ADDIS ABABA UNIVERSITY
THE SCHOOL OF GRADUATE STUDIES

THE HIV/AIDS EPIDEMIC AND ITS DEVASTATING CONSEQUENCES ON THE LIVES OF WOMEN IN NEKEMTE, EAST WELLEGA

JIRA MEKONNEN

JUNE, 2005

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JIRA MEKONNEN

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BY
Jira Mekonnen

COLLEGE OF SOCIAL SCIENCES
APPROVED BY BOARD OF EXAMINERS:

Hirut Tesfaye	
ADVISOR	**SIGNATURE**
Mesganaw Fantahun	
EXAMINER	**SIGNATURE**
Meheret Bekele	
EXAMINER	**SIGNATURE**

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List of Acronyms

OSSA -	Organization for Social Services for AIDS
FGA -	Family Guidance Association
TPLF-	Tigray People Liberation Front
NH-	Nekemte Hospital
NHC-	Nekemte Health Center
OI -	Opportunistic Infection
PLWHA-	People Living With HIV/AIDS
EPRDF -	Ethiopian Peoples' Revolutionary Democratic Front
MOH -	Ministry of Health
ART-	Anti Retroviral Treatment
NGO-	Non Governmental Organization
ANC-	Ante Natal Clinic
HAPCO-	HIV/AIDS Prevention and Control Office

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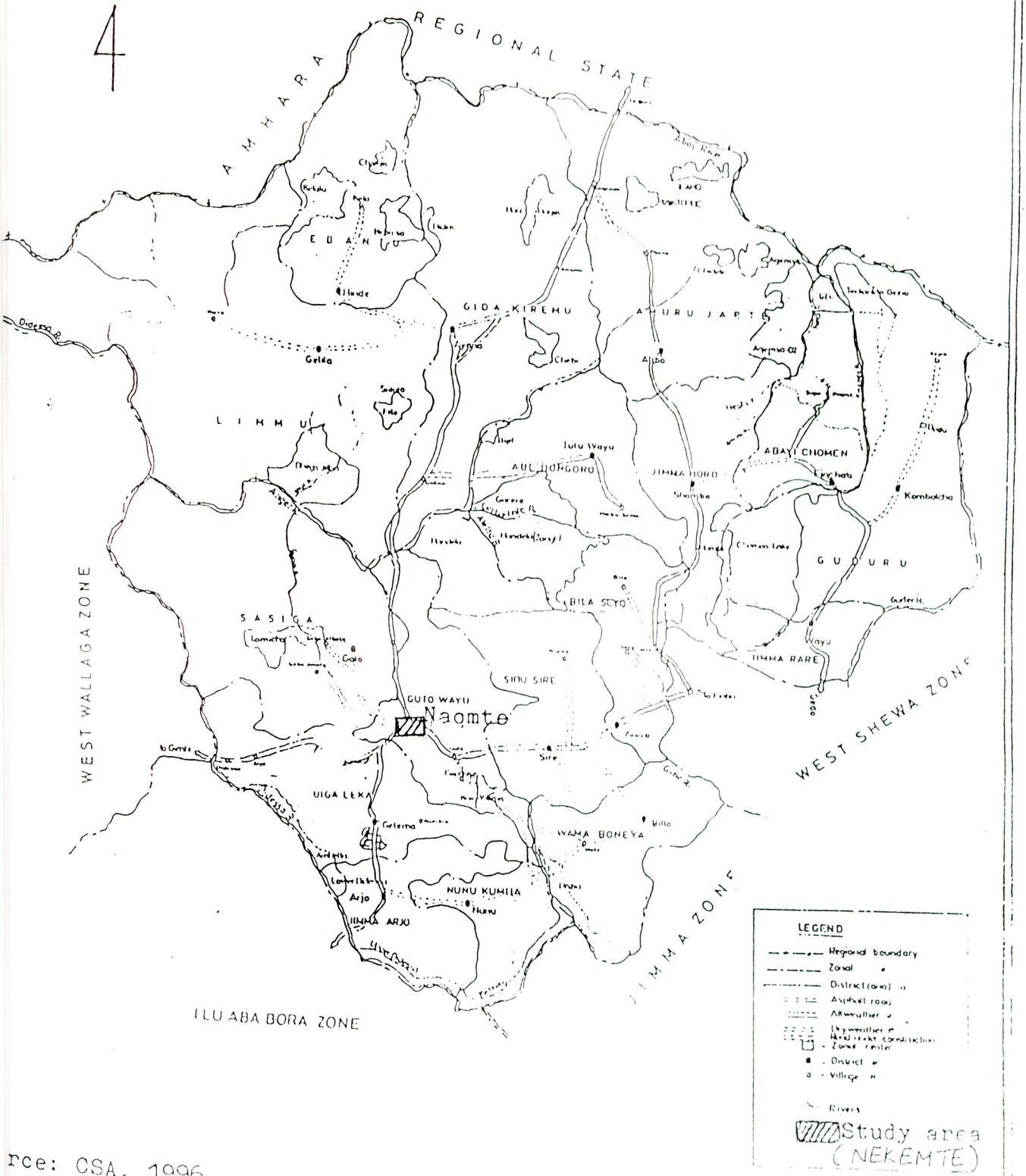

rce: CSA, 1996

Glossary of Local terms

Ayyaana - a common name for lesser intermediary spirits who performs th order of Waaqaa

Baddaa- High land

Badda-daree- medium temperate land

Birraa - short rainy season that lasts from September to mid November

Bona- Dry season which lasts from Mid December to mid March

Gammoojjii - low land

Ganna- the major rainy and cropping season from mid June to mid September

Nefegna- the system that brought armed Amhara settlers to the area mainly during the reigns of Minilik and Haile Selassie

Qaalluu Oromo ritual expert

Waaqa the Supreme Being in Oromo religion

Gada the socio-political system which the Oromo invented before centuries

Qubee- the Latin script adopted with slight modifications for the Oromo Language.

Ekeraa- Ghost spirit believed to dwell in the place where the deceased person one's lived and contacted through the mediums

Booranticha- The Ancestral Spirit in the indigenous Oromo religion

Jinnii- the Devil Spirit

Teff- One of the cereal crops in the area

Ancootee- a local food endemic to the area

Godarreee- a local food crop

Ateetee-	ritual ceremony of females
Halagaa-	non-kins between whom marriage is allowed
tella-	a local beverage(an Amharic term)

Abstract

The research has tried to make deep investigations into the consequences of the HIV/AIDS epidemic on the lives of women in Nekemte, East Wellega. The study has mainly focused on women and tried to explore their coping mechanisms with the disease. The data for the research has been gathered mainly through the field work and all the pertinent anthropological research methods have been applied. Observations of people living with the virus, mainly women, were made at various places: in Nekemte Hospital, at OSSA, and at their residential areas. Group discussions of the individuals were conducted to analyze their reactions. Further, detailed interviews were made with most of the informants to know more about their perception of the virus and to comprehend the causes of their HIV contraction.

The case of women in our country in this regard can not be an exception to the turmoil in general. Further, the features of HIV contraction in the study area shows that the area now stands above all others in its HIV contraction rates when compared with the remaining major towns in Oromia. Besides, women in the area whether they are married, divorced, widowed or separated are not on the safe side because of the economic, social, political and biological factors under which they live. From the analyses of the cases, it has been found out that the virus is seriously ravaging the area at an alarming rate. The other useful point to be mentioned from the research is the fact that the fight against the epidemic is at its infancy and that a lot more is needed to educate the masses to help them attain behavioral changes in this respect.

It has been found out that most of the women who were interviewed and are now living with the virus are engaged in having multiple sexual partners as a means of securing the deteriorating living conditions. Because they live under harsh economic conditions, it has become a common place for them to practice unsafe marriage and remarriages usually on temporary basis. In these cases, the marriage is accomplished based on little or no intimacy between the couples. Hence, it is obvious that such a marriage collapses sooner or later.

On the other hand, when women and young girls realize that they are already infected with the virus, they are more likely to escape to other areas where they are given little or no attention than their male counterparts. Accordingly, except very few of them, those women who were interviewed and many others who are identified as HIV positive came from other towns and villages in the vicinity. These women and the young girls do not have the intention to visit their parents and relatives back in their villages, or see them in one way or another.

Under some instances, there are couples who make HIV test on their own, but hide their statuses from their partners. This situation has been found to be one of the most pressing issues for medical personnel because they are obliged to refrain from exposing one's HIV status if the patient does not want to. So, the fact that such couples tend to cheat their (better) half has already proved a real difficulty for the success of the battle against the epidemic in the study area.

The research is organized in to six chapters. Chapter one introduces the work and gives highlights about the need to study HIV/AIDS, the purpose for which the research has been conducted and the significance of the research and the methods used in data collection. Chapter two is all about the review of relevant literature. In chapter three, the general backgrounds of the study area vis-à-vis its location, climate, culture, language and religions of the people in the area are examined. Besides, the various traditional marriage practices in the area have been explored and their implications for HIV/AIDS have been analyzed. The place of women in the midst of the AIDS pandemic has been found that women are now number one victims of the virus especially in those countries were the social status of women is generally low.

The remaining chapters, five and six, basically deal with the roles of institutions in the fight against the epidemic in the area, and the analyses and findings of the cases. It has been realized that there are few government and non governmental organizations in the area which deal with the issues of HIV/AIDS.

CHAPTER ONE

INTRODUCTION

There has never been a time in human history when disease did not exist. The history of epidemics dates at least as far back as 1157 B.C to the death of the Egyptian Pharaoh, Ramses V from small pox. Over the centuries, this extraordinarily contagious virus spread around the world, changing the course of history time and again. Even now, malaria in underdeveloped countries afflicts 300 million people, killing about 2.1 million each year. Thus, epidemics are not new to humankind, but the fear they pose on each generation is (Stine 1999: 2-3). Aggleton and Homans (1988) say the following when talking about earlier epidemics that have inflicted heavy losses on human beings. "Throughout the previous decades, and may be earlier, people had been contracting peculiar, unnamed disease and sometimes dying from it" (1988:20). There are also similar human catastrophes to be cited in the Ethiopian context, though the recurrent drought, famine and war account for the majority of the disasters.

In spite of the fact that the world has been experiencing different types of epidemics at different historical times, currently, the entire world has faced the threat and the all-encompassing devastations brought about by the HIV/AIDS pandemic more or less the same way. The existing sources indicate that AIDS is believed to be a global pandemic that has already become one of the greatest challenges our planet is currently facing, as there is no region on earth that has ever been spared by the disease (UNAIDS 2004:7).In other sources, it has been pointed out that HIV/AIDS is a truly world menace because of the consequences it brings to all spheres of human lives: social, political, economic, psychological and other aspects of societies are the prime the targets of the pandemic(UNAIDS,o4).

Some of such opportunities are the existence of women's economic dependency, the societal views on the existing gender relations that obviously favor males, and the constantly deteriorating status of women in most societies. The gender relations which, in our societies, place women at such awkward positions have their own roles to play in the spread of the HIV/AIDS epidemic. The fact that women are treated as inferiors, and should always depend on their male counterparts for most of their daily life situations greatly contribute to their vulnerability to the virus.

Under the conditions where women remain the most disadvantaged as a result of the longstanding societal views on them, it would be quite difficult to halt the virus from spreading to the general public, and hence, the attempts to address the fight against the virus should basically focus on providing better living conditions for women in particular and enabling them to acquire relatively stable social and economic statuses.

Therefore, the fact that everyone should genuinely participate in the campaign against the pandemic is out of question. In the light of this pressing issue, the devastating consequences of the disease especially on the lives of women in Nekemte has been studied anthropologically so that all concerned bodies would make interventions in order to incapacitate the spread of the virus to the broader masses causing heavy and unimaginable losses to the various aspects of life.

1.1. Statement of the Problem

AIDS is primarily defined as a severe immune deficiency, and is distinguished from virtually every other disease in history by the fact that it has no constant, specific symptoms. The history of AIDS is a human affair and is part of a cultural process of attempting to come to terms with a new and often terrifying series of events.

AIDS is no more an ordinary pandemic. When it was first discovered two decades ago, HIV/AIDS was a mysterious, little-known disease. Today it is a rampant menace to all humankind. Yet, to discuss how it is transmitted and how we should respond to it is to touch on issues that we find difficult to discuss in public-issues of sex, drugs and deep-rooted prejudices about personal behavior. We can not, however, afford to remain politely silent while the virus rolls on in its destructive course. The specter of HIV/AIDS already casts a dark shadow all over places (UN Chronicle, 2004).

The expansion of the HIV/AIDS pandemic in sub-Saharan Africa has rendered efforts in bringing about significant improvement in economic and social conditions extremely complex. Because of HIV/AIDS, gains that have been achieved in the areas of improved health and better access to education and training are being eroded. According to UNAIDS (2002) cited in MOH (2002), approximately 70% of the world's 40 million HIV-positive population lives in sub-Saharan Africa. The source also indicates that out of the 5 million newly infected persons in 2001, 3.5 million live in sub-Saharan Africa (MOH, 2002).

From the above tangible information, one can understand the pressing situation of the epidemic in Ethiopia as it is one of the countries in the area. The damage it is inflicting on the broad masses in Ethiopia in general is also going beyond imagination. According to the predictions of the Ministry of Health 2002, in the year 2001, there were estimated 2.2 million HIV positive and AIDS cases in Ethiopia. This figure was expected to increase in a more or less consistent manner over the coming 12 years: from the 2.2 million estimated, it would increase to 2.6 million in 2006 and to 2.9 million in 2010 (ibid).

It is obvious that HIV/AIDS has become the object of extensive medical and social researches and policy making and of widespread media and public discussions. Yet, the place of women in the epidemic and the attention given to them has been kept to the minimum. Alternatively, in some cultures across the

world and in Africa in particular, they (women) have been presented as transmitter of HIV to men and children, considering the epidemic as "women's disease"(Stine, 1999).

Such a position or trend should not be any longer tolerated as production and reproduction and/or development of a given nation cannot be attained in the absence of women. Carovano cited in Ankrah (1994:533) states that "AIDS education must stress the value of women's lives." Women should, therefore, be the major focus of research on AIDS in order to spare their lives and to have healthy nationals and a promising vision for a nation.

Existing literatures on women in sub-Saharan Africa indicate that they are more vulnerable to HIV/AIDS because of a number of reasons. Some of them are: women usually hold low socio-cultural positions: that there is severe political subordination on women; that they have low economic status which forces them, in some cases, to engage in such risky activities as prostitution; and that they lack access to education or paid labor market,... and so on (Anannia 2000;Brewer 1994;Kloos 2004;Stine 1999).

Further, there are many indications for women to be more susceptible than their male counterparts. This situation has been referred to, by some researchers, as 'feminization' of the epidemic. According to Stine (1999), beginning 1993, there were five million HIV positive women worldwide. In 1998, there were 23.5 million HIV positive women (i.e. 47% of the HIV positives were women. Six million 300,000 of them have died. There would be about 28 million HIV positive women globally by the end of 1999, and 7.2 million would have died (ibid: 330).

On the other hand, the latest report of UNAIDS (2004) provides a far more threatening figure on the further deterioration of the conditions of women with reference to the virus. According to the source, every year brings an increase in the number of women infected with HIV and, nearly half of all persons infected

between the ages 15 to 49 are women globally. In Africa, in particular, the proportion is currently reaching 60%.

Besides being the majority of those infected, women and girls are now bearing the brunt of the epidemic in other ways too: it is they who principally take care of sick people, and they are the most likely to lose jobs, income and schooling in the face of the epidemic. They may even lose their homes and other assets if they are widowed by the virus.

Currently, nowhere is the epidemic more apparent than in sub-Saharan Africa where 57% of adults infected are women, and 75% of young people infected are women and girls. In this region, on average, there are 13 infected women for every 10 infected men- up from 12 infected women for every 10 infected men in 2002. The difference between infection levels is more pronounced in urban areas with 14 women for every 10 men, in rural, where 12 women are infected for every 10 men (UNAIDS, 2004).

In a similar development, the condition of women in Ethiopia with regard to the virus is expected to be congruent with the above situation or even worse at times. So, it would be worth studying about the entire conditions of women in the attempt of bringing them out of the flood of the epidemic. In order to save the lives of women in general and that of the entire society in particular, we need to devote our time and energy to know the possible causes for the fastest spread of the virus among the communities and women in the study area. To this effect, the research has made thorough examination of the following crucial points.

- How are women with HIV/AIDS treated by their families, neighbors and the communities in Nekemte?
- What are the social, economic and other conditions that expose women to the contraction of HIV/AIDS Virus?

- What are the kinds of care and treatments that they receive from the different institutions that operate in the area?
- What are some of the duties and responsibilities of women in bringing about changes in behavior regarding the HIV/AIDS epidemic?

In this research, therefore, these and other relevant points have been explored through detailed examination of the different angles of the epidemic. The challenges being encountered by women living with HIV/AIDS and the efforts being made by different bodies in the area in the fight against the virus were analyzed. Finally, it is hoped that the findings of the research will throw light on to the damages inflicted so far by the epidemic and the work could contribute in provoking further research interests on the topic and /or other pertinent issues to be conducted in the study area.

1.2. Objectives of the Study

The research has the following general and specific objectives.

1.2.1. General Objective- the overall objective of the research is to understand some of the conditions that facilitate the exposure of women to HIV infection and to know its consequences on the day-to-day lives of women in the study area.

1.2.2.Specific Objectives-the following are some of the specific objectives of the research:

(a) to identify the social, economic and cultural factors that lead women or young girls to HIV contraction;

(b) to explore the kinds of care and treatments rendered to women living with the virus by governmental and non-governmental organizations in the area;

(c) to realize the extent to which women with HIV/AIDS are received by their neighbors and relatives;

(d) to assess the level of the behavioral change so far attained from the lesson drawn from HIV/AIDS;

(e) to explore the overall impacts of HIV/AIDS on women in the area.

