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SOCIO-CULTURAL AND BEHAVIORAL ASPECTS OF HIV/AIDS AMONG YOUNG ADULTS IN BAHIR DAR TOWN, NORTHWESTERN ETHIOPIA

BY

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SOCIO-CULTURAL AND BEHAVIORAL ASPECTS

OF HIV/AIDS AMONG YOUNG ADULTS IN

BAHIR DAR TOWN, NORTHWESTERN

ETHIOPIA

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List of Acronyms

. ADA- *Amhara* Development Association

. AIDS- Acquired Immune Deficiency Syndrome

. ANC - Antenatal Care/Clinic

. ARBOH - *Amhara* Regional Bureau of Health

. BA - Bachelor of Arts

. BDSZAO - Bahir Dar Special Zone Administration Office

. BDZWPO - Bahir Dar *Zuria Woreda* Police Office

. CD Player - A player in which compact disk is played

. CD-ROM - Compact Disk -Read Only Memory

. CSA- Central Statistical Authority

. CSWs - Commercial Sex Workers

. CVM- *Centro Volentero Missioni*

. DKT - "Dink Kistet Letena"

. ECA - Economic Commission for Africa

. EPLF - Eritrean People Liberation Front

. HDO - Health Department Office

. HIV- Human Immunodeficiency Virus

. IV - Intravenous

. KAO - *Kebele* Administration Office

. MA - Master of Arts

. MD - Medical Doctor

. MHA- Megebare Hawariyat Association

. MoH - Ministry of Health

. GOs - Governmental Organizations

. NGOs - Nongovernmental Organizations

. OSSA - Organization for Social Services for AIDS

. PLWHA's - People living with HIV/AIDS

. RTI - Respiratory Tract Infection

. SOSA - Sociology and Social Administration

. STDs - Sexually Transmitted Diseases

. TB - Tuberculosis

. TV - Television

. UN - United Nations

. UNAIDS - Joint United Nations Program on HIV/AIDS

. UNICEF - United Nations International Children's Emergency Fund

. USAID - United States Agency for International Development

. WHO - World Health Organization

ABSTRACT

This thesis is a study of the socio-cultural and behavioral aspects of HIV/AIDS among young adults (in the age-bracket 20-29) in *Kebele* 4 Administration of Bahir Dar, Northwestern Ethiopia. The objectives are to: (i) investigate socio-cultural meanings of and

conceptions about AIDS among young adults; (ii) study the socio-cultural context of AIDS and its impact on sexual activity among young adults, including the gendered aspects of attitudes and behavior regarding sex and HIV risk; and (iii) examine young adults' beliefs, knowledge, attitudes, practice and behavior towards PLWHA's, and PLWHAs' experiences in the community and the health care system. The study is based on 100 days of fieldwork, which included participant observation, interviews and discussions with local officials, and young informants, a focus group discussion, and case studies of 15 young adults (7 males and 8 females), and 3 PLWHA cases (1 female and 2 males).

The thesis first describes the daily lives of young adults in Bahir Dar as a basis for understanding the social context for youth behavior and attitudes. This discussion shows that many youth live in a context of poverty, unemployment, high drug and alcohol abuse, male dominance and female submissiveness, and vulnerability.

It is within such a context of vulnerability youth construct their understanding of HIV/AIDS. They generally have an adequate understanding of the nature of HIV and its modes of transmission, but the use of youth narratives reveals youth conceptions of HIV/AIDS incorporate a broader set of dimensions including moral, social and behavioral/individualized notions. For the youth, AIDS is commonly conceived as a symbol of moral failing and a form of God's justice. AIDS also represents certain social categories, social problems, gender inequality, and a mechanism of social control. In addition, AIDS is co-nceived in terms of its social function in the society. Alternatively, AIDS is also associated with individual characteristics and outcomes such as self-destructive behavior, a self-inflicted random occurrence, a romantic/desirable form of death, as well as with sexuality. The thesis also gives substantial attention to youth sexuality because it is strongly intertwined with the reality of HIV/AIDS in terms of youth conceptions, mode of transmission, and changes in sexuality in response to the epidemic. Youth sexuality is a function of sexual attitudes, social significance of sex, risk perception and risk-prone behavioral and social contexts.

