that have to be recognized. Among others the following skills are required to be observed

Self governing skills

It could define as controlling ones emotions, proper self-expressions and protecting one and others from possible hazards. This skill will enable facilitators to control and lead the discussion as intended.

Frankness

It is a process of sharing one's own feeling without deviating from the predetermined stand, values and or objectives. For example, if participants pose a question

that cannot be answered by the facilitator it is better to get the support of colleagues or professionals rather than trying to be knowledgeable or capable to give the answer.

Self-initiation

These skills are inner desire that enforce to take actions, be creative and make things to happen. With their regard, if the situation is not ripe to bring about the desired change, facilitators need to take the initiative to create favourable atmosphere to achieve the discussion objective.

Vision

Facilitators should be visionary to bring about success. They are expected to realize the knowledge and potential of participants and coordinate and guide the discussion towards effective social change.

Social Skills

Skill is an ability that an individual has to have in order to know the feeling of others.

Relationship is one of the important factors to create understanding. Relationship is a process of providing and receiving information, expressing our feelings and ideas. Understanding is the processes of exchanging ideas between two or more people interacting for mutual actions. There are five major understanding processes.

- Talking to oneself (self talk)
- Communicating between two or more people.
- Body language.
- Mass media or public media information.
- Organizational communication.

Methods of creating mutual understanding

- Understanding of others' feelings.
- Use words that initiate participants and spark the potential of instigating the desired change.
- Build positive thinking and impact.
- Tolerance on point of differences
- Negotiation
- Confidence to express facts