1.3. Significance of the Study

There are obviously numerous talks, panel discussions, conferences, workshops, and advertisements on the issues of HIV/AIDS and its consequences on the entire lives of societies day in, day out. All these 'noises' have so far had little practical contributions to the battle against the virus in the country. The fact that HIV/AIDS is ravaging all corners of the society, and that the number of citizens who fall prey to the virus has been steadily increasing from time to time, are tangible evidences which suggest the failure of most of the projects on the issue. The other point worth mentioning is that most of the conferences and workshops on HIV/AIDS are held in expensive halls and conference rooms where, however, people can come together under a tree to confer and solve their problems if there is a willing and an actual determination to help and benefit the victims. First, what has so far been done did not take into account the socio- cultural backgrounds of peoples, and hence remained less meaningful. Therefore, I believe that the anthropological study of the severe epidemic will greatly contribute to halting the pace at which the virus is devastating the area. This research will, therefore, have the significance of contributing to the field of Social Anthropology; benefit health officials in their attempts to fight the disease; it could be used as a tool by national planners, governmental and non-governmental organizations in exploring the socio-cultural aspects of the disease as they are believed to facilitate the further aggravation of the epidemic in the area. Finally, the paper gives clues as to how the virus is affecting the people in the area with special reference to women and their coping mechanisms.

The selection of the study area and the topic of the research have been made for a number of reasons. First of all, I have a good knowledge of the area including the language, the culture and other social aspects of the people. The second point was intended to set out to check the truth of the rumor that Nekemte as a town and zonal capital of the area currently has the largest HIV infection rates when compared with the rest of the areas (zones) in Oromia. So, the attempt here is to realize some of the reasons behind the mystery of the epidemic in the area. The HIV/AIDS epidemic has not yet been anthropologically studied especially in the area and that is why pertinent sources are scanty. So, it is thought that the thesis will be used as a reference material for further studies on HIV/AIDS and/or other relevant issues in the area.

1.5. Research Methodology

The data for the research were basically qualitative in nature. The field work was conducted from the beginning of February to the middle of April, 2005,and a total of 20 people, mostly women were incorporated into the research. The data have been made available from the different organizations in Nekemte. Such institutions were Nekemte Hospital, OSSA, Nekemte Abdi Association and Family Guidance Association, with whom rapport was established through frequent contacts. Most of these institutions have done their best in accessing me to the respondents and to other useful sources.

Both primary and secondary sources were included into the research in order to compare and contrast what the available sources say about HIV/AIDS with the actual situations on the ground in the particular site. In the primary data collection, anthropological research tools like observation, different types of interviews and group discussions were employed. Observation of HIV patients at their residential areas was done mainly to see and analyze the conditions of the patients and to see their overall situation. Unstructured, but in-depth interviews were conducted with the PLWHAs in order to know more about them

and their general backgrounds, and to realize how they view their lives with the disease, and in a way, to investigate their coping mechanisms with the virus and to comprehend many other relevant issues. In group discussions, the responses of individual respondent's vis-à-vis the others were closely checked and cross-checked. Besides, few male respondents were also integrated into the data to realize their feelings about their female counterparts in the context of HIV/AIDS. Informal chat and discussions with the PLWHAs were done at all places in order to gather adequate information about their daily life experiences.

Interviews were held with hospital officials, and with administrators of OSSA and FGA to understand more about their feelings and attitudes towards their clients and to know what they do in dealing with the HIV/AIDS patients. The selection of key informants was made possible with the suggestion and collaboration of OSSA officials and its counselors who know much about the patients and their residential areas.

The review of secondary sources on HIV/AIDS in general and that of women (both in the world and in the Ethiopian cases) in particular has been made. In this way, books, articles, pamphlets, and seminar/workshop papers were reviewed and analyzed.

As is obviously the case, the research was conducted under circumstances which are relatively comfortable and warm. The fact that the people in the area are hospitable and easy to deal with made me feel at home .The majority of the patients, though they live under painful conditions as a result of the virus, have always remained cooperative. Besides, most of the institutions where the research was conducted were more or less recipients except under conditions in which the concerned officials are sometimes absent from appointments.
This does not, however, mean that all was fine with the field situations. There was the obligation of getting admission letter from the zonal administrators to

get to the community .Yet, the administrators were busy occupied with the frequent meetings they hold every now and again. This made me wait for five days to receive the letter. Further, they look at students from a university with great suspicion, attaching things to the frequent political turmoil to have its roots in the universities.

The other mentionable problem encountered was the fact that most the existing institutions that operate in the area on the HIV/AIDS issues incline to associate everything of the disease with OSSA. For most the institutions, OSSA should bear all the responsibilities of tackling the endless problems to be faced by the patients and their families .In this way, a total of one week was spent before actually meeting the patients for interviews, observations and other purposes of the research.

Finally, the HIV patients in the area and the respective officials have been interviewed by a number of individuals at different times. This condition has already the patients to become more impatient and pessimistic about the outcomes of interviews and discussions for their current living conditions.

Having said this, I would like to concentrate on what other researchers have said by way of literature review on the subject in the following chapter.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. What is HIV/AIDS?

AIDS is an acronym standing for Acquired Immune Deficiency Syndrome and is caused by a virus called HIV-Human Immune Virus. AIDS is an umbrella term for any or all of the known opportunistic diseases and their symptoms. AIDS is an illness now characterized as the presence of HIV and certain opportunistic infections and diseases that affect both the body and the brain. HIV/AIDS has already become a national as well as global issue in all countries of the world since it appeared two decades ago.

According to Alcorn (1999) cited in Annania (2000), AIDS is a fatal clinical condition resulting from long-term infection with HIV. HIV progressively weakens the body's immune defense system, until it no longer able to fight off infections, many of which are normally harmless. When the immune system is severely damaged by HIV, several opportunistic infections will be present at once. These are called so because they are caused by organisms which are normally controlled by the immune system but which "take the opportunity" to cause disease in an individual whose immune system has been damaged. One or more of the opportunistic infections likely cause death other than the virus itself. .

The major means by which HIV is transmitted include blood contacts, untreated blood products, semen, cervical and vaginal secretions and possibly through breast milk. There is, however, no evidence for AIDS to be transmitted by saliva and tears.

2.2. Some Arguments about the Origin of HIV/ AIDS

In the following section, the debates about the whereabouts of HIV/ AIDS have been briefly discussed. The issue about the origin of the virus that causes AIDS has always remained controversial among scientists in the field of medicine and other relevant areas. The debate has continued to the present especially between two continents: Africa and the USA. Or one may say that it is swinging between the developed and underdeveloped worlds. The HIV virus is now widely accepted to have emerged in the 1980's or in 1981 to be precise (Stine 1999).

More than any other disease in recent memories, AIDS has generated myths and far-fetched theories about its origin, its causes and even its very existence. These are probably linked to the fear and denial prompted by a virus which is fatal, incurable, and sexually transmitted and can potentially infect people for years before they show any signs of illness.

There were occasions when the origin of HIV/AIDS was associated with unidentified flying objects (UFOs) which when crashed to the Earth released a "new organism" that would wipe out humanity. The 1987 Soviet presses were linking AIDS with American biological warfare research (ibid).

There are also reports of extremism, that AIDS is "clearly an ethnic weapon, a biological weapon" designed specifically to attack nonwhites (CDC weekly, 1988 cited in Stine 1999:4). A 1990 survey of 1,000 black American church members in five cities found that more than one-third of them believed that the AIDS virus was produced in a germ warfare laboratory as a form of genocide against blacks (ibid:398).

Two decades after its emergence, researchers are still baffled by the question: 'Where did the AIDS virus come from?' AIDS is now known to be caused by two human immune deficiency viruses, HIV-1 and HIV-2. The former, the cause of most AIDS cases worldwide, appears to have spread from Central Africa mainly through heterosexuals. While the later has so far been confined mainly to West Africa and the islands of its coast, according to sources.

Yet, most of these theories about the origins of HIV/AIDS have been speculative rather than verifiable, and several of them have caused offenses, particularly those which refer to sexual practices with monkey blood (Gilks, 1991 cited in Stine: 1999).

The prevailing theory is that humans were first infected through direct contact with HIV-infected primates. The primate-to-human scenario is easier to accept than humans infecting primates. Humans have hunted, handled and even eaten primates for thousands of years.

Adam Carr (*AIDS in Australia, 1992*) cited in Stine writes that the most widely accepted view on the origin of HIV is that the virus is endemic to a remote part of Central Africa, possibly in the mountains of eastern Zaire, and that it began to spread to other parts of Africa only after the area had been penetrated by the Europeans in the 20thCentury.

In colonial Africa, it is quite possible that a low but persistent level of AIDS cases could have gone unnoticed by the poorly developed health services of the time. In the 1970s when rapid urbanization and its attendant social changes began in the former Zaire and neighboring countries, the epidemic began to accelerate and come to the attention of health authorities. By that time, it would have begun to spread to other countries. Tourists, soldiers, guest workers and other travelers would have taken the virus to Europe, the Caribbean, and North America (ibid: 45-46).

Discussions of the African origin of HIV have caused controversy. Some African governments protested at suggestion that African was responsible for the AIDS epidemic and denied that AIDS was a problem in their countries. Further, some denounced the "racist" Western media for their reporting AIDS as an African plague.

Some religious officials regarded AIDS as an act of God against the homosexuals for practicing a biblically unacceptable life style that included the use of drugs, alcohol, and sexual promiscuity. They present AIDS as an evidence of "God's revenge" on permissiveness. For them, there would be no AIDS epidemic if the laws of Moses have been genuinely followed (Homans 1988:32).

In summary, there are at least three possible origins of the AIDS virus (1) it is a human-made virus perhaps from a germ warfare laboratory; (2) it originated in the animal world and possibly crossed over onto humans (3) HIV has existed in small isolated human populations for a long time, and given the right set of conditions, it escaped into the larger population (ibid: 46).

Whatever the origin, one has to carefully know that HIV/AIDS is a disease of all human races, now found in every corner of the globe. It has infected and killed heterosexuals and homosexuals, women and men, white and black, young and old, rich and poor, the promiscuous and the inexperienced. The global pandemic has already become both omnipresent and omnipotent, and this is a fact which no one can deny.

In the early days of the epidemic, researchers in the field and other concerned bodies were thinking that HIV/ AIDS was only a health problem that would put pressure on doctors and nurses, further deteriorating the already existing shortages of medical facilities in some countries. There were also occasions when the epidemic was associated with certain groups of people in a society. Based on such early impressions, it was thought that AIDS was a disease that is found in certain distant corner of the globe, confined only to certain segments of a society. No one ever thought that, therefore, the pandemic will one day become a multifaceted disease that shall touch upon every sphere of human lives in every corner of the planet in such a brief instance of time that it could be difficult to imagine.

Currently, there are many obligations that make us accept this piece of truth. To this effect, one needs to consider the numerous factors that create favorable conditions for HIV/AIDS because the virus does not spread spontaneously, but on the contrary, is influenced by the existing social, economic and political environments. So, in the following sections, some of the major issues related to HIV/AIDS and its consequences on societies will be briefly discussed.

2.3.1. AIDS as a Socio- Cultural Issue

One of the areas where the impacts of the virus can be felt is in the sphere of social issues. This is mainly because epidemic diseases usually have profound social effects. AIDS is undoubtedly one such a disease, with its impacts varying from one society to another. In most poorest countries, such as ours, the disease may extremely reduce the number of adults who can produce food and care for the young and the old, in addition to exacerbating food crises, increasing the number of orphans and needy people, weakening human capacities in different sectors and in the long run, changing the fabric and the normal functioning of societal structures.

According to Blaikie, even in the absence of the HIV pandemic, the future looks rather dark and pessimistic for many of the peoples in Africa. The continent is looking in to the new millennium with decades of constant and never ending emergencies like war, diseases, food shortages, large scale population movements, and the mal-distribution of food, debt as well as the effects of swinging structural adjustment programmes (Blaikie, 1992:152).

With the existence of these realities, one can not overlook the annihilating consequences to be met in the face of HIV/AIDS and the enormous social impacts will obviously be with us for the years to come. The rising number of its victims, the age group it greatly attacks, the toll of its pain, the dependency and the deaths resulting from it will all have huge negative impacts on our societies, and elsewhere in the world.

One cannot deny the fact that many of the major features, imagined threats and the paranoia resulting from the disease have already become part of people's daily experiences. They are sensed and observed far and wide. In addition to this, the breakup of families, the collapse of marriages, the attachments of stigma and discrimination, the sufferings of the victims and their care givers, and the languishing of the whole family are indeed very worrying.

Worse of all is the epidemic's unique ability to attack and deface not only the physical body of patients but their social body as well. That is to say, AIDS distorts the social relationships that normally exist between peoples. In this regard, the disease has almost become synonymous with the most profound stigma - the attachment which now seems impossible to avoid. Regarding this issue, Homans says that despite the fact that different people try to overcome it, the stigma attached to AIDS has become the universal facts of the epidemic which people everywhere experience in one way or another. It has recently been suggested that AIDS is an illness with a triple stigma: it is connected to

stigmatized groups (i.e. in the early days of AIDS, especially in the Western world, the disease was associated with certain groups of people like homosexuals, injected drug users, and some other minority groups); it is sexually transmitted (this being an issue which people all over rarely talk frankly about), and that it is a terminal disease (as the victims are hardly spared by the disease (Homans 1988:28).

According to sources, the gender inequalities that exist in most societies aggravate the rate at which the virus spreads to the general public, exacerbating the social crises. UNAIDS, in its recent global report indicates that the gender imbalances in sub-Saharan Africa make it much more difficult for women in the region to negotiate on condom use. Furthermore, sexual violence, which damages tissues and increase the risk of HIV transmission, is widespread in the area particularly in the context of violent conflict. In countries where the general population prevalence is high and women's social status is low, the risk of HIV infection through sexual violence is high (UNAIDS, 2004:22). In addition, the HIV transmission risk increases during forced sex situation. Moreover, condoms are rarely used under such circumstances (WHO, 2001 cited in UNAIDS, 2004:40); Matthews and Little, 2002 cited in AJAR, 04:58).

Therefore, the existing social situations of our societies, in which women are still given rather lower social positions, will have its own messages to convey for the already confronted social crises brought about by the HIV/AIDS epidemic.

2.3.2. AIDS as Economic and Development Issue

The second most important area worth considering regarding the impacts of HIV/AIDS is in the sphere of the economy. HIV/AIDS has the potential of devastating the economy of a nation in a number of ways. In the first place, the disease removes the productive members of a nation - farmers, doctors, and service providers among others, and thus burdening the economic and social fabrics of the country. It further complicates most sectors of a society and the economy in particular.

Because HIV/AIDS is a disease that mainly affects the working age group (especially those ranging 15-50 years), the consequences of the epidemic will potentially result in acute shortages of labor, the loss of expensively trained specialists, great number of orphans and severely overloaded health and other forms of service sectors. The loss of such personnel will eventually lead a country to a state of poverty from which way out would be quite doubtful, makes the country wade through the ocean of the epidemic.

One obvious repercussion of HIV/AIDS is poverty. Poverty, apart from being associated with poor nutrition and a breakdown of immunity systems, in itself, is likely to increase the vulnerability of people to HIV/AIDS. It contributes to unsafe sexual practices as a result of lack of proper knowledge and inadequate access to means of protection. Both Desmond (2001) and Whiteside (2002) cited in AJAR (2004) emphasized the complex, multifaceted nature of the relationship between poverty and HIV/AIDS. According to these scholars, the labor migration induced by rural poverty can contribute to the spread of the disease, and similarly, poor, single mothers may be forced to become occasional sex workers in order to survive Poverty, moreover, plays an important role in influencing sexual decision making by limiting individuals' resolutions in sexual relationships. Gender power imbalances, which are rooted in gender role

norms, therefore, play a pivotal role in sexual decision making and in explaining the vulnerability of women to HIV infection (AJAR, 04:58).

Besides, women may also abandon safe sexual practices in exchange for economic and financial security, despite knowing the risk of doing so, which is the result of women's socially structured dependence on men for material and economic resources. Young women often engage in sexual intercourse at an early age for material gains or favors from sexual partners. Hence, the vulnerability of women to HIV/AIDS is often closely associated with so-called 'Transactional sex', and need not only thought in terms of 'formal' institution (Hunter, 2002; Zierler and Krieger, 1997 cited in AJAR, 04).

In spite of all these impacts of HIV/AIDS on a country's economy, the long-term economic and social costs of the disease had hitherto been grossly underestimated. Projections now suggest that some countries face grave economic consequences unless the epidemic is brought under control, and the cost of AIDS in terms of new resource needs and lost labor could be more devastating (OPEC FUND,04).

Further, the epidemic is erasing decades of health, economic and social progresses, reducing life–expectancy by decades, slowing economic growth, and deepening poverty, driving households to destitutions and exacerbating chronic food shortages. The epidemic also causes household expenditures to rise as a result of medical and related costs, as well as funeral and memorial costs (ibid, FAO, 2003a cited in UNAIDS,04).

2.3.3 AIDS as a Medical Problem

In the early days of the HIV epidemic, it was normally thought that the disease was more of a medical issue than any of the other social sectors. A lot of research works were dedicated to this effect, and were emphasizing on the consequences of the epidemic on this sector. But with the passage of time and from the experiences gained from the disease itself, people started to visualize other social events as well.

Yet, researchers are indicating that AIDS is and will continue to be, the most serious health crisis the world has to face this century. The AIDS pandemic has come to symbolize an age where fear, prejudice and irrationality battle against reason, responsibility and collective endeavors. So, its being a severe medical problem is beyond doubt, as it poses many difficult moral and political challenges on the modern world (Homans, 1988).