People living with HIV/AIDS are an important aspect of the significance of HIV/AIDS in the lives of the youth. The thesis therefore discusses the psychological and social status of PLWHA's, the care and treatment available to them, and their self-help efforts. PLWHAs' reactions to their HIV-positive status ranges from emotional reactions such as shock and confusion, resort to begging, moral judgements about their past behavior, self-blame, and feelings of experiencing retribution, lack of desire to discuss one's concerns about AIDS with anyone except concerned people. The social status of PLWHA's is characterized by stigma but also acceptance by some. Institutional care provided to PLWHA's consists of considerate treatments by certain medical professionals on the one hand, and social biases by others on the other

due to lack of awareness and belittling attitudes on the part of some workers. The family and, especially women, are a primary source of care for PLWHA's, but moral judgements on the part of caregivers and attempts to control information flow about PLWHAs' status may affect the level of care provided. Self-help Association of PLWHA's is accessible to PLWHA's, but is weakened by resource shortages.

CHAPTER ONE

INTRODUCTION

This is a Master's thesis to investigate the Socio-cultural and Behavioral Aspects of HIV/AIDS among Young Adults in Bahir Dar Town, Northwestern Ethiopia. The aim of this thesis is to explore socio-cultural meanings of and conceptions about AIDS, the cultural context of sexual practices, and youth's beliefs, behavior and attitudes towards PLWHA's, and how they are, in turn, perceived by them. The thesis is primarily concerned with setting, actors, perceptions of HIV/AIDS, sexuality, risk behavior, processes, and also in meaning(s) - how people make sense of their social lives, experiences, and the structures of the world. People create and define the socio-cultural world through their interactions. With a focus on the everyday, face-to-face processes of social interaction, we could thus gain insight into their socio-cultural world.

The thesis is based on case studies of 15 young adults, 20 key informants, and 7 focus group discussants. The fieldwork for the thesis was conducted among young adults (in the age-bracket 20-29) and people living with HIV/AIDS (PLWHA's), in *Kebele* 4 Administration of Bahir Dar.

The world, we live in, is invariably changing for better or for worse. People are faced with new challenges and problems. For instance, the world population is constantly told of doomsday scenarios: Global Warming, Nuclear Accident Meltdown, Meteor Impact, Ozone Depletion, Landfill - the list is almost endless. The world now faces a lethal new epidemic. In the early 1980s, doctors in the United States noticed increasing frequency of an unusual form of pneumonia, and the first victims were five gay men. Suggestions for a name resulted in the acronym, AIDS (Acquired Immune Deficiency

Syndrome) which was finally coined and accepted by the United States Center for Disease Control in 1982 (Scambler 1991: 193; Barnett & Blaikie 1992: 1).

Since then, HIV/AIDS has become a world-wide pandemic and health problem. It is exploding over the world very rapidly. We are witnessing, at the threshold of a new millennium, what may amount to the biggest health and development challenge the world has ever confronted. The number of people infected with HIV in the world has already reached an estimated 34.3 million in 1999 and with about 95 per cent living in the developing world and a staggering 70 per cent in Sub-Saharan Africa alone. What is more, the rate at which the transmission is spreading is alarming. In 1999 alone, an estimated 5.4 million people were infected (UNAIDS 1999a: 1).

Numerous serological studies in African countries have revealed the extent and severity of the epidemic (quoted by Fesseha 1993: 3). The continent has the highest prevalence of AIDS in the world today with some 23.3 million people infected (UNAIDS 2000: 2). Across the continent, the regional differences in AIDS prevalence rate are considerable, even though no country has escaped the virus. The countries with the highest prevalence rates are in the East, Southern, and Central parts of Africa (Oppong 1998: 437).