The challenges to be encountered by societies are so enormous that most of the developing nations are in a situation where they can not shoulder them. In most of such nations, the prevention coverage is extremely low, with only few of their peoples having meaningful access to basic prevention services. According to UNAIDS, 04, in low and middle income countries in 2003, only one in ten pregnant women was offered services for preventing mother- to-child HIV transmission, and an even smaller proportion of adults aged 15-49 years had access to voluntary counseling and testing services.

In a similar way, in Ethiopia where poverty has already reigned over all aspects and is striking hardest and deteriorating the entire life, there exists more frightening health care services for its HIV/AIDS patients. This implies that the reassessment of the country's approaches to public health strategy, health care resource allocation, medical researches and public mass education need worth reconsidering for the benefit of the masses. Besides, there are also implications

full-scale programming through a coordinated participation of all concerned bodies.

Regarding the situation of AIDS in Ethiopia, Kloos says that HIV/ AIDS has become the most important health problem in the country and a threat to the social and economic fabric of the nation (Kloos, 04: intro).

2.4. AIDS as a Global Threat

There are a number of reasons as to why the pandemic remains a world threat.

1. The virus is mainly transmitted during sexual intercourse. Since few human societies talk openly and honestly about sex, this makes the disease difficult to discuss; and since sex is a very private activity, it makes the transmission of HIV very difficult to control.
2. It has an extraordinary capacity for change and rapid global spread. In spite of HIV/AIDS campaigns in most countries, there is little evidence so far of any slowdown in the spread of the epidemic.
3. There is a long asymptomatic period between infection and illness. On average, it takes about 10-12 years for someone infected with HIV to develop AIDS. This long asymptomatic period is rare in other human infectious diseases. The long period that occurs between cause and effect has made it difficult to persuade individuals or even governments to take the pandemic seriously.
4. HIV/ AIDS is more serious than many more common diseases because of the age group it attacks. Because it is transmitted sexually, it predominantly kills peoples in their 20 through their 40's. The death of this group, a working force in the society, would cause a much greater impact on the social and economic aspects of a society.

5. HIV/AIDS requires the use of some of the most expensive and toxic drugs in medical history (Stine 1999:12).

Richard Biritwun of the World Health Organization says there are four major problems confronting the world today: environmental pollution, drugs, famine and HIV/AIDS. Environmental pollution and drugs may be considered as problems of the developed world, famine is most frequent in developing world. However, HIV/AIDS is a public health problem throughout the world (WHO, 1989:45). But currently, AIDS is not only a public health problem as was then stated, but it is now a disease that is affecting all spheres of social life and all types of people in the community.

AIDS is basically distinguished from virtually every other disease in history by the fact that is has no constant, specific symptoms. It is an unprecedented threat which affects people in all regions of the world. Besides the human suffering, its psycho-social impact is enormous and is of profound importance to the individual, the family and the society at large (Were, 1989:56).

According to Mohammed, at the beginning of September 1989, there were a total of 177,965 confirmed cases of AIDS world-wide; 31,146 in Africa, 119,662 in the Americas, 413 in Asia, 25,219 in Europe and 1,525 in Oceania Mohammed cited in CAMAS (1989). This figure has rapidly increased beyond imagination in the early 1990's.

Regarding the rapid expansion of HIV/AIDS across the world, the World Bank 2002 cited in Lamptey has estimated that about 42 million people were estimated to be living with the virus by the end of 2002. That same year, 3.1 million people have died of the epidemic while another 6 million were newly infected. The virus, unheard of two decades ago, now has infected more than 60 million people worldwide. In addition to this, approximately 14,000 new infections-12,000 adults and 2,000 children occur each day (Lamptey: 02).

Other scholars argue that HIV/AIDS is the disease of the poor and the underdeveloped worlds. One such a scholar is Stine who puts the issue in the following way:

> ...the most important identifying variable for the virus is income. Regardless of race, orientation, or language, those in the lower economic brackets are more likely to become HIV-infected. As the pandemic spreads, it is becoming a disease that can affect any person regardless of sexual preference or race, but in particular, it is becoming more of a disease of the poor, the group with in any society that has inadequate access to health care. It is also becoming the disease of the underdeveloped nations (1999:11).

When further strengthening this fact, other scholars have come up with more frightening figures. Lamptey indicates that at least 95% of new HIV infections each day occur in less developed countries especially in sub-Saharan Africa. Besides, the International Labor Organization (2002) has suggested that at the end of 2000, over 36 million people were living with HIV/AIDS, and out of this, two-third of them were in sub-Saharan Africa (ILO, 2002:40).

2.5. Ethiopia in the HIV/AIDS Context

Ethiopia now has an estimated total population of 71 million in mid 2004, and this is expected to grow by 2% annually through 2025. Ethiopia's population is young with 44% under the age of 15 years. 85% of the country's population currently live in rural areas, and the annual per capita income is estimated at 100 US Dollar (MOH, 04). The history of the country indicates that Ethiopia encountered recurrent drought, famine, internal/external conflicts, manmade and natural calamites during the last three decades. On top of all these misfortunes is the HIV/AIDS epidemic now.

According to sources, HIV/AIDS was discovered in Ethiopia in 1984, one to two years later than other sub-Saharan African countries. HIV/ADS surveillance activities began in 1989 with two reported cases to MOH. Since then, the epidemic appears to have steadily spread in the country. It is now believed that about 87% of HIV infection in Ethiopia is due to heterosexual or multiple sexual partners, the relatively virulent HIV-1 being the major strain in the country. Besides, there are also other cultural practices that account for the spread of the virus. Some of such practices are: female genital mutilation (FGM), Uvulectomy, blood letting, skin cutting, tattooing and other various piercing practices (MOH, 02 and 04).

In Ethiopia, it has been indicated that the virus first spread primarily through commercial sex workers, soldiers and truckers among the major towns, and gradually led to the infection of the general public in both urban and rural areas of the country.

According to the Ministry of Health 2000a cited in MOH 2002, the HIV/AIDS prevalence in Ethiopia remained low in the 1980's but sharply accelerated through most of the 1990's, rising from an estimated 2.7 percent in adults (15-49 years age group) in 1993 to 7.3 percent by 2000. The lower rate reported for 2000a (6.6 percent) was largely due to sampling bias rather than a decrease in HIV incidence (MOH, 2002).

Although no comprehensive study has been carried out regarding the economic and social impacts of AIDS on Ethiopia, the World Bank (2000a) estimated that the epidemic has already caused a one-percent annual reduction in economic growth, which, together with the declining life expectancy and labor force reduction is systematically undermining the country's efforts to reduce poverty through improvements in health, education, agricultural production and household food security. There are also evidences for the social impacts of the

disease as there are high morbidity and mortality in young adults, who traditionally provide care for both children and the elderly.

What makes the whole condition of AIDS more horrifying on the global level in general and that of Ethiopia in particular is the fact that women have remained number one victims of the disease. Ankrah (1994) states that the rapidly increasing spread of HIV among African women is one of the many tragedies of the AIDS epidemic. The Ethiopian Ministry of Health 2002 says that the gender ratio of HIV infection in Ethiopia has changed over the years from male- to-female dominated rates in the late 1990's, indicating its spread in the wider population. Females now have significantly higher AIDS rates than males in the 15-24 age groups, apparently due to their earlier commencement of sexual activity (MOH, 2002).

On the other hand, it is now a fact agreed upon that sub-Sahara Africa is the most severely affected part of the world where more than 2/3 of all PLWHAs in the world are living, though the area accounts for only 10% of the world's population (Stine, 1999). The global pandemic is now number one killer in this part of the world, and the fourth worldwide. Ethiopia, according to the Horn of Africa Journal of AIDS (2005) has the third largest HIV positive population in the world following India and South Africa, and is home to the sixth highest infection rate in the world. Although difficult to measure, the impacts of the epidemic in Ethiopia have been significant. The epidemic has already exerted its pressures on most of the societal spheres particularly in the areas of the economy, social, political, developmental, health, and others and will eventually reverse the slime gains so far attained from different spheres.

Data before few years estimated that there were about 2.2 to 3.0 million HIV infected Ethiopians are in the country, and about 1.2 million children were orphaned by HIV/AIDS. However, the latest estimation of MOH 2004 is found to be much smaller than the earlier figure by the same ministry. According to

this source, it is now estimated that there are at least 1.5 million Ethiopians living with HIV/AIDS (3.8% male and 5% female; 12.6% urban and 2.6% rural), out of which about 96,000 are children under the age of 15. Yet, the current figure is staggering to cope with for our poor nation. The source points out those results in the last few years indicate some encouraging signs that the epidemic is progressing at a lower rate, though the rate of change is not sufficient enough to be self-satisfying. This is mainly because given the large size of the population and the magnitude of the damage already inflicted, it will take one a number of years to see noticeable declines in prevalence and incidence reduction. With regard to the potential reasons for the decline in the rate of infection, the source suggests some of the following factors. First, there has been a significant increase in the number of surveillance sites in rural Ethiopia. The second factor is the introduction of modern software technology to analyze the data gathered. Further, all the regional and national estimates are self-weighted by their relative urban/rural population sizes and, the various intervention programmes made at various levels have greatly impacted the relative spread of the virus. There are also indirect evidences of behavioral modifications like the increase in the distributions of condoms from less than one million in 1996 to about 66 million in 2003, and the substantive increase in voluntary and premarital HIV testing. Hence, it would be rational to suggest that there is some degree of behavioral change in the community. However, the aggregate numbers are still staggering and with a lot of socio-economic and resource implications (MOH, 2004).

The estimated number of new AIDS cases in the adult population in 2003 was 98,000 (46% male & 54% female) while that in children was 25,000. According to the same source, some 90,000 adults and 25,000 children had died of AIDS in 2003, and there were an estimated 539,000 AIDS orphans in the country. Besides, about 245,000 PLWHAs were in urgent need of antiretroviral treatment (ART).

Under the present situations, there are obviously various impacts that the virus is exerting on the different sectors of the country. So, the analyses made in this regard show that the impacts are far and wide and in every corner of social spheres. The influence of the virus on the demography of Ethiopia shows that the population is being reduced by the epidemic. In the year 2000, for instance, about 0.6% of the population was lost to HIV/AIDS. In 2002, 0.8% of the population was consumed, and in the year 2004, the figure rose to 1.1%. The predictions made by the source for the years 2007 and 08 are 1.6% and 1.8% respectively. These facts and predictions indicate that there will be steady increase in the death of citizens if the current trend of the spread of the virus continues. The death rate will be the highest for the young adults (15-49 years), a segment of the society which now account for a 3rd of all deaths in the country due to HIV/AIDS. Regarding the pandemic's effect on the population at the continental level, UNAIDS 2004 predicts that by 2025, 38 African countries will have populations which will be 14% smaller than predicted in the absence of AIDS unless response is dramatically strengthened.

On the other hand, the epidemic is expected to reduce the life expectancy (LE) of Ethiopians by 4.6 years. Accordingly, in the year 2000, the expected LE without AIDS was 53 years, and with AIDS, it was 49 years. In 2002, LE was 54 years without AIDS, and 50 years with AIDS. Similarly, in 2004, the LE without AIDS was 54 years, but only 50 years with AIDS. The projections made by the MOH in the 5th national report indicate that the condition will remain unchanged for years to come, and hence by the year 2008, LE without AIDS will rise to 56 years, but with the epidemic, it will remain at 50.

The other impact area to be considered is in the education sector where a 5% increase in the death of teachers has already been registered, and is attributed to AIDS and other related diseases. A research conducted by the Ministry of Education (MOE) in the year 2003 (cited in MOH,2004) indicates that absenteeism of one week out of a semester was reported among a 3rd of the

teachers due to sickness of the teacher or members of his/her family. In addition, school dropout rates increased from 1996/97 to 2000/2001 - again due possibly to sickness and death of parents. There are also indications that education costs are on the increase as a result of the replacement of non-productive teachers and the premature payment of for terminal benefits. It is, therefore, believed that these factors are expected to contribute adversely to overall cost and quality of the education service, though they can not directly and solely be attributed to the impact of HIV/AIDS (MOH, 04:19).

With regard to the industrial sector, the source points out that the sector is also facing similar situation with the presence of the virus among the work force. In the year 2002, the impact of the virus was most severe in the wholesale trade, and retail trade followed by the manufacturing, agriculture and public service sectors consecutively. The sector is, therefore, expected to suffer from such major consequences as reduced productivity as a result of HIV- related illnesses in workers, the quitting of skilled workers of their jobs due to sicknesses, shortage of skilled manpower due to HIV/AIDS and the increased absenteeism of workers from their jobs and finally a rise in medical costs due to the epidemic.

Generally, the current HIV prevalence and conditions related to it have the following features. The trend of the epidemic from 1982 till 2003 suggests three key points: a continuing gradual rise in national prevalence (3.2% for 1995; 4.1% for 2001; 4.2% for 2002 and 4.4% for 2003); an urban epidemic that has peaked and plateaued at high prevalence levels; and a very gradual but steady rise in HIV prevalence in rural Ethiopia. The 2003 HIV prevalence is higher among women (5.0%) than men (3.8%) and is higher in urban (12.6%) than in rural (2.6%). Younger females who are living with HIV/AIDS outnumber males, while more males are observed in older age groups (30+years). On the whole, women are infected at a much earlier age (15-19)

than men (20-24), and the stigma and discrimination associated with HIV/AIDS is rife through out the country (MOH, 2004).

2.6. HIV/AIDS and Opportunistic Infections (OIs)

HIV/AIDS is acknowledged for its gravest effects on the normal functioning of the immune system. The virus gradually deteriorates the active functioning of the body by exposing it to a range of parasites that do not cause harm in people with intact immune systems. These parasites cause a disease in someone with HIV/AIDS as conditions become more favorable for them to act with the suppression of the patient's immunity. Hence, the suppressed immune systems give way for the manifestation of opportunistic diseases and cancers. Opportunistic diseases are, therefore, those diseases which strike the body when the normal immune system is critically weakened by other diseases like HIV/AIDS. Thus, opportunistic infections (OIs) occur after a disease causing microorganisms get the opportunity to multiply and finally invade the host tissue as a result of the compromise of the immune system.

Existing sources indicate that OIs are associated, directly or indirectly with about 90% of deaths in AIDS patients, compared to 7% due to cancers and 3% due to other diseases. This is basically because when the immune system is suppressed and weakened; parasites such as virus, bacteria, fungi, and others that commonly and harmlessly inhabit the body suddenly become pathogenic and/ or are reactivated. Their trend of invasion seems to correlate with the ages of the patients, in that way, elders become more vulnerable to them than those in their primes because the older one gets, the more his/her immunity is weakened and the more he/she becomes more susceptible to the pathogens.

Therefore, the AIDS pandemic is rather horrible as it makes its patients more impressionable to an endless series of infections and AIDS patients rarely have just one infection. The mix of the OIs may depend on the life style and the environment in which the patients live or have lived. Here, the geography

together with the patient's financial capacity determines so much about the varying patterns of OIs. Stine 1999 indicates that AIDS patients in Africa often die of severe bacterial infections because they do not have the antibiotics or the clinical case they need, and most of these patients live so short that they do not develop the various OIs. In other areas, patients are likely to develop other forms of infections since they tend to live longer.

According to MOH 2004, HIV/AIDS has accounted for an estimated 38% or 54,000 of all tuberculosis (TB) case incidences in Ethiopia in 2003. This proportion is expected to continue to rise in the years to come, contributing to a total projected TB caseload of 180,000 by the year 2008. Further, the consequences of the co- infection of TB and HIV/AIDS have already resulted in major problems for the country's health sector. The report issued in 2003 by the TB Leprosy Prevention and Control Team of the MOH lists some of the following major problems to be attributed to the co- infection of the two diseases: increase in the number of TB patients; low cure rate of TB patients; high mortality during treatment; high rate adverse drug reactions leading to a large number of defaulters; high rate of TB recurrence, and increased rate of drug resistance.

Generally all the symptoms that an AIDS patient demonstrates, i.e. the chills, night sweats, fever, weight loss, anorexia, pain and the neurological problems are the cumulative effects of the several OIs that eventually bring about the death of the patient, other than AIDS itself. Hence, HIV/AIDS alone does not kill its patients, but only in collaboration with the various opportunistic diseases (Stine, 1999).At this point, it is important to see the general background of the study area by describing its geographic, climatic, religious and other features.

CHAPTER THREE

GENERAL BACKGROUND OF THE STUDY AREA

In this chapter, the overall view of East Wellega Zone and that of Nekemte has been presented in terms of its geographical features i.e. its location, topography and climate. Besides, the historical background of the people, the culture, language and religions that are dominant in the area are briefly discussed so that the general situation of the study site can be grasped.

3.1. Historical Background of the Area

The former province of Wellega administrative region was incorporated in to the Ethiopian Empire between the years 1880-1890 by Menelik II of Ethiopia. History tells us that the province was, then, divided in to three administrative regions. These three administrative regions were a) Leqa Nekemte and its dependencies led under the local officials of the Bakare family b) Leqa Qellem, which was ruled by the Jote family and c) Horro Guduru and Arjo which were ruled by the Amhara officials appointed by the Emperor (Tesema, 1980).

However, during the reigns of Haileselassie (1930-1974) and the Military Dergue (1974-1991), the province of Wellega included the present day East, West and Asosa areas. In a similar way to Menelik's reign, Wellega was once again divided in to three administrative regions, by the current EPRDF-led Ethiopian government. The areas in the north-western part were annexed into Benishangul-Gumuz People's Region, the areas to the west became West Wellega Zone at Gimbi, and the remaining areas became East Wellega at Nekemte.

Thus, according to the present day federal administrative division, the zone in which the study area is found is East Wellega, and is surrounded by the Amhara National Regional State in the north, by Ilu-Abba Bora and Jimma

There are three agro-ecological zones of human habitations in this area that are locally known as *baddaa* (high land) 2000-3000 ms; *badda-daree* (medium temperature land) - 1400-2000 ms, and *gammoojjii* (low land) 1200-1400 ms above sea level. The *baddaa* zone has a monthly temperature of 10-16°c and has almost a temperate climate (Nekemte Meteorology Station 1998). The rain is almost continuous from March to November with variations in amount. The people in the area divide the rainy seasons into three depending on the amount of rainfall. They are *Ganna, Birraa* and *Bona. Ganna*, the major warm and heavy rain and cropping season from mid June to mid September; *Birraa* is characterized by its small rainy season from mid September to mid November. Bona is the driest season from mid December to March.

The *Baddaa* part of the region is known for its comfortable climate both for habitation and agriculture. It is the most populated and intensively cultivated ecological zone. The major crops produced in this zone include cereals (mainly barely, and wheat) pulses (mainly peas and beans), where as the animals raised include cattle, sheep and horse.

The *Badda-Daree* has almost a subtropical climate with corresponding temperature of 16-20°C with relatively lesser rainfall than *Baddaa*. The major crop produced in this area is *teff* whereas other cereals (such as sorghum and maize) and root crops (such as potato, sweet potato, and Oromo potato) are also widely cultivated. Horses and sheep are almost peculiar to *baddaa*, but the other animals are available in all ecological zones. *Badda- daree* shares the characteristic features of both *baddaa* and *gammoojjii* and is more conducive for habitation and agricultural activities than *gammoojjii*.

Gammoojjii, which constitutes the major portion of the region, has almost a tropical climate with relatively higher temperature (20-24°C) but lesser amount and reliability of rain, and consequently is less populated and less cultivated than the other two ecological zones. Though the soil is fertile and good for

cultivation, the unreliability of rain and the presence of human and animal diseases in addition to crop pests made this area less populated and less cultivated. The common crops are millet, *ancootee* and *goodarree* (both local food crops), sweet potato, potato, cotton, oil crops, orange, mango, avocado, banana and lemon (Teshome, 1999).

The *baddaa* includes areas around the present day Jimma Rare, and Jimma Horro in the north east, highlands of Bila Sayyo, Sibu Sire and Guto Wayyu in the center, and highlands of Nunnu Qumba in the east and parts of Arjo and Diga leqa in the south. The *Badda - Daree* is confined to the central part of the region and many other areas with narrow low altitude are bisected by wider flat plateaus. The *gammoojjii* is mainly situated in the marginal bordering areas of Fincaa'aa and Abbay Valleys in the north east, Angar and Didessa valley extending from north- west to south- west and areas around Gibe and Wama Valleys in the south-east (Ibid).

The zone has many rivers such as Didesa, Fincha'a, Angar Garchi, and many other streams which flow from the highland to the lowlands, making many falls and crossing the wider plains. Fincaa'aa is the only river yet used for large scale hydro-electric power plantation and sugarcane production. Many of the rivers in the area have great potential for fishing and are rich in different animals including hippopotamus, crocodile, and varieties of birds which could be sources of tourist attraction (Ibid).

The *gammoojjii* (plain areas of Fincaa'aa, Guttin, Uke, Angar, Didessa, Wama, and Lugo) has humid, warm climate, slash tropical vegetations, plenty of rivers crossing them, and thus has high potential for food and marketable crop production (Nekemte Meteorology Station).

3.2. The People

According to written documents and oral histories, the early Oromo groups, Borana and Barentuma, made their routes of settlement in different directions. Borana took to the western Oromo land further dividing into Macca and Tuulama in its increase of settlement to the west (Trimingham, 1976:9). With an increase in population and the need for farm and grazing lands, the Macca groups extended their settlements to the present Western Shoa, Wellega, Jimma and Ilu Abba Bora while the Tulama groups expanded to the wider Shoa areas (Tesema, 1980; Knustsson, 1967; Lewis, 1965). Most of the writers viewed this increase of Oromo land holding as migration and purposive expansion. The settlement and extending farm land holding could not be migration and/or intended expansion but a natural phenomenon that usually result from the unavoidable population growth.

Studies show that the Oromo of Wellega are one of the Macca groups who in the earlier times made their centers of settlement around the upper Gibe basin. With the rapid increase in population and lack of communication at the time, different smaller Oromo communities with different local names were formed separately in the entire Western Oromia. Thus, presently Tume and Hulle Oromo groups are living in Ilu Abba Bora and Jimma respectively, while Leqa, Sibu, Jimma, Guduru, Amuru and Nonno groups are living in different parts of the present Wellega (Tesema, 1980). This part of Macca Oromo had been said to have undergone significant political differentiations and thus formed political groups of which the best examples can be the five Gibe states and Leqa smaller local hereditary monarchical and centralized states led by *motis* (King) whose succession was in the primogeniture line (Knutsson ,1967).

Oral traditions show that the known Oromo democratic socio-political system, called *Gada* was violated by some *Gada* officials and this turn of event gradually resulted in the formation of smaller local states, mainly the Leqa in about 1770s under the Bakare family, who were fighting among themselves to dominate one anther and finally the existing resources (Tesema, 1980).

The general historical situation of the area during the time of Minilik shows that the imperial policy brought about the transformation of the socio-economic relation on the local people in which the regime and the *neftegnas* became beneficiaries whereas the local peasants were made to be victims of the system. In this case, the advent of Minilik's rule with its complete destruction of the whole living conditions in the area led the local people to live in long-lasting and miserable life.

Under the rule of Haile Selassie, too, like the other subjugated peoples of the Ethiopian empire, the Oromo of the area were leading no better life than it was under Minilik's. During this regime, there was a continuous Amhara settlement schemes in the area which evicted the local peasants from their lands, turning them in to a state of landlessness. Thus, there was a great deal of land and man power exploitation by the regime and its new settlers in the area at the time.

There are numerous instances where people make a comparison between Haile Selassie's brutal regime with that of the Italian occupation of (1936-41) in which they prefer the later together with Christian missionaries who attempted to expand social infrastructures like roads, bridges, schools, hospitals, and others.

Similarly, under the Dergue regime (1974-1991), the peasants of the area were little benefited in terms of socio-economic developments. The nationalization of the land remained, in the actual sense, nominal and ineffective. The land redistribution system which had a lot of shortcomings resulted in peasant inequalities. The peasants were levied land and agricultural produce, were made to contribute for war and militia families (in cash, in kind and in labor) and for the construction of resettlement sites. There was no free market and the peasants were forced to sell a portion of their produce at a fixed government low

prices for which they also paid sales tax. This greatly reduced the productive interest and innovativeness of the Oromo peasant of the area, because the system did not allow the peasants' work to result in tangible reward to the individual family. On the other hand, the price of consumer goods of such items as salt, sugar, clothing and simple but necessary farm implements and inputs had increased many times and were unavailable.

Here the regime's socio-political, economic, and military policy greatly contributed for the total deterioration of the socio-economic life of the people in the area. The peasants were neglected, exploited, and were deprived of access to improved agricultural implements, better seeds, better livestock breeds, or generally better agricultural technology. The huge human and material resources were basically spent on military, resettlements, and villagization programs. These undoubtedly affected the agricultural production of the peasants and the economy in general (Teshome, 1999).

With regard to the current EPRDF government, it is obvious that most of the grievances from the former regimes have continued to persist with little or no change on their approaches to ruling the peasants. The land redistribution problem created by the Dergue remained unresolved. High land use taxes and war contribution are still levied on the peasants of the area, and significant social and agricultural technologies have not yet been expanded. Worse of all, in the name of democracy, the people are denied of their natural rights to survive as they can not freely trade and accumulate capital, express their views on public meetings for fear of being categorized as supporters of the opposing political front. According to the views of the local community, the local cadres of the Oromia Regional State are known to frequently intimidate, chase and imprison whom they think hold contrary political views to theirs. The intimidation and the chasing seem to cover almost all types of people, cutting across ages, education, social status and religion, according to people in the area.

From the historical background of the people, one can understand that the oppressive and unjust socio-economic and political systems which usually stand on behalf of the ruling classes have been the major causes for the deterioration of the socio-economic development of the people. The ruling systems were/are not directing the material and human resources to the development of agricultural and industrial but work to words the sustenance of their political authorities.

Generally, although the area is known for its abundant natural and human resources, it remained one of the poorest and least developed areas in the country.

3.3. The Language

The language of the people under study is Afaan Oromo, a language which belongs to the eastern Cushitic, a sub-group of the Afro-Asiatic language family (Lewis, 1965 Cerulli, 1922). It is, thus related to such languages as Agaw, Somali, Sidama, Konso, Afar and Saho. The Oromo language is the common language of all the Oromo people. Every Oromo national can communicate with little or no difficulty with every other Oromo from another corner of the land. This does not, however, mean that the language has no regional variations or dialects.

Afaan Oromo has, of course, regional dialects as in many other languages in the world due to such reasons as the vastness of a land or territory over which the language is spoken, the large number of its speakers and cultural or social influences from the outside world and so on. Most of these and other reasons are obviously pertinent to the Oromo case. Cerulli in his study of Oromo Folk literature divided Oromo dialects into three:

a) The eastern dialect - spoken in eastern Oromia and Wallo

b) Tulama dialect - spoken in central Oromia

c) The Macca dialect - spoken in western Oromia. The dialect of the people under study is, therefore, that of Macca.

Other than being the mother tongue of more than 30 million Oromo living in the country, Afaan Oromoo is also a lingua-franka of the many nations and nationalities in the country (Geda Melba, 1988). Some of these groups are the Harari, Gurage, Barta, Anuak, Gumuz, Sidama, Amhara, Argoba, and others. Besides, according to sources, Afaan Oromo is believed to be the third most widely spoken language in eastern Africa after Hausa and Kiswahili respectively. After the fall of the Dergue regime in 1991, the Latin script, called *qubee*, has been adopted for the language with slight modifications. Since then, therefore, the language attained a written status and became the medium of instruction in Oromia. This turn of event is believed to have enormous contributions for the revival of the language, the culture, and the identity of the Oromo people in general.

3.4. Religions

Understanding the religion of a certain group of people is important for a number of reasons. The normative attitude and behavior of a society is shaped, regulated and legalized by religious sanctions. Thus, people's acceptance and resistance to an innovation is mostly determined by their religions. Similarly, among the people under study, early socialization in the family is carried out through religious indoctrination and habitation. Besides religion also governs marriage rules and sexual behaviors.

Presently, there are three religions among the people

1. The indigenous Oromo religion (i.e. the belief in Waaqaa (God);
2. Christianity, and
3. Islam

The belief in *Waaqa* is said to be the native religion of the society whereas today the majority of the people in the study area are Christians. Muslims account for a small number of the people. Yet the two introduced religions tend to dominate the native Oromo religion. So, it is important to deal with it in order to understand the basis of the psychological make-up of the people.

The people's religious practices are first of all characterized by the practices that are undertaken in groups of families, relatives or neighborhoods. Second, the religion underlies the belief in one Supreme Being called *Waaqa* who is the creator and sustainer of everything on earth and in the heaven.

There are lesser intermediary spirits called *ayyaana*, who perform the orders of Waaqa in the religion. The *ayyaana* are saint-like divinities each seen as manifestation of the *Waaqa tokkichaa* (one Waaqaa). They also believe that the Supreme Being leads and governs every aspect of life and solves any immediate problems. It is also believed that the *ayyaanas* inhabit in natural objects.

People do not, however, worship and believe in the natural objects, but in their Supreme Being (Waaqa) through the *ayyaana* inhabiting in these objects. They view that the *ayyaanaa* do not order by themselves but perform the order of Waaqa. They are *Waaqa's* creations. Thus, the religious practices like offerings, sacrifices and prayers are considered to be relayed to their Waaqa through the *ayyaanas*.

The people also believe in the presence of ancestral spirits usually called *Boorantícha*, which is much more than ego's father's and mother's *ayyaanas*. For them everything including man has dual nature, the real physical object and its *ayyaana* (spirit).

They also believe in the existence of life after death in the form of *Ekeraa* (ghost spirit) which is believed to live in the place where the deceased person once lived with his relatives, but do not believe in suffering after death. Punishment for sin and wrong doing is believed to take place during the life time and not after death.

Sources indicate that the religion's ultimate goals are directed to material needs. The offerings, prayers, and other practices are for the request of better wealth, health, leadership, rain (good weather), large number and good mannered children, fertility, and the like. Among the people, Waaqa occupies an important place and in its religious aspects is reflected in the daily economic, social, and political lives of the individual, family, group or the entire community.

Some writers have failed to identify the exact meaning of Waaqa and have tended to confuse the concept. Ludorphas (1982), for instance, generalizes that the Oromo believe in heaven as Supreme Being, while Cerulli (1922) says that for the Oromo, Waaqa is both heaven and Supreme Being. In both cases, the concept of Waaqa has been confused because they basically focused on *Waaqa's* nature.

Obviously, the daily life of the people is regulated by the ultimate value of the Waaqaa, and it is believed that if His rules are violated, then Waaqa withdraws His guardianship and causes punishment by sending such spirits as *jinnii* (Satan) which are always ready to harm humans.

Offerings and sacrifices are made for the chastening spirits though the ultimate reference of the offerings is not for them, but to Waaqa who guards them and order the spirits not to inflict damages. This shows that the people believe that Waaqa withdraws His guardianship when one violates His commands and rules. Accordingly, such acts as lying, stealing, offending elders, eliciting

sexuality, interfering into *Waaqa's* works such as fertility are against His orders.

On the other hand, every creature in Oromo is believed to have his /her /its *ayyaanaa*. It is also believed that some individuals called *Qaalluu* have special *ayyaanas* through which effective relationship between the people and their Waaqa is maintained. Such a person is a ritual expert and is like a Bishop in Christianity and Imam in Islam. Furthermore, *Qaalluu* is pure and highly respected in the community. He is a preserver and protector of the Oromo culture. In *Qaalluu's* village, spiritual practices such as giving advice and remedies in case of misfortunes and diseases are undertaken. The Oromo *Qaalluu* is different from the *Qaallichaa* of the Amhara which is vagabond, more of magical practitioner given lower social status and ran for his own benefit (Knutsson, 1976).

Generally, the majority of the people in the study area are Orthodox Christians with recently growing number of Protestants. Whichever "modern" religion dominates, members of all religious sects still tend to practice the native Oromo religion. As Bartles (1983) account shows, they still visit *Qaalluu*, practice *ateetee* and celebrate *ayyaanaas*.

The Gender relation that prevails in the area show us that because of the patriarchal nature of the society, women are made to hold lower social positions, and as a result, lack the access to economic sources. It is the husband who owns the existing properties including the wife herself. Women are usually socialized in such a way that they should full fill the needs and expectations of the society. In that case, they are expected to rear children, feed and care for the whole family, fetch water from a river, prepare farm lands together with other family members, weed and thresh crops, and do many more. In other instances, they are also involved in petty trading through which they contribute to the economy of the family.

It is believed that women do myriads of activities devoting about 16 hours of their time each day. The work covers all sorts of routines, and it is hard to find a job in which women do not participate. Generally, women in the study area are engaged in house works, farm activities and small scale trading though they live under a social condition which does not regard their labors and contributions to the various aspects of families and they community.

3.5. Marriage Systems in the Area

In dealing with the issue of HIV/AIDS, one needs to discuss about family relationship because the types of marriage a given community exercises and the relative stability of the marriage contract will have a greater impact on the spread of the virus. Marriage is the beginning of family formation and is the basis of conjugal family. As an institution, it regulates mates, offspring, procreation, rearing of children and also controls the society at large.

As marriage is not a mere biological fact, a family is also not a mere biological unit, but a social organization held together by a complementary economic needs, moral codes and integrative force of the whole social organization. Like many east African societies, marriage among Oromo functions mainly as an alliance between two large non-kin locally called *halagaa*. Among the Oromo, marital relation between the two groups never dissolves even after the death of either one or both of the spouses. In a situation where a husband dies, a marriage arrangement called *dhaala* (where the woman is made to marry the deceased husband's brother to maintain the bond, to preserve their children and property) takes place. In earlier times, *hirpha* (a marriage of a man to a sister of his deceased wife) had also been used to keep such bond. This occasion is arranged in the presence of elders and relatives of two groups.

Thus, marriage in the society is not only an individual issue but also an affair of a wider social group. Among the people, it plays a significant role in mate selection, marriage process and its stability. It is with this view in mind that the people incline to make mate selection and marriage arrangements for their children. However, this event is becoming a thing of the past, and it is the couples who are personally involved in to the business in the majority of cases.

Marriage is normally performed in order of birth of children and thus the father deals with the mother, grandparents and other close relatives when they think that the boy is physically ready enough for marriage. They select a mate for him through a careful investigation of such factors as rule of exogamy, equality in prestige and status, purity from diseases like leprosy and elephantiasis (which people think are hereditary), similarity in occupational caste, hardworking, hospitality, household management, fecundity, attention to children, sociability of the girls' parents, girl's home-skills, physical fitness and personal behaviors. More emphasis is given to the girl's parents than the girl herself because it is thought that the girl will have similar qualities to her parents'. This condition is usually accompanied by the usual saying among the Oromo, *"Haadha (warra) ilaalanii intala fuudhu,"* which means, you have to observe the mother (parents) to marry the girl.

Marriage is exogamous, i.e. a marriage from one's blood kin *(fira dhiigaa)* is regarded as incest (*haraamuu*). They identify this by recalling descent line through male (*jilba lakkaa'uu*). It is the custom of people to teach their children to count their male descent lines beginning from their early ages, [usually from the present to seven generation (grand fathers) back or even more]. Thus, the rule establishes that there should be, at least, twelve genealogical distances on the father's line and nine on the mother's lines between the two persons to get married.

Polygamous marriage is socially acceptable and is widely practiced. First, such a marriage enables a person to form social networks, through which he gains social and economic security. Secondly, acquiring a number of wives is thought to be the addition of household labor both from the wives and the children they bear. Thirdly, it is thought that having many wives enables a person to have higher possibility of perpetuating his lineage through bearing a number of children. Fourth, it is also considered as one of the mechanism for resolving the problem of childlessness where a man remarries if the first or the second wife happened to be barren, or unable to give birth to the desired number of children.