In Ethiopia, the extent of the problem is also increasing very fast. The epidemic of HIV and its clinical manifestations has now been recognized as the most serious and pressing national health problem. There are over three million people living with HIV in the country (UNAIDS-Ethiopian 2001: 1). However, the number of cases is underreported and does not reveal the full extent of the health crisis the country is facing. A few serological studies in Ethiopia revealed the extent and severity of HIV epidemic. The results of these studies indicate that HIV is widespread in urban areas throughout the country. Prevalence rates among commercial sex workers, for example, are about 65-70 per cent (MoH 1998: 8). Moreover, the results of the other serological study indicated the HIV prevalence among 200 TB patients in Felege-Hiwot Hospital in 1997/98 were 42.5 per cent (Sirak 1999). HIV prevalence among 260 pregnant women included in sentinel surveillance at Bahir Dar Health Center antenatal clinic in 1999/2000 was 20.8 per cent (MoH & USAID-Policy Project 2001: 21). In this town, 188 cases of HIV/AIDS were reported to the Health Department Office of The Bahir Dar Special Zone Administration from Oct 2000 through June 2001 (HDO 2001: 55-57).

Table1. Reported Cases of HIV by Age and Sex in Bahir Dar Town (from Oct 11, 2000 through June 27, 2001).

Age Group	M	F	Total
0- 4	9	3	12
5-14	3	1	4
15-19	0	0	10
20-24	3	23	36
25-29	25	27	52
30-34	21	0	31
35-39	2	3	25
40-44	4	4	8
45-49	3	4	7
50+	2	1	3
Total	92	96	188

Source: HDO, 2000-2001

Table 1 shows that age-sex distribution of HIV cases in Bahir Dar. Out of a total of 188 reported cases of HIV positive - 96 were females and 92 were males. This, of course, contradicts the general feature of the nation at large, where there were more females than males in the age categories 20-24 and 25-29. Generally, the data confirm the discussion that the youth in the age-bracket 20-29 are a high-risk group. The predominance of female PLWHA cases in this age-

bracket, of course, indicates that young female adults are more vulnerable than older females and males, as reported by other studies (Dear 1994: 6; Kloos 2001).

1.1. Statement of the Problem

The spread of HIV is a function of biological, social, cultural, economic, and political processes. The study focuses on socio-cultural factors, since the transmission of HIV reflects the behavior of populations. Such behavior is, in turn, embedded in the social and cultural factors that characterize various populations. These factors condition risk-behavior partly because they determine conceptions regarding causation, levels of risk, etc.

HIV transmission occurs in many different behavioral and social contexts, which can determine who in the population, may be exposed and how they might respond. Populations with different social characteristics have different rates of HIV/AIDS (Rushing 1995: 5). In Africa, commercial sex workers (individuals who exchange sex for money, drugs or gifts), soldiers, truck drivers, businessmen, and young adults have been identified as high-risk groups. Each has its own unique characteristics shaped by local, social, cultural, and other factors (Barnett & Blaikie 1992: 69; Rushing 1995: 5). AIDS must therefore be understood within the totality of society's social and cultural dimensions (Feierman & Janzen 1992: xvi). However, knowledge of the social and cultural dimensions of AIDS is rudimentary (King 1993: 73). As HIV infection is spread through socially structured, culturally meaningful

behaviors about which there is much still to be learned, one must consider these myriad contextual factors in a particular locality (quoted by Baer *et al.* 1997: 179). This inquiry therefore addresses conceptions of AIDS among male and female young adults at places of entertainment in *Kebele* 4 of Bahir Dar.