3.5.1. Types of Marriage in the Area

Generally, eight types of marriages are practiced in this area.

1. ***Naqata*** (marriage by betrothal) - is the most common type of marriage in the area and is arranged mainly by the parents in which there is regular marriage payment for the accomplishment of the ceremony from the boy's parents. The girl's parents are expected to supply items for the couples and prepare large feasts on the wedding day.
2. ***Sabbatmarii*** (marriage by pleas to the girl's parents) is the second widely practiced type of marriage. In this type of marriage, the boy together with his attendants (usually elderly and respected persons) directly go to the girl's father's homestead and temporarily camp there and appeal to the girl's father for the girl's marriage to the boy.

Through a great deal of discussion and negotiations between the elders and the girl's father and his relatives, the marriage is accomplished on that very day with no wedding ceremony or feasts. This marriage can happen between fiancées or between new couples mainly to reduce the marriage expense and to shorten the time of the marriage accomplishment.

3. ***Hawwii*** (secret selection in marriage) - is a marriage accomplished by secret dealings of a man and a girl with the aid of a go - between usually a woman who can facilitate the communication between the two agents. The marriage is usually done without the knowledge of the girl's parents. People engage in this type of marriage as a result of economic problems they have to accomplish the regular marriage and when the parent's selection happens not to fit with the choice and desires of the boy and the girl.

4. ***Butii*** - is a marriage by abduction and it usually happens when the formal marriage appears impossible or very difficult due to such reasons as inequality of the parents' statuses and the unwillingness of the girl to marry the man or due to other similar reasons.

5. ***Aseennaa*** - is the fifth type of marriage in which the spinster (called *haftuu*), without the knowledge of the man and his parents, enter into the boy's parent's home to marry the boy. The cultural norm forces the boy and his parents to accept the marriage if it ever happens. It is only on rare occasions that the girl is refused and if this happens, she will be sent back with gifts, clothes and cattle from the boy' parents.

6. ***Dhaala*** **(levirate)** - is a marriage arranged between a widowed woman and her deceased husband's relatives, mostly younger, full or classificatory brother, to preserve the children and properties of the deceased man to his kins.

7. ***Sigabii*** - is a marriage of a widowed woman to a man who had once been her servant. It could also be a marriage between a girl and a youngman who lived with the girl's family for sometimes (as their servant).

8. ***Hirpha*** - is a marriage of a man to a sister of his deceased wife. *Hirpha* is usually done to preserve the children of the deceased woman and has the

intension that the sister of the late woman would be "good mother" for the children (compare no 6) (Teshome, 1999).

In addition to all the well-founded marriages in the area, there are also occasions when people suddenly come together and establish a marriage. People move from place - to - place now more than at any time in history due to jobs, trading, and the search for better lives in towns and cities or on being employees at certain offices or as soldiers operating in certain areas. These conditions have brought people from different backgrounds into contact and facilitate conditions for engagement without going into the details of what traditions normally demand. The intermarriage is highly practiced by the younger generation who are relatively relaxed and less conservative when compared with the older ones. The intermarriage, which is passing over the traditions of the area, is currently taking place between Oromo coming from different places, and other ethnic groups who have come to the area for different purposes. There are also numerous occasions when especially young ladies, get married to someone whom they think, is better off economically than themselves, regardless of his background.

Generally, the different marriage practices, although they are in the most cases culture-bound, have a lot to contribute to the spread of HIV/AIDS in the area. This is mainly because most of them are performed under the condition that little care is given for such a pressing issue. A given community of people should realize the pros and cons of the relatively permanent institution other than exercising for tradition's sake and for the mere maintenance and sustenance of the culture. Nowadays, the condition of HIV/AIDS, which is threatening the very existence of the people themselves, forces everyone to be vigilant and more careful about everything one does, especially in marriage issues where the continuation of a generation takes its initial step.

Most of these marriage practices are similar to one another in the sense that they are culture - based and are usually geared towards the fulfillment of the duties of establishing marriage lives. However, in the case of *butii*, the couples are made to come together through forceful means which makes the ladies the obvious victims. In the case of *sigabii*, because the seducing males usually come from other areas, the marriage is spontaneous and short-lived.

Whereas in all others, those who come together at least have some information about the other side though the mere physical knowledge can not be the ultimate foundation of a healthy family. Therefore, what ever the marriage type, there are always grounds for the couples to be infected if care is not taken. Thus, it is time for the would-be couples to negotiate on the issues of HIV/AIDS and test their blood before rushing in to sex and end up in marriage. The current trend of testing blood for the purpose of marriage should be promoted and encouraged.

3.6. Women and HIV/AIDS

3.6.1 Women in the Society

Women account for about half of the total population of most societies around the world. In Ethiopia, they account for 49.7% of the population according to Central Statistics Authority, 1990. Women in different societies face nearly similar conditions of life in their day-to-day activities. They are, in most cases, considered as inferior to their male counterparts. The categorization has been accepted as a universal feature of cultures across the world, and a culture that does not degrade the status of women is rarely available. According to Barbara and Bogale (1995), women in Ethiopia are considered as legal minors who should always be owned by someone; say father, family or husband. Societies across Africa usually make life orientations from the earliest childhood in which male and female children are socialized differently and come to visualize their roles differently from each other right from this time onwards.

In the particular case of Ethiopia, the role of girls becomes more defined as they approach the age of puberty. Girls begin to learn a lot from their mothers after they reach nine or ten and are trained to carry out domestic activities effectively and on the way, prepare themselves well for other skill and arts of womanhood. The family, where children are first socialized in to different roles, remains an important site where economic and cultural units are also combined to shape and orient children. Contrary to the girls, boys are expected to learn from the daily activities and experiences of fathers, and eventually prepare themselves for manhood. The traditional family is, therefore, an institution in which children are shaped according to the expectations of the family and the larger community around.

Despite the divergent roles of children due to societal expectations, in most societies, much more is expected from girls/women than the boys because of the existence and prevalence of culture that considers women as home makers, caretakers, wives, mothers and grandmothers. Besides their endless duties and responsibilities at home, they are also expected to contribute to other sectors as well. In the agricultural sector, for instance, women contribute about 60% of the output in our country. Their active involvements in the daily routines as well as in the various sectors are, therefore, living witnesses for their being a pivot upon which a society rotates.

Besides, Topouzis cited in Barbara and Bogale (1995) when illustrating the plight of women farmers in Africa says that with the potentially devastating economic, social, and environmental consequences developing across Africa, evidence shows that nearly two-third of Africa's fast-growing, poverty-stricken population consists of women. Women are severally exposed to poverty and destitutions as a result of the limited financial resources and economic opportunities they have in the society.

3.6.2. Women and their Places in the Pandemic

The HIV/AIDS pandemic has been characterized as the disease that infects every individual members of a society. However, the rate at which the members of a society are infected by the disease has not been uniform. Some are more vulnerable than others due to a number of reasons. Young people (14-30 years of age) are more likely to be infected by HIV than those who are older and more experienced than they are as a result of the group's basic features: being interested in testing life from their own experiences, having high sexual desire and the tendency to exercise it, and the absence of appropriate knowledge about the disease. This is not, however, to testify that the other members of a society live AIDS-free life. AIDS is obviously a disease that unsparingly infects and affects all members of a society.

Yet the condition of women with regard to HIV contraction is even worse than all others, and according to some sources, the global pandemic has already been 'feminized', and it is being referred to as the disease of the poor world and of women. According to Stine (1999), women, children and teenagers were on the periphery of the pandemic through 1998. For the UNAIDS, in the early days of the pandemic, men vastly outnumbered women among those infected. The proportion of females infected by HIV worldwide steadily grew and by 2002, about half of all people infected were women and girls. In addition to being the majority of those infected, women and girls are now bearing the brunt of the epidemic in other ways, too: it is they who principally take care of sick people, and they are the most likely to lose jobs, income and schooling when infected by the virus. Women may even lose their homes and other assets if they are widowed (UNSIDS, 04). Therefore, there can be little doubt that HIV/AIDS is increasingly becoming a disease with the face of women or girls. Stephen Lewis, the UN-Secretary General's Special Envoy for HIV/AIDS in Africa (cited in UNAIDS, 04) says that the "pandemic is now, conclusively and irreversibly, a ferocious assault on women and girls worldwide."

Women in the developing and economically backward nations are believed to be the prime victims and sufferers of the consequences of the virus. Sub-Saharan Africa, a region of the world that is most characterized by its extreme poverty and social instability usually resulting in family disruption, high level of other sexually transmitted infections, low status of women, sexual violence, ineffective and high labor migration, now accounts for about 90% of all the global HIV/AIDS pandemic. In this area, the rapidly increasing spread of the virus among women is one of the many tragedies of the epidemic. WHO reported that in 1993, there were more than 4 million African women infected with HIV. After some years, women accounted for about 50% of infection in developing countries (ibid).

Currently, however, the figure is expected to reach 60% as each year brings an increase in the number of women infected. Accordingly, in sub-Saharan Africa, 57% of adults infected are women, and 75% of young people infected are women and girls (ibid). Generally, women are currently in the midst of the epidemic as a result of the deteriorating socio-economic conditions in most areas and due to the existing traditions that entitle them to lower social status (ibid).

3.6.3. Some Factors That Contribute to Women's Infection by the Virus

There are a number of general and specific conditions that make women and young girls to be more vulnerable to HIV/AIDS than any other members of the society. These factors are so interconnected that the existence in one usually presupposes the coming into view of the other. They are typical to some societies and are more likely to be taken for granted. Further, for some others, the attempt to fight against the conditions that lead to misconceptions and under representations of women in the society tends to confront fierce resistance as the struggle would connote the reversing of the 'natural' course of

the social life. There are also occasions when different attachments are given to the status of women in a society, of which some are of divine origin. However, some Western societies have succeeded in achieving the relative goals of improving the social statuses of women in their societies and enabled them to stand on their own feet and equally claim their rights with men.

As the history of the epidemic indicates, HIV/AIDS combines a series of factors which in one way or another, contribute to the spread of the virus at an alarming rate. Some of these factors are economic, social, biological and political in nature, and in most cases, determine vulnerability to the virus especially for women, children and young adults. Understanding the pandemic vis-à-vis these determinants help recast HIV/AIDS as a universal human rights issue (Lamptey, 02:5).

The economic development of a nation governs the level of the living standards of citizens of a given country. Countries are classified into different layers of development based on their economic achievements. The economic status of a country has a lot to do with the health and welfare of citizens of a country. It is now generally accepted that the economic development of a given country and its ability to defend diseases are directly proportional. That is to say, the wealthier a nation, the stronger will be its defense system and the better its health facilities, and vice versa.

HIV/AIDS is acknowledged for its collocation with poverty and in most cases, poverty-stricken regions are the most severely affected ones.. Different sources relate HIV/AIDS to chronic food shortages, malnutrition, and social instability. The area most famous for these features is the sub-Saharan Africa, where 24% of the world's undernourished people live (UNAIDS, 04). In this part of the world, the largest percentage of HIV prevalence is always registered as a result

of the continuously deteriorating living conditions of the general population and that of women in particular.

When it comes to the issue of women in relation to the epidemic, the fact that they are economically dependent on men, that they face domestic violence, and experience non-consensual sex in most areas make them more vulnerable to the infection of HIV/AIDS. Moreover, illiteracy, overwork, short life expectancy and high maternal and infant mortality rates, in general mark the lives of the poorest of poor women and their dependent families (Barbara and Bogale, 1995).

In addition to the economic factors discussed above, the socio-cultural situation under which women live also plays its roles in this regard. The socio-cultural features of a society are quite important in shaping the general condition of women. They signify the way women are treated, perceived, societal expectations from them, and other cultural features. Therefore, it is the position of women and the relationship between women and men, their social status and the existing gender inequalities that should be central issues in the fight against the spread of AIDS.

Sources on the socio-cultural aspects of women point out that in the majority of cases, there are evidences of gender imbalances which eventually lead women living with AIDS to experience greater stigma and discrimination. The 2001 UN Declaration of Commitment on HIV/AIDS recognized that gender inequality is fuelling the epidemic at a horrifying rate. Besides, women do not have the cultural power to negotiate on their own destinies, and whatever male partners forward is expected to be received passively. For many women, including the married ones, their male partners' sexual behavior is the most important and decisive risk factors in the regions where women are regarded as subordinate. On the other hand, marriage and other long term monogamous relationships cannot be a guarantee for women's safety, and hence, do not protect them from

HIV virus. According to UNAIDS, it appears that marriage actually increases women's HIV risk because men in most cultures are expected to wander to find sexual partners whereas the wife should stay indoors feeding the children, caring for the old and the sick in addition to busily occupying themselves with the household routines.

The biological makeup of women is another major point that likely increases their susceptibility to the HIV virus. Women are biologically more vulnerable to HIV infection than men because HIV in semen is in higher concentration than in vaginal and cervical secretions and because the vaginal area has a much larger mucosal area for exposure to HIV than the penis (Stine, 1999 and UNAIDS, 04). According to the same sources, women are 30% more likely to be HIV positive than men. African women between the ages 15-24 are 3.4 times more likely to be infected than their male counterparts. Besides, data from a number of studies suggest that male-to-female transmission during sex is about twice as likely as to occur as female-to-male transmission. Moreover, young women are biologically more susceptible to infection than older women before menopause (ibid).

Generally, women remain more vulnerable to the infection of the HIV epidemic due to the combination of factors and the intermingling of conditions together with the longstanding socio-cultural views and perceptions of most societies towards the female sex. These conditions coupled with their biological features will always make them number one sufferers from the disease unless corrective measures are taken to tackle the acute problem.

3.6.4. Some Features of HIV Contraction in the Study Area

The study area (Nekemte) has shown some kind of steady growth in HIV prevalence since recent years when compared with other major towns in Oromia. Data from Nekemte Hospital and Nekemte FGA indicate that there are evidences that suggest the truth of this claim.

From the monthly Voluntary HIV Counseling and Testing Summary of FGA in 2004, it can be understood that females of certain age group are more vulnerable than males of the same age. According to this data, out of 49 females (aged between 20-24 years) who were tested, 9 of them became HIV positive. On the other hand, from the 65 males of the same age tested, only one of them was found to be infected.

In a similar way, females aged from 25-29 years were more infected than their male counterparts. The source indicates that out of the 25 females tested, ten of them were infected with HIV, whereas only 3 males of the same age were found infected out of a total of 46 tested at the center. The figure tends to rise even for those females who are nearing their menopause stages.

Table 1

Monthly Voluntary HIV Counseling and Testing Summary Table

Number of persons counseled and tested by age and sex

Age Ranges (Years)		Pre test counseled	consented and tested	Post test counseled	HIV positive test result
<5	M				
	F				
Total					
5-14	M	2			
	F	1			
Total		3			
	M	9	9	9	

20-24	F	49	49	49	9
Total		114	114	114	10
	M	46	46	46	3
25-29	F	25	25	25	10
Total		71	71	71	13
	M	32	32	32	3
30-34	F	6	6	6	1
Total		38	38	38	4
	M	8	8	8	
35-39	F	7	7	7	
Total		15	15	15	
	M	6	6	6	3
40-44	F	3	3	3	2
Total		9	9	9	5
	M	3	3	3	1
>=45	F	1	1	1	1
Total		4	4	4	2
Grand total		312	309	308	34

Source: FGA, (Nekemte), 2004 .

From the summary table, females from the ages 20-29 are found to be severely affected because of some potential reasons like early commencement of sex, early marriage practices and the divorce that consequently follow such premature marriages, the practice of having an affair with many males, and the biological reasons that make them more vulnerable than males.

On the other hand, on the comparison made between groups of people with different marital statuses, it has been shown that no group is spared by the virus although some are more infected than others.

Table 2

A Table showing the number of females tested and their marital statuses

Marital status	# of tested females	# of HIV positives
Never married	201	15
Married	36	5
Separated	22	3
Divorced	36	8
Widowed	14	3
Others	-	-
Total	309	34

Source: FGA, Nekemte, 2004.

The above table indicates that those women who are divorced and live without attaching themselves to one sexual partner are found to be more liable to HIV infection than others. From the source, out of the 36 divorcees tested for HIV in the area, 8 (i.e. 22.2%) of them were found to be infected. And out of the 14 widows tested, it was found that 3 of them (i.e. 21.6%) were infected with the HIV/AIDS viruses, making them stand next to the divorcees.

On the other hand, we can see that those women who are married were among those infected, accounting for 13.8% among those infected with the virus. This suggests the fact that marriage by itself can not be an insurance for most women against HIV/AIDS. Generally, women whether they are married, divorced, separated or otherwise live under certain conditions are always chased and infected by the deadly HIV virus, as has been witnessed from the study area, and the fact that the virus is currently spreading among women at such an alarming rate heralds the immense damages to be inflicted by the virus on the general public in this particular site.

In a similar development, the MOH, in its 5th national report made the following comparison of Health Centers in the Oromia the following way (from the years 1989-2003).

Table 3

A Comparison of HIV Prevalence (%) Rates at Seven Urban ANC Sites in Oromia

Region	Site name	1989	92-93	1995	1996	1997	1998	99-00	01	02	03
OROMIA	Alemaya HC									2.5	2.2
	Chiro HC										4.4
	Jimma HC								8.6	16.9	10.2
	Mettu Hosp.		10.7					4.0	10.5	11.6	10.8
	Adama HC								18.7	16.0	10.8
	Nekemte HC								9.1	11.3	13.0
	Shashamane HC							14.3	13.1	-	8.7

Source: MOH, 2004 .

According to this source, although some of the health centers (Adama, Shashamane, and Jimma) had high HIV prevalence before few years, none of them has a continuous rise in HIV prevalence and is not under pressure from the virus. Nekemte is, therefore, an exception in that the HIV prevalence is continuously growing from 9.1% in 01, to 11.3% in 02 and 13.0% in 2003. The prevalence in Adama in 2001 was 18.7% when Nekemte's was almost half way behind that of Adama in that same year. After two years from 2001, Nekemte's prevalence has grown by 3.9 % whereas those of Adama and Shashamane were retarded by 7.9% and 4.4% respectively from 2001 to 2003. The same is also true for all the remaining urban ANC sites available in the data.

This data further implies that the study site (Nekemte) remains the only site that has shown a rapid increase in its HIV positive population when compared with some of the major towns in the region. The evidences in this data and in the former tables, obviously indicate that the study area's current HIV condition coincides with the fear of those concerned individuals and institutions about the overall and threatening conditions of the virus and the alarming rate at which the virus is spreading in the area, making it possibly the first amongst other areas in Oromia under its current situation.

Generally, although the secondary sources are not quite adequate to refer to the entire trends of the HIV prevalence among women and the general population in the particular site, I feel that they can be taken as a tool to detect the overall situation of the virus in the area. Yet, further research should be conducted on the issue in order to arrive at a more comprehensive conclusion on the overall impacts of the HIV/AIDS epidemic on women in particular.

Having seen the general background to the study area and the impacts of HIV /AIDS on women, the next chapter discusses the roles of institutions in helping women and PLWHA cope with the virus in the area under study.

CHAPTER FOUR

THE ROLES OF INSTITUTIONS IN THE BATTLE AGAINST HIV/AIDS IN THE STUDY AREA

The fight against the HIV/AIDS epidemic is in its initial stage in most countries as there can be no country or community that proudly claims it has fought the battle successfully against AIDS, and then sit comfortably in a way that the virus can no more be a threat to it. The shadow of the epidemic, undoubtedly, casts all over places and on each and every individuals and communities throughout the world.

The history of the epidemic has already proved that it demands the combination of the various efforts of individuals and institutions in a society. The coordination and combination of efforts would mean the utilization of the existing skills and resources to halt and eventually terminate the spread of the virus. Therefore, the roles of institutions in this regard are of cardinal importance and could become more meaningful if there are interactions and goal- oriented communications among them.

In Nekemte, there are few institutions that are currently involved in the issues of HIV/AIDS and make their constant efforts to treat the patients of the virus. In the following sections, attempts have been made to explore and analyze the duties and responsibilities of such institutions in relation to the HIV/AIDS epidemic.

4.1. Governmental Institutions and Their Roles

In Nekemte, there are very few government bodies which provide various services to HIV patients on regular basis or occasionally and only when the need arises. The government-administered bodies are Nekemte Hospital, Nekemte Health Center and Nekemte HIV/AIDS Secretariat Office of East Wellega Zone.

4.1.1. HIV/AIDS Prevention and Control Office of East Wellega

The Secretariat Office of HIV/AIDS at Nekemte was established after the national HIV/AIDS Prevention and Control Office (HAPCO) was founded in 1987. At the national level, the office has the objectives of coordinating and facilitating intervention efforts and helping those involved in the campaign through the provision of necessary and pertinent guidance and other technical supports in order to effectively fight and incapacitate the spread of the virus. At the zonal level, though similar and more specific objectives exist, their feasibility has been found to be rather doubtful and more or less ineffective as the office is not doing well to make its objectives a reality.

To begin with, the office does not have adequate and well-trained personnel who would coordinate and create useful relationship with the broad masses and with the institutions that render services to PLWHAs. It has been found out that the office does not make any follow-up of any of the institutions that deal with HIV/AIDS, nor does it have a client to visit it.

Most of the HIV patients interviewed swear that they do not even know the name and existence of the office in the area. The office has not yet done any practical duty with regard to the alleviation of the problems of the patients. Therefore, it is quite difficult to say that it is operating to the fulfillment of its duties and responsibilities and to the achievement of its basic objectives.

Generally, the office is obviously non-existent except for its name. It does not have anything to provide for the PLWHAs and the institutions. One sees the employees of the office sitting idly and busying themselves with chatting. They do not even seem to have a clear division of labor ,and when one goes to the office to get information about their duties and responsibilities, it is normal for him rush here and there to find the right person in the office.

4.1.2. Nekemte Heath Center (NHC)

The next government institution that deals with HIV/AIDS is NHC. NHC has been engaged in providing the services of blood testing and sending patients whose blood is infected to OSSA if they need help and guidance. At this center, patients of HIV/AIDS do not receive any special care and treatment other than testing their blood and because the center is very crowded, people who want to have an HIV test complain about the mistreatment of the nurses. This center does the blood testing in a room where they also serve other patients.

4.1.3 Nekemte Hospital (NH)

Nekemte Hospital is one of the most important places where people frequently go to receive various types of medical and other services. It is the biggest and the oldest hospital in the zone and possibly one of the most crowded in the country. The hospital gives HIV testing and counseling services to its numerous clients in a room where other services are also delivered. The testing and counseling services are done by one nurse. Hence, in her absence, the service is expected to terminate for some times. There are instances where the nurse is summoned for meetings on the issue of the epidemic, no one being in charge of the duties and responsibilities of giving all the necessary services. The researcher observed the leaving of Sr. Sarah for a time of one week for Addis Ababa in which his regular contact was interrupted as a result. People give blood from 8:30 AM - 11:30 AM in the morning, and come back at 3:00 PM to know the result of their blood. They are also given both pre-and post testing counseling services by the same nurse.

According to Sister Sarah, people come to the hospital to test their blood and know their HIV statuses from near and distant places, and for various purposes. One major reason is to make pre-marital HIV test. The pre-marital

HIV test is being done by the young people and it has been suggested that the rate of the test is on the increase now. Although most of such people come from Nekemte and other smaller towns in the vicinity, some others come from the rural areas. The dwellers from the rural areas are informed and encouraged to test their blood before marriage from such places as the church and *kebele* gatherings.

The couples from both areas come together to do the testing and to receive their results before their wedding days. Sr. Sarah told the researcher that at least one of the couples, unfortunately, is usually infected with the virus. Under such a condition, it is likely that the promise of marriage breaks up, resulting in the abuse of all the feasts that have been prepared for the ceremony. It has been pointed out that the problem is usually manifested in the rural areas where the testing is not done well in advance before the nearing of their wedding days.

The other reason why people want to check their blood is when there is a quarrel between married couples, and when they happen to live separately for some weeks or months as a result of the quarrel. Upon reconciliation, one of the two couples decides not to sleep with his / her partner before checking and knowing about their blood. It has been realized that this trend has now become a fashion to claim the testing when such a condition occurs between married couples and is being used as a criterion to reestablish their lives.

In spite of this encouraging progress on the side of most couples, there are also occasions when married couples go to the hospital at different times and separately to test their blood and know their HIV status. Some of such couples, on condition that they become HIV positive, decide not to expose their situations to their marriage partners, although they continue to live together, making the other side ignorant of the deadly secret. Sr. Sarah raises a number of such instances where people never tell their HIV status to their couples.

Under this circumstance, the nurses and hospital officials have nothing to do because the rule forbids them from exposing one's HIV status if the victim does not want to .Sr. Sarah told me her own experience in which she was warned by a man not to tell his wife the fact that his blood was infected, and further intimidated her to kill if she does so under any situation. For the man, telling the secret is bringing his marriage life to an end, and as a result, dispersing of his children. Therefore, here clearly lies the dilemma of attempting to convince individuals to become more frank and honest in order to spare the lives of their partners and prevent the collapse of families.

Some people who may have undergone unsafe sexual practices willy-nilly decide to test their blood. This group of people includes high school and college students and other concerned people in the town. The basic reason here is the people's determination to know their status in the midst of the storm, and to take more care in the future as far as the epidemic is concerned. It is their doubts and suspicion that trigger this group of people for blood testing and after knowing their status, they are likely to become more stable regardless of what their test results may be.

The last groups of people who come to the hospital to test their blood are those who have heard the news that HIV positive people receive some kind of financial and other forms of supports from certain institutions in Nekemte. When the poverty-stricken people, especially women, go to such organizations as OSSA, Nekemte Mekane Yesus or Orthodox Church to get some help, they are requested to produce a medical certificate from the hospital which describes that they are HIV positive and deserve help. The women are then forced to go to the hospital to collect the certificate. What surprises most about these people is the fact that they tend to be stubborn and do not easily accept the truth of the news that they are free from HIV/AIDS, and there can be no certificate for them to write to the organizations. It is obvious at this juncture that they have gone to the hospital with the preoccupation that they have to be HIV positive, and

must receive all the necessary services which others get from the institutions. The majority of these groups of people are, according to my informant, women who usually go to the hospital accompanied by their children.

These women closely watch the lives of other HIV positive women in their village who regularly receive money from the institutions, and then they attempt to exploit similar opportunity. For the 'healthy' women, the sick women seem to live a better life than their own as a result of what they earn. So, it is from these expectations that when their attempts fail, they find it incredible, and keep on arguing with the nurses for some times. This has been found to be a typical instance where people prefer HIV/AIDS to their poverty. Some other reasons for blood testing in the area are before pregnancy, after sexual assault, and usually after the death or illness of a partner.

Nekemte Hospital, is therefore, so busy with these and other similar issues of HIV/AIDS, in addition to its domestic activities of treating other patients. On top of this, the test room does not always have all the necessary facilities used for the purpose. According to the rules and regulations of HIV/AIDS, a person who has received his / her blood test result and those who are waiting for their turns to receive should not mix. Those who have known their results are required to take a different route lest the others read their facial or emotional expressions and get disturbed or worried about themselves. Yet, a single room is used for all the various services in Nekemte Hospital: blood testing, telling results, giving pre-and post counseling services, and treating people for family planning issues.

4.2. Non - Governmental Institutions and their Roles

4.2.1. Family Guidance Association, Nekemte Branch (FGA)

As the name implies, Family Guidance Association of Ethiopia (FGA) is an NGO more concerned with family planning issues. The association provides different services to women and men under different conditions. Currently, however, with the fastest spread of HIV/AIDS in the area, they have begun to offer mass education on the HIV/AIDS epidemic and teach people by going from place to places. So, the broad masses get education about the consequences of the epidemic, the mechanisms of its transmission and the ways of saving oneself from the virus. Like Nekemte Hospital, FGA also tests the blood of individuals and gives counseling services. However, since their main focus is on family guidance and mass education, their participation in AIDS campaign is not yet satisfactory.

4.2.2. The Ethiopian Red Cross Society, Wellega Branch (ERCS).

The ERCS at Nekemte is a regional office for the two zones in Wellega. The office at Nekemte, therefore, coordinates all its operations in the entire province of Wellega. As far as HIV/AIDS is concerned, the ERCS provides training services to able-bodied HIV patients. The patients are trained in fields or skills like tailoring, wood and metal works, and in knitting. There are ten females and 35 male trainees in their workshop, and many more have become independent through the training and experiences they acquired from the office. Besides, the office pays a monthly office rent of 200 birr for *Abdi* Association.

4.2.3. The Abdi Association *(Waldaa Abdii Naqamtee)*

Abdii is the local term which means 'hope' and it implies the patients' optimism about the future. The *Abdi* Association was established on July 9, 2000 by the initiation and active participation of 16 PLWHAs. It was basically founded and is being led by *Obbo* Waggaa Dhaaba, a dedicated man who has lived with HIV/AIDS for the last ten years. There were a number of reasons that brought

about the formation of the association according to *Obbo* Waggaa. The following are some of the general objectives of the association.

a) To get to know each other - the PLWHAs in Nekemte did not have a ground to come together and share their views and discuss on matters related to HIV/AIDS, especially before *Abdi* was established. So, the aim here was to bring together all the PLWHAs under one umbrella;
b) To help the orphans of HIV/AIDS in their daily life situation by making contacts with concerned bodies;
c) To defend the rights of the PLWHAs in the society;
d) To unite together to get various services and to make their voices heard to the broad masses;
e) To work together to educate the broad masses about the epidemic by moving from place to places and to areas where people gather together like at church, mosque, meetings, market places, and governmental and non-governmental offices.
f) To set an example of oneself and tell people that AIDS is a reality and that it is possible to live with it.

According to the chairman of the association, *Obbo* Waggaa, their association has performed the following major activities at various places in Nekemte and its environs.

1. They (members of Abdii) have educated the prisoners at the zonal house of correction in Nekemte;
2. They gave mass education to about 300 people at Bakke Jamaa area in Nekemte;
3. They offered mass education for police officers and the people at Jimma Arjo (in which about 500 people participated);
4. They educated about 200 peasants at Giddaa Ayyaanaa on an AIDS day; and

5. They introduced themselves to the members of the zonal administration staff, and offered them intensive education about HIV/AIDS. After the introduction to the administrator, Abdii was relatively recognized by the personnel.

To be a member of *Abdii*, one has to produce a medical certificate for being HIV positive. Besides, an applicant is expected to show some kind of willingness to disclose his /her HIV status and to participate in mass education to be conducted by the association.

It has been found out that the current members of *Abdi* are all people with poor economic backgrounds and those who have no money to help themselves or relative to care for them. Most of them have come from distant places like Gimbi, Bakko, Arjo, Ayyana and other areas. So, they are generally deserted and needy people who look forward to someone or an organization to lend them a hand.

For *Obbo* Wagga and others, however, the number of their members has remained so low through the years because those who are economically stable have places to live and other basic necessities of life never want to expose about their HIV status and join them. According to these informants, therefore, no one except the destitute exposes themselves and talk about their HIV/AIDS issues to others.

In addition to this, the majority of *Abdi* members are women (28 out of a total of 46). The informants say that those who bring applications for admission are also women in most of the cases. *Obbo* Waggaa's reason for this condition is more convincing. He says compared with men, women are poorer, and are more vulnerable to the virus; women have the cultural obligation to feed their children and other members of their families. So, their living conditions at home and the expectation of the community usually oblige them to be the first to come to the front to disclose themselves. Going to institutions to get or

receive different forms of support will become mandatory for them. However, one can not think of this to be done by males in the area due to social and cultural reasons.

The ages of the members of *Abdi* Association ranges from 16-32 for females, and 28-40 for males. The members of the Association take turns to open and work in their office. They also trade small articles at their verandah and try to contribute to their staggering income. If it happens that a member of *Abdi* becomes sick, as is usually the case with some of them, someone from among them will be assigned to attend on to the patient, and when necessary, provide services to the sick. If unfortunately the patient dies, *Abdi* members will be the first to arrive and facilitate the burial ceremony. This is one of their commitments as a member of the association. Besides, they also participate in other social life activities in their community.

4.2.4. Organization for Social Services for AIDS (OSSA)

OSSA is a very important and useful organization with regard to the issues of HIV/AIDS in the area. It is the most coordinated and most efficient and relatively more successful organization in this respect. The organization is headed by two qualified and determined individuals, and has a total staff of five persons.

The organization has been engaged in providing all types of supports to most of the certified HIV patients. They give regular house-to-house counseling services through their counselors. OSSA counselors are determined to do their jobs on their own willing and receive very small amount of money for the services they offer. They usually go from one dwelling area to another and visit the patient they are assigned to every two or three others days. Through the counselors, OSSA firmly controls the daily activities of their clients and frequently gathers reports about their whereabouts. The control is done mainly to avoid any further infection by the victims, in case they involve in a sexual relationship

with someone who does not know about the patients, and who may be free from the virus. For OSSA, however this is not a simple task of achieve the desired goal.

So, a client who wants to get married (i.e. if he/she does not have one yet) has to first of all consult OSSA officials. Those clients who do not obey the rule usually face the consequences of losing their services from the organization

The organization has a lot more responsibilities of engaging itself in mass education at different sites. They also give trainings of various types to their clients in addition to the financial and counseling services they offer. Although OSSA is serving many HIV patients, they still believe that many more people lack the courage to disclose their HIV status, and hence do not come to their organization at all.

With regard to the cooperation they are entitled to receive from the concerned government bodies, the deputy manager of OSSA told me that the bodies neither cooperate nor create a problem to their activities. The government bodies already know and appreciate all the useful jobs performed by OSSA, though they have not yet provided any tangible technical and/or financial supports either for OSSA or to other similar institutions, or to the patients individually.

4.3. The Achievements of the Institutions

There are a number of government and non-governmental institutions which are directly or indirectly engaged in the battle against the HIV/AIDS epidemic in the area. Most of these institutions are doing their best to cope with the spread of the virus. The institutions have, however, limited human and material resources in the majority of cases. Nekemte Hospital is one such an instance where a single nurse does many different things with all her possible efforts. The scarcity of human and material resources is one of the major problems the

hospital currently faces. And as a result, it becomes obstacle to the fight against the epidemic since a single nurse can not effectively treat all those who come to visit her.

The other serious problem is that institutions do not have horizontal relationships with one another and coordinate their efforts for a unified struggle against the AIDS epidemic. The need to unite and cooperate, in this front is seriously lacking, and in most cases, managers of the institutions, including that of OSSA, complain about shortages of money they have and the inadequacy of their capacity to cope with the ever sprouting HIV patients.

The concerned government bodies in the area are more concerned with their own businesses and do not seem to realize the impacts of the epidemic in the country in general and in their area in particular.
These bodies have remained reluctant in doing their best in this regard though their political power gives them a lot of mandate to set their own examples for the crucial campaign against the virus. Their grave silence has been observed from the fact that the zonal administrators and HAPCO officials have so far done little or nothing to alleviate the problems of the HIV patients and to coordinate and provide basic supports for the concerned organizations.

Under the conditions of disunity, it is quite doubtful to achieve the desired effects. So, in order to be more successful, all the existing government and non-governmental organizations together with other concerned agencies should open their doors to the absolutely crucial issue of HIV/AIDS and orchestrate their efforts to act as a unified body, and contribute their shares to the eventual eradication of the disease. The time of watching one organization doing everything for the desperate patients has to cease. Next, the researcher feels that analyzing and presenting the cases of individuals will clearly show the situation of women and HIV/AIDS and the magnitude of the problem.

CHAPTER FIVE

5.1. ANALYSES AND FINDINGS

In this section, the analyses of the data gathered during the field work have been done and presented, and to this effect, a number of cases of individuals who were carefully observed and interviewed were incorporated, and findings from the research have been presented and then discussed.

5.1.1. Case One: *Ema.

Ema was born in the town of Fincaa'aa in the year 1968. She is now 29 years old. She now lives in Nekemte with her seven years old son. His father was a TPLF soldier who once came to Fincaa'aa as a defense force to fight against the insurgents that operate in the area. Ema happened to get married to him as a result of the sympathy he showed to her when she was in a prison cell in Fincaa'aa town. The married couples went to Mekele after two years of living together in different areas in the country. The husband suddenly died in the battle Ethiopia fought against the Eritrean government at Badime. After the death of her husband, Ema decided to return to Fincaa'aa, bearing her son. She, however, left her birth place because of some inconveniences and, finally established her life in Nekemte.

After coming to Nekemte, Ema says she had been sleeping with males whom chance brings for her. Nobody was worrying about a disease then, and she says it was that irresponsible act that exposed her to HIV/AIDS before six years. Her son is fine and is free from the virus. Ema was not urged to test her blood by anyone. It was just her soul that made her do so, and she says she was surprised when doctors told her that she was infected. She went to the hospital not because she was sick, but for fun, and labeling a healthy woman as 'infected' meant little for her at the time.

** All the names used in this chapter are pseudonyms and all their ethical issues have been kept.*

However, with the passage of time, she came to accept the truth of what doctors once told her. Surprisingly, Ema, even today, after living with the virus for six years, is physically strong and looks quite healthy.

In the meantime, Ema started trading different alcoholic beverages with the money she received from OSSA. She was able to attract different males into her grocery. The business became incredibly lucrative for her. Some of the males were visiting her not only to drink alcohol but to persuade her for sexual activities. Ema has been trying to convince such males by showing them her medical certificate which testifies her infection with HIV virus and at times presenting her ID card of *Abdi Association*. Some of the males even know that Ema is actually infected, but say they never hesitate from sleeping with her. Some others do not actually know her status and never tend to accept what she tells them about herself. Ema could not succeed in convincing the males because for most of them, she produced a false certificate with which she receives money from OSSA. And she does this mainly because she is poor, and not because she is HIV positive.

The researcher proved the truth of the situation both from OSSA officials and from Ema's counselor. They say that the condition has greatly worried them as no one has been able to convince the males not to advance on to her for sex.

Although Ema was facing the problem at different places: in her grocery, on the road, in her village and at other places, she was in the meantime living with two husbands at different times. Even though the two husbands know that Ema was living with the virus, she does not know anything about the men. Similarly, Ema confesses that males whose HIV status is not officially known frequently visit her for similar purposes.

5.1.2. Case Two: A Teacher

A teacher of about 38 years works at Hareto Secondary School as a vice principal. He is a diploma holder and is married before nine years. His wife is a TTI teacher at the same area. They have two children. Their life started to take unexpected turn when one of their children fell sick and died after a while. They did not test the blood of the deceased child though it paved the way for their suspicion to grow from time to time. This time, the vice - principal decided to go to a private clinic in Addis Ababa to know about himself. In the clinic, the doctor did not plainly tell him about his HIV status, that he is infected. But the teacher was filled with doubts from the way he was treated. Upon returning to Hareto, the teacher told all about his suspicion to his wife. Because he became restless, he convinced his wife to go to Nekamte Hospital to have HIV test together. (There is no HIV test in Shambu Hospital). They were both found to be infected with HIV. They did not speak to anyone about their infection for fear of potential consequences like discrimination, loss of their regular jobs and others. These are some of the reasons as to why they both do not want to disclose their 'secrets'. The teacher says, "Time has to reveal it, not us". He says that people in his area know well about HIV/ AIDS, but very few of them do care. On his behalf, he confesses that he had been having an affair with numerous ladies before his marriage as is usually the case in the area. He also believes that those he had been sleeping with are all fine now. So, he does not have a single woman to trace his infection to.

However, according to Sr. Sarah, who knows well about the couples, the wife told her that she (the wife) was told by many villagers in Harato not to get married to the teacher because he was known to have been infected already. But the wife refused to accept what people were telling her about him and got married to him (the researcher did not meet the wife).

The teacher complains the absence of mass education in his area on the issue of HIV/AIDS, and seriously fears that people will be severely infected in the

near future because of what he described as 'traditional sexual and marriage practices.' People are still engaged in raping, abduction, and commonly practice promiscuity. These, together with the fast increase in population and the sharp deterioration of living conditions, will eventually lead to great destruction in the area, according to the teacher.

Finally, the teacher believes that people should learn from the mistake of others, and this is possible only if people living with AIDS disclose themselves and speak frankly about their experiences with the virus. (However, the teacher himself is not yet ready to take such a courageous measure!).

5.1.3. Case Three: Gurree

A woman called Gurree was born and brought up in Nekemte. She has a child of 10 years. Gurree is 31 and had her first marriage before 15 years. She said that after regularly quarreling with the husband, she left him bearing a child.

After this occasion, she became a cook at a teacher's house in Nekemte. The teacher was married and had six children. The teacher secretly had an affair with Gurree and kept on filling her with lots of high sounding promises. Gurree became pregnant and gave birth to a child, who is now six years. Unfortunately, the teacher died after a while, and she left the house with her two children.

A third husband came, this time an EPRDF soldier. The soldier used to live in the same village with Gurree. He started urging her for marriage, and because she refused his request, he tried to intimidate to take her life with a bomb. This gravely frightened Gurree making her life rather hopeless. Some villagers who realized the worsening of the situation began to interfere, and eventually convinced her to marry him other than dying and leaving her two children to nobody. Then she unwillingly agreed to marry him. The soldier husband lived with her for few years and then died of AIDS after painful illnesses.

After every attempt has collapsed, she arrived at the conclusion to go to a village in Arjo area to live peacefully with her mother and her younger sister. But things did not become smooth. Her younger sister did not accept them warmly, instead beat them all severely and forced her to leave the area. So, Gurree and her children had no choice except returning to Nekemte.

Because of the fact that she was suspected by her own mother and sister, a sort of doubt started to ring in her ears. Then, she felt that she must go to Nekemte Hospital to know all about herself. She was tested together with her two children, and unfortunately, Gurree and her elder daughter were found to be HIV positive. The son of the teacher was free from the virus. Gurree says her daughter was infected because she used to share razor blade and other sharp tools with them.

Gurree now lives in a new site in Nekemte where people do not know about her. She lives on selling *tella*. She also receives 100 birr / month from OSSA, and she is now trying to produce a certificate for her daughter so that she will be received and helped by OSSA.

Gurree says all her neighbors and her landlord do not know anything about her and her children. However, her fear is the coming of the day when things are exposed and villagers start to harass her and her children. She says this is what actually worries her every time. Finally, Gurree believes that she was infected by the soldier husband though the second husband (the teacher) also died of AIDS.

5.1.4. Case Four: Baaccuu

Baaccuu was born in rural area in Nekemte. She is 28 years old. She was first married to a very young man through abduction. She says she was engaged to someone else when she was abducted. The young husband did not treat her in a way that a husband does for his wife because he was too young to be a good

husband. Due to this reason, Baaccuu says she suffered a lot in the company of the immature husband. As a result, she decided to leave him and went back to her families. The husband did not care about her departure though she was pregnant then. She started living on her own, selling firewood to Nekemte.

After some time, she came to live in Nekemte and engaged herself into commercial sex, which she says made her life relatively better than it was before because of the money she earned from the job. She stayed in a hotel for about two and a half years, and later became sick. The owner of the hotel chased her out because he suspected her illness. She was told by the medical personnel that she is HIV positive. The nurses advised her to look for an organization which could support her.

Baaccuu suspects that it was the hotel life that exposed her to the deadly virus, though she does not have a particular man to blame for. It is now three years since she knew her HIV status, though she has not yet told it to her families or intends to do so in the future.

Baaccuu is currently living with another infected woman in a room rented for them by OSSA. The woman has a husband who knows that his wife is infected with HIV/AIDS. However, both Baaccuu and the woman do not know anything about the HIV status of the man. The woman is rearing a male child orphaned by the epidemic.

Baaccuu says her neighbors once revolted against them because they came to know that they are living with the disease. The neighbors said, "We can greet them, but never eat or drink with them." However, she accepts that people have improved such behaviors after OSSA offered them mass education. Yet, she says that people still discriminate against them in various ways and as a result she is rather pessimistic about her life and visualizes it as wastage.

5.1.5. Case Five: Daaqxuu

Daaqxuu was born in Gute and learned up to grade eight in the village. In1993 E. C, she came to Nekemte to continue her high school education. The following year, she suddenly became sick and went to a clinic in Gute. She was closely examined by a doctor and after sometimes, the doctor wanted to know more about her and then put a number of questions to her. On a certain day, the doctor told her that he wants to marry her. This event was a turning point in Daaqxuu's life. The doctor kept on promising a lot of things for her. These promises tantalized Daaqxuu, and because she is from a poor family, she immediately agreed to the person's request and married him ceremonially after a year. After five months of their marriage, the doctor became seriously ill. Daaqxuu became eager to know about his problem, but the doctor was mentioning such diseases as gastritis, TB, and others.

In the meantime, he was transferred to Nekemte. However, he did not want to go to Hospital (may be because most people in the hospital know him). The doctor had three children from his deceased wife, and this was a secret which Daaqxuu never knew until towards the end of the doctor's days. She was later told (by others) that his ex-wife died of HIV/AIDS.

The doctor died after 10 days of staying in bed in the Hospital. He, however, did not tell Daaqxuu anything about his illness, and neither did his colleagues in the hospital. However, later on, some nurses advised her not to use his cup because he might have had a TB. Besides, they regularly urged her to have an HIV test just for safety reasons.

The constant urging and advice of the nurses put Daaqxuu into some kind of doubt. So, she went to FGA and tested her blood. Her suspicion became true and she was already infected with the virus. Daaqxuu is now a member of *Abdi Association*, and she receives money from OSSA. She participates in mass education with OSSA and the association. However, she has not yet disclosed to her parents in Gute about her HIV virus. She says that she once convinced her

father by telling him that she has recovered from her illness. Daaqxuu is now living in a house built by the doctor together with his three orphan children.

5.1.6. Case Six: **Xomboree**

Xomboree was born and brought up in Shambu before 32 years. She learned up to grade six in Shambu and left her parents in search of a better life, and to find someone who can educate her properly. She first escaped to Jare where she became a cook. After two years of living in a certain house, a young man from the neighborhood approached her with the intention of marriage. She immediately agreed to what the young man said, and she had her first sexual experience with him.

The young man went to Nekemte to look for a job (he was grade 12 complete then), but Xomboree returned to Shambu. She repeatedly quarreled with her mother and the step-father. This condition made her leave the area for the second time, this time to Gidda. In Gidda, she continued with her usual job, being a cook. In the course of this life, Xomboree says that males have been promising and cheating her every now and again. After living in Gidda in many places, she decided to go to Nekemte, to live on her labor (*hojii humnaa*). She suddenly met an investor who later took her to *Lemlem Bereha*, where she got married to a man whom she says is a dedicated Christian. She gave birth to a child who died after a year.

Xomboree became sick in a similar way to her child, and went to Nekemte Hospital to know about her illness. The HIV virus has made its way in to her blood. Xomboree's husband was tested and he, fortunately, is free from the virus. They are now living together and Xomboree says because both of them are devoted Christians, she can not suspect the transmission of the virus on to her husband.

Xomboree confidently says that all the men she had been sleeping with, including her current husband are fine, and she was infected because she

committed adultery and acted out of the laws of God. According to her, because she believes in God the Almighty, the day is near when she will be liberated from the virus.

Further, Xomboree says that she does not want to disclose her being HIV patient to anyone because, according to her, one need not tell his / her secrets to human beings, but only to God. The researcher was told by sister Sarah that Xomboree frequently quarrels with them (hospital officials) when they advise her to collect condoms for her husband. But she has not yet accepted this advice because of her strong religious feelings and attachment to God. Sr. Sarah says Xomboree's stand is that it is God who can prevent AIDS, not the use of condoms. The issue has remained a dilemma for the hospital officials when it comes to such individuals with strong religious feelings.

In addition to the religious views of Xomboree, Sr. Sarah told me an occasion in which a man whom she knows well lost all his family members to HIV/AIDS became free from the virus as a result of his devotion to God. His freedom has also been proved medically. This miracle is mentioned by many people in Nekemte as a great wonder in the area. The once - infected man has married a woman and is living an AIDS - free life now, according to Sister Sarah.

5.1.7 Case 7: Aadde Berhane

Berhane was born in Eebantu area. She has so far been married to three people. The third (last) husband married her and died after a month. He told her that he is HIV positive few days before his death (in 1991). Berhane became sick after few months of her husband's death and was found to be infected, too. She has not yet told her status to her two children, or to her parents in Ebantu. She says that she hides herself from people who come from her village (Ebantu). However, all her neighbors in Nekemte know that she is sick but peacefully live with her and none of them discriminating her against her and her children.

Berhane says males always cheat a female if she is poor. Poor girls / women are easily seduced by the lulling talks of most males who have some money. This was what exactly happened to Berhane. She says she fell into a trap of a merchant from Gimbi (the 3rd husband) because she is very poor and needs money. The rich man infected her in one month's so-called marriage. Berhane says the husband promised to give her all his money after his death, but she could not get a single coin because his two brothers broke the box of birr and took every thing away. She had been working as a cook in many places to win her daily bread and to bring up her two fatherless children. But now she is a tailor (trained by OSSA), and she also earns some money from the organization.

When talking about the issue of HIV/AIDS in the area, Berhane says that because life is further deteriorating in the area, and because there are no factories to provide job opportunities for young people, their future is seems dark. Young people who complete grade 12 or graduate from private colleges usually wander here and there in the town, spending their times unwisely and unnecessarily. Under such terrible conditions, it is likely that the infection of the people by the virus greatly increases. (Berhane mentions a tangible instance where a relative of hers from Gidda, is now seeking a job in Nekemte after completing grade 10). She says such hopeless people will eventually turn to doing "unnecessary things" merely to survive, making themselves more vulnerable to HIV/AIDS. By "unnecessary things" Berhane means engaging in commercial sex work, a life style which some young girls consider as a job opportunity.

5.2. Discussions of the Cases Studied

From each of the cases discussed above, we can find out some of the following important points with reference to the devastating consequences of the virus on the lives of women and the general public in the study area. It has been found out that all the women I interviewed, and many of those living with the virus agree that they have been engaged in having sex with a number of males due to various reasons. Because of the very nature of the life style, it is usually difficult for them to trace the source of their infection to a particular person. Besides, they also assert that they have married and remarried a number of times. The marriage and remarriages are often practiced, in most cases, as a mechanism of escaping from the poor economic conditions under which they currently live. They are also initiated to involve in a marriage of some sort as a result of the existing cultural influences. Culturally, a lady of certain age is entitled to marry in one way or another to someone who claims her as a wife. The marriage could sometimes be held between couples that are not yet, physically ready and mature enough to bear the expected social responsibilities that are likely to accompany married lives.

The likelihood that such a marriage end up in divorce is high, and after the collapse, the couples tend to try and retry marriages or indulge themselves into committing sexual crimes with others. In the course of the exercise, women are more likely to be infected and bear the burden of HIV/AIDS because of their inability to negotiate on condom use and to decline the sexual advances made by males, and the cultural attributions that subordinates them to lower social statuses demanding from them to offer what men demand from them.

In addition, women are occasionally forced to live out of the sight of their parents and close relatives when they realize that they have contracted the HIV virus. The majority of my informants who now live in Nekemte came from other areas. They settled their lives in the town so that they do not easily meet relatives, or come across someone who knows them well. Besides, they do not

at all want to go back to their birth places, or intend to inform their parents about their HIV statuses.

The virus has, therefore, alienated the patients from their kins, though most of them are currently engaged in mass education coordinated by OSSA and *Abdi Association*. Their greatest fear is that if they meet their relatives under their current living conditions, parents and relatives could be insulted, harassed or even discriminated as a result of their 'wrong doing'- engaging in sexual crimes, marrying and remarrying out of the consents of their parents and eventually contracting a disease which people consider as a curse and fear very much about. Therefore, the awkward conditions of life brought about by the epidemic have to remain part and parcel of the patients' daily experiences and should not be shared by relatives.

On the other hand, for some of the patients in the study area, disclosing their HIV status to relatives and colleagues would mean the immediate loss of their jobs and facing strong alienation from everybody around. The loss of jobs possibly throws them into poverty and hunger, resulting in further collapse of their families in an unimaginable way. In spite of attempting to hide HIV statuses, there are times when a family member suddenly falls ill in a way that villagers and neighbors suspect the symptoms demonstrated by the patient. The death of a family member suddenly fills everyone with doubts and gives them the courage to test their blood and know their HIV status. For such families, the loss of their member in an unidentified way provides them with the first impression of the intrusion of HIV/AIDS into their 'territory'. A number of women informants confess that they were brought to the knowledge of the virus after they missed their family member, notably a child or even their husbands.

The other chronic situation that is happening in the study area is the fact that some married couples test their blood in the absence of their partners and never want to expose their HIV status if it all happens that they are already

infected. The irresponsible couples go to the extent of warning and intimidating medical personnel if they suspect that their secrets will be released to their marriage partners or to those who know them. Worse of all is the fact that medical personnel can not tell one's HIV status to his /her relatives if the victim does not want to. According to the law, one has to show his willingness so that the result of the blood test could be exposed to others. Otherwise, medical personnel have the mandate to keep the secret of their patients, and often refrain from it. They rather give an indirect impression to the relatives about the nature of the illness of the patient.

The spread of the virus is also further aggravated by what, in most cases, people do as a result of traditions. In spite of the local recognition of traditional marriages in the area, the practices do not take in to consideration the health of the couples, and are more likely to expose the participants to a hazardous life when it comes to the issue of HIV/AIDS. In some of these practices, young girls are made to marry men who are more experienced than themselves. The young and inexperienced girls are required to meet either the demands of the males or face the consequences of being abducted. In the latter case, there are obviously painful repercussions that follow. The practice also deprives the victims of their natural rights to make their own decisions on their own destiny. There is a high probability of divorce in such marriages in which young women are forced to go to nearby towns and practice prostitutions as a way of life. In the meantime, they are exposed to unprotected sexual intercourse and suffer from the consequences.

In the early days of the virus, the patients were isolated by being denied the right to certain social life conditions. The discriminations were manifested through such measures as refusing to shake hands, avoiding rendering cares where they are sick or unable to look after themselves, avoiding the patients from sharing household furniture like cups, bed, glasses, and others with them. These behaviors have more or less changed their courses with the passage of

time. Although there are encouraging and affirmative progresses in this regard, the identified and certified HIV patients still blame their landlords and neighbors for the pseudo rapport they establish with them. Neighbors and those who frequently meet the patients at some places or in the village incline to turn their backs to them in away that 'subtly discriminates' the patients. As a result, the HIV patients in the area move to the extent of being pessimistic about themselves and most of them visualize themselves as a 'big round stone in the middle of a heavy traffic'. They are not, for instance, visited in their office *(Abdi Association)* by people in the area except by journalists who come from other areas, or those who may want to gather some kind of information about the patients and their ways of life with the virus.

In the absence of a foreseeable change in behavior from the broad masses with reference to these practices, the only tool available should be to persevere constantly to provide formal or informal education. Mass education that honors the cultural and psychological makeup of the people could undoubtedly contribute to the shaping of the longstanding social behaviors. When stressing the importance of education as a solution to the overall problems of the HIV/AIDS pandemic, Michael Kelly in a World Bank publication of 2004 expressed it in the following way:

> In the absence of biomedical remedies, the only remedy left to society is education. Education is part and parcel of every intervention against the disease. It is the social vaccine to be relied on. Evidence is growing that informal education, not necessarily education about HIV or reproductive health, makes a huge difference. Hence, we must use all our energy to ensure that every young person has access to good quality education. Further, the impact of education in rolling back the disease will be increased if there is good HIV education in the curriculum (2004:8).

To the accomplishment of the immensely important task of providing appropriate and more meaningful education for the broad masses, strong and determined leadership should be in place. According to Kofi Annan, the UN-Secretary General, the greatest challenge is to extend the extraordinary examples of leadership to the mainstream of everyday life. And the mass mobilization of every sector of society remains the only weapon. In the context of the study area, mass education which is offered intermittently, is basically confined to Nekemte and its environs, and rarely covers those who live in the remote rural areas. The unavailability of informal education for the rural communities has already given the epidemic the chance to stretch its invisible hands to the villagers. The epidemic is now rife among the communities as the random blood tests of the villagers who come to the hospital indicate.

Currently, although the virus is knocking on every one's door, there are only few known HIV patients in the area because for most people, the disease is believed to be the cause of social inconveniences. According to the officials of NH and OSSA, there are very many individuals who have not yet got the courage to disclose themselves to others. But with the release of ART for all, it is expected that the number would double and may go beyond they capacities of the existing institutions.

When the overall view of the study area is considered, there are social, economic, and political conditions which pave the way for women to contract HIV/AIDS. The lower social status to which women are entitled and the chronic economic conditions under which they live further facilitate their exposure to the virus. Women are not actually benefiting from the current political structure because most of their issues are sensed and echoed at the policy level. So, there is acute shortage of appropriate body that is responsible for coordinating their affairs though this does not mean that there is no government office that has 'woman' as its core title.

The lack of concern and negligence by the administrators for the people over which they rule has remained open to different interpretations and a point of debate for some. A useful point to consider for officials, however, is the fact that things would remain at policy level if the people for whom the so-called 'development' is intended excludes the health and general welfare of the entire population.

The concept of development is being confused in the sense that the term (in this particular area) has been confined to some forms of construction. However, with the human resources receiving little attention, there can be no betterment of the lives of the people. Hence, the war waged on the epidemic will become a futile attempt since people first seek to get their basic life necessities fulfilled before proceeding to other issues like HIV/AIDS. According to UNDP (2001) cited in UNAIDS, (2004), the concept of human development is broadly defined in such a way that it encompasses all aspects of human lives.

> Human development is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. The most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and be able to participate in the life of the community. Without these, many choices are simply not available, and many opportunities in life remain inaccessible.

When considered carefully, there are not yet conducive environments available to ensure the development of human resources in the study area. They are, currently, almost absent, and pave the ways for the epidemic to ride swiftly along all the courses of life, making the broad masses in general and that of women in particular its prey.

CHAPTER SIX

SUMMARY AND CONCLUSIONS

6.1 Summary

The HIV/ AIDS pandemic has remained the major threat to the very existence of society as a result of the heavy damages it inflicts on all spheres of societal life. It has already placed multiple challenges before the international community, cutting across every sector. According to UNAIDS, 04, these challenges include the following major points. First, AIDS is now both a global emergency and a long-term development crisis that requires an exceptional and sustained response, far beyond the scale of what we have seen to date. Second, there is a universal recognition that AIDS is reversing decades of development progress in the most-affected countries. Therefore, strengthening the response to AIDS must be a central part of development programming and practice. And finally, developing new strategies to deal with the disproportionate impact of the epidemic on women, girls and orphans should be taken as a priority by governments and concerned bodies.

The global pandemic has now reached the stage where it can be considered as the immediate cause of all sorts of crises in human lives. The devastation brought about by the virus becomes more threatening when it comes to the context of developing countries where it now casts shadows on all aspects of life. In these countries, the virus is number one killer and is a multifaceted enigma. The 2002 MOH report indicates that there were an estimated 2.2 to 3.0 million Ethiopians, mostly women, who were infected with HIV/AIDS, and about 1.2 million children are orphans of AIDS. However, this earlier estimation of MOH has been found to be reduced in its latest issue on the same topic, and the 2004 report indicates that the current spread of the virus was found to be lower than it was expected. Though the Ministry provides a number of reasons for this, it does not, however, mean that the spread of the virus has actually

been halted. There are, on the contrary, plenty of evidences which signal the conditions of the virus to be one of the highest on earth.

The study has tried to address some of the following important questions (stated under section 1.1) 1) How are women living with HIV/AIDS treated by their families, neighbors and the larger communities in Nekemte? 2) What are the social, economic and other conditions that expose women to the contraction of the HIV/AIDS virus? 3) What are the kinds of care and treatments that women receive from the institution that operate in the area, and 4) What are some of the duties and responsibilities of women in bringing about changes in behaviors regarding the HIV/AIDS epidemic?

The overall objective of the study has been meant to address these useful questions. To this effect, 20 people, mostly women, were interviewed. Among these, seven of them were carefully chosen and their cases and brief histories were presented. In addition to this, observation of the individuals was done at various places. In-depth interviews and group discussion were also conducted with the informants. Informal interviews and discussions were held with officials of OSSA, NH, and FGA to gather information about their clients (PLWHAs).

It has been found out from the research that women in the study area are infected by the virus due to a number of reasons. The informant women confess that they have been engaged in some kind of unplanned marriages which eventually result in divorce, a sad event that is usually followed by remarriages usually performed to secure their lives. In addition, the remarriages are often frequented as a result of the low intimacy they have with their sexual partners and due to the hasty decisions they make when doing so. Most of the ladies who are now victims of the virus make such decisions on their own and on being out of the sight of their parents and close relatives. This is usually done after escaping to distant places from their places of birth to where they could

hardly be identified and little talked about. Hence, most of my informants came from the neighboring *wored as* or adjacent areas to live in Nekemte.

There are indications from the area that people have more or less brought a relative change in behavior at the present when compared with earlier experiences regarding the stigma and discrimination that may follow the contraction of HIV/AIDS. Yet, the patients complain that the existence of discrimination by the neighbors, close relatives and others is obviously in its place and a fact that can not be denied. The patients condemn the people for the very subtle kind of discrimination they make against them.

From the research, it has been proved (mainly through the secondary sources) that the study area has currently the largest HIV infection rates when compared with the rest of the major towns like Jimma, Adama and Shashamene in Oromia. According to the 5th national HIV report of MOH, the town of Nekemte is the only area where HIV contraction has steadily grown over the past 3-4 years. When in other areas, say in Adama, the spread of the virus among women has been hampered from the years 2001-2003, in Nekemte, on the other hand, it has been continuously rising. The HIV/AIDS has spread among the general population in the area at such an alarming rate that the area is now cited as an example of high HIV area in the entire region(see table 3). There are a number of factors that further aggravate the conditions of HIV/AIDS among women in the study area. Such factors are economic, social and political in nature and are inseparably boundup together. Besides, the heavy military presence in the area has its own parts to play in worsening the overall conditions of women with reference to the epidemic.

There are few institutions that operate in the area actually involving themselves into the business of HIV/AIDS. These institutions include NH, OSSA, FGA and NHC. Of these, it is only OSSA, which directly engages itself in the active participation of tackling the problems posed by HIV/AIDS. In fact, it would have been very difficult to imagine the life of the HIV patients in Nekemte in the

absence of OSSA. It is from this organization that the patients receive most of the necessary guidance and counseling services in addition to the monthly salary of 120 birr with which they insure their lives, and the regular visits and follow-ups made by the dedicated counselors of the organization. The patients praise the care and treatments they receive from the organization, and also appreciate the dedication and kindness of the officials.

In the case of the other organizations, the issues of HIV/AIDS and the need to treat the patients is taken as part of their daily routines, and services are delivered to HIV patients in a similar way to those of the other clients. In fact, the services given to HIV patients at NH and NHC are basically confined to testing blood and sending the infected ones to OSSA so that they would be helped. The HIV/AIDS Secretariat Office in Nekemte is almost alien to most of such services and is not yet in a position to help and/or coordinate those engaged and doing their best in the fight against the epidemic. The patients and the involved organizations testify this fact as none of them, so far, received any kind of services or supports from the office.

Generally, women in the study area are being exposed to the HIV virus as a result of their having multiple sexual partners, the very poor economic conditions that eventually drive them to commercial sex or their engagement in frequent marriages to secure their life, their inability to pay for medical treatments and their low access to information, condoms ..... and so on.

6.2 Conclusions

The HIV/AIDS pandemic is a fundamental, global issue which undoubtedly has become one of the major concepts that demand top priority among governments and individuals. The state of emergency that has been declared by the epidemic on the global as well as at national levels requires urgent reactions and coordinated responses from all concerned bodies. The United Nations Programmes on HIV/AIDS indicates that low and middle income countries face four fundamental issues in building their responses to HIV/AIDS:1) Strong leadership and concrete commitment from all sectors of government and society 2) Coherence and efficiency as national and external resources are committed, used and accounted for, 3) a strengthening of national capacity to absorb resources and mount effective AIDS responses, and 4) the production and use of strategic information to guide policy and programming decisions (UNAIDS, 04: 153).

A more powerful public reaction to HIV/AIDS should go hand in-hand with wide-ranging efforts to improve the living condition for the majority of the population. For a country to actively and fully engage in the campaign against the disease, it is mandatory that all citizens should be able to find decent jobs without leaving their families and their communities, women should be empowered and get the opportunity to be economically independent and brought to the status where they could decide for themselves, the quality and coverage of public health and education that is equally available for all citizens should significantly improve. Under the atmosphere where these conditions are not adequately provided, the efforts to incapacitate the spread of the virus to the general public causing heavy and unimaginable damages will only become a futile attempt and therefore remains ideal.

The experiences of living with the virus for the last two decades show that the course of the epidemic can be reversed with the right combination of leadership and comprehensive actions. An impartial and dedicated leadership, widespread and targeted public awareness and intensive prevention efforts could bring the

desired outcomes and enable a nation to succeed in reducing and eventually eradicating the HIV/AIDS epidemic. Besides, the veil of silence and stigma that has crippled the endeavors to respond to AIDS should immediately be lifted by all means.

Existing sources and the experiences gained from the epidemic indicate that the AIDS virus has to be fought for the following major reasons: a) HIV/AIDS is a development issue, not merely a health affair. It affects the social, economic and psychological well-being of individuals and communities, conditioning national capacities for political development. b) HIV/AIDS affects not only individuals but also institutions as well c) the struggle against the virus requires new knowledge and determined leadership.

Generally, the spread of HIV/AIDS at the turn of the new millennium is a sign of mal- development indicating the failure to create more equipped and prosperous societies over large parts of the world, possibly keeping on challenging us for decades to come though how long it stays with us and how much damage it inflicts on us is entirely up to each and every one of us. The fact that new infections can be prevented and that the quality of care and treatment for the HIV patients can be improved is the most useful lesson drawn from the disease. Obviously, if a nation does not take the necessary measures in the face of the epidemic now, it is likely that the debt shall be paid sooner or later.

References

African Journal of AIDS and Research (AJAR) (2004). Vol. 3(1). Printed by NISC Pty Ltd, Grahams town, South Africa.

AIDS in Africa (1994). Ed. Paula J. Brewer. Raven Press, Ltd., New York, USA.

AIDS and the African Mother and Child by Dr. Miriam K. Were, UNIEF, in *the Proceeding of the 7th CAMAS Congress and All Africa Conference on AIDS and HIV Infection*; 1989, A.A Ethiopia.

AIDS in Ethiopia (2002). Diseases Prevention and Control Department; Ministry of Health, 4th ed. Addis Ababa.

AIDS in Ethiopia (2004). Disease Prevention and Control Department. 5th National Report of the Federal Ministry of Health, Addis Ababa, Ethiopia.

Anannia Admasu (2000). "Coping with the Challenges of AIDS: The Experience of Persons with HIV/AIDS in A.A. and their Relations with Institutions Rendering Health and Counseling Services." *U*npublished M.A Thesis, in Social Anthropology ,A.A.U.

Appraisal of AIDS Control Programmes in Africa by Dr. Richard Biritwun, WHO Geneva in the Proceeding of the 7th CAMAS Congress and All Africa Conference on AIDS and HIV Infection. Eds. Edemariam Tsega, Prof. Kemal Abdulkadir, and Mulugeta Mengistu, Dr. (between Nov. 26-Dec. 2, 1989) A.A. Ethiopia.

Bartels, L, (1983). *Oromo Religion: Myths and Rites of the Western Oromo of Ethiopia. An Attempt to Understand*, Berlin: Dietrich Reimer Verlag.

Central Statistics Authority (1990). *Population and Housing Census of Ethiopia, 1984: Analytical Report at a National level.* Addis Ababa, Ethiopia.

Barbara A. Dicks and Eddle Senay Bogale in *Women and Sustainable Development in Africa (1995)*. Ed. Valentine U. James, Praeger Publishers, USA.

Cerulli, E. (1922). *Folk Literature of the Galla of Southern Abyssinia.* Harvard African Studies, Cambridge: Mass.

Gada Melba (1988). *Oromia: an Introduction.* Khartoum, Sudan.

Gerarld J. Stine (1999). AIDS Update 1999. Prentice Hall, New Jersey.

Helmut Kloos (Introduction) in *North East African Studies (2004)*. Vol. 7 No. 1; Published by Michigan State University Press.

HIV/AIDS and the World of Work by ILO (2002). ILO Global Program on HIV/AIDS and the World of work, Geneva; International Labor office.

Horn of Africa Journal of AIDS (2005). A Publication of People to People. Vol. 2, issue 1, Printed by Central Printing Press, A.A.

Knutsson, K.E. (1967). *Authority and Change: A Study of Kallu Institution Among the Mecha Galla of Ethiopia*. Guthenburg Ethnografiska Museet.

Lewis, H.S (1965). *A Galla Monarchy: Jimma Abba Jifar, Ethiopia 1830-1932*. Madison: The University of Wisconsin Press.

OPEC FUND Newsletter (2004). Vol. el, No. 4 Printed in Vienna, Austria.

Piers Blaikie (1992). *AIDS in Africa. Its Present and Future Impact*. Belhaven Press, London.

Prevalence and Trends of the Spread of HIV-1 and HIV-2 in different parts of Africa by Professor Idris Mohammed, MD FRCP. In the Proceedings of the 7th CAMAS Congress and all Africa Conference on AIDS and HIV Infection (1989); A.A, Ethiopia.

Reaching Out On AIDS (2004). UN Chronicle. Published by United Nations Department of Public Information; Quarterly Magazine, Vol. XLI No. 1 New York.

Social Aspects of AIDS (1988). eds. Peter Aggleton and Hilary Homans. The Falmer Press, London.

Tesema Ta'a (1980). "The Oromo of Wollega: A Historical Survey to 1910." Unpublished M.A thesis in History, A.A.U, Department of History.

Teshome Deressa (1999). "Peoples Perception of Population Pressure and Attitude Towards Planned Parenthood: the case of Naqamte Environs East Wellega." Unpublished M.A. Thesis in Social Anthropology A.A.U.

Trimingham, A.S. (1965). *Islam in Ethiopia*. London Frank Cass and Co. Ltd.

UNAIDS (2004). *4th Global Report on the AIDS Epidemic.* UNAIDS Publication and Information Center. Geneva, Switzerland.

Women and Children and AIDS by E. Maxine Ankrah in AIDS in Africa (1994) (ed) by Paula J. Brewer. Raven Press, Ltd, New York, USA.

World Bank (2000a). *Project Appraisal Document.* Rept. No. 20727AFR. Washington, D.C. World Bank.

Ema with her son

Baaccuu and her roommate holding an orphan child

Daaqxuu and the orphan "daughter"

Obbo Waggaa being interviewed in the office of Abdii

The researcher interviewing one of the women

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 sources of materials used for this thesis have been duly acknowledged.

Name: Jira Mekonnen

Signature: Jmam

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Addis Ababa

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