Conversely, AIDS also has an impact on sexual activity. Knowledge of the disease and PLWHA's could bring about enormous changes in how young people view sex. The notion of 'safe sex' forces them to question many of the assumptions they hold about sex. It demands that the youth re-evaluate forms of sex and challenges the belief that men have little voluntary control over their sexual desires. AIDS further challenges what is considered 'natural' or 'normal' about sex. In being advised to practise safer sex, young male adults are being urged to be 'unnatural.' Thus, they have the 'condom solution.' Condom use may conflict with their expression of sexuality. Cultural attitudes towards condom use, especially among young males, may make them very difficult to accept. Condoms are seen as wasting time, preventing flesh-to-flesh contact or even belittling the sperm by obstructing its entry into a partner (quoted by Barnett & Blaikie 1992: 160). For abstinence, the treat of the disease robs young adults of the expectation of sexual fulfillment and of marriage. Sex is therefore set about with extreme anxiety. The expectation of sexual fulfillment is completely abandoned in favor of celibacy. Young abstinence does not like this new use - the contaminated 'modern' plastic that is completely against God's or Allah's will in the Bible or Holy Quran respectively. The study presents the socio-cultural aspects of AIDS and its impact on sexual activity among young adults, including the gendered aspects of attitudes and behavior regarding sex and HIV risk.

Disease does not only affect the physical body but also the 'social body,' the relationships between people (1992: 3). This holds true for AIDS. Attitudes towards people living with HIV/AIDS are associated with perceptions about AIDS, which are unusually negative and extreme. Generally, ostracism of PLWHA's has been common; people with HIV/AIDS have

been stigmatized as moral deviants and outcasts (Rushing 1995: 170). The research examines young adults' beliefs, behavior, knowledge, attitudes and practice towards PLWHA's, and PLWHAs' experiences in the community

and the health care system.

1.2. Significance of the Study

HIV infection and AIDS is a multi-dimensional problem that needs a multi-faceted solution. Although there is much overlap between "medical anthropology" and public health (for example, Master of Public Health theses on knowledge, attitude, practice and behavior), one of the most significant aspects of the disease is its socio-cultural meaning distinct from its medical meaning. This anthropological inquiry therefore attempts to shed light on the socio-cultural conditions which might expose young adults, its impact on people's behavior and social life, and the perspective of the study population. The study therefore contributes to: (1) interdisciplinary vs. creating distinction between medical and socio-cultural perspectives; (2) interventions that attempt to modify behavior and

perceptions, and (3) programs that provide assistance to PLWHA's.

1.3. Objectives of the Study

The proposed study was generally designed to investigate socio-cultural aspects of AIDS among young adults in Bahir Dar town. The specific objectives of the research are:

i. to investigate socio-cultural meanings of and conceptions about AIDS among young adults;

ii. to study the socio-cultural context of AIDS and its impact on sexual activity among young adults, including the gendered aspects of attitudes and behaviour regarding sex and HIV risk; and

iii. to examine young adults' beliefs, behavior, knowledge, attitudes and practice towards PLWHA's, and PLWHAs' experiences in the community and the health care system.

1.4. The Setting

Bahir Dar has a very long history and has been known by *Bahir Dar Kidane Mihret* since 14th century and by *Bahir Dar Giyorgis* since 17 th until the advent of the Italians in the 1930s. When the Italians abolished the administration of the Church in the area, the town was given a new function, as a military base and as an administrative centre for the southern Lake Tana Region. From this time on, the town became simply known as Bahir Dar and having Master Plan beginning in 1965 (Seletene 1988: 124; Demeke 1999: 16).

Bahir Dar is one of the zones in The Amhara National Regional State. The city is located 565 km north of Addis Ababa, and lies in the northwestern section of the sovereign state. Bahir Dar was also proclaimed a special zone in June 1995 and officially began its administrative function in December 1995. Its present general land area is 28 square kilometer.

Bahir Dar lies at the southern shore of Lake Tana. Although there are a few hills and ridges in the landscape, particularly to the West and South of the town, the topography is generally flat, with an average altitude of 1795 meters above sea level. Areas 1820 meters above sea level are used for residential and different services. The geographical coordinates of the town are 11^{o} 38' 30" north Latitude and 37^{o} 10' 30" east Longitude. The town enjoys a tropical climate with a mean annual rainfall of 1521 mm, and an average annual temperature of 17.5^{o}c (Demeke 1999; Chernet & Gebeyehu 2000).

The latest population census enumerated a population of 96,140 (CSA 1995: 244) living on a built-up area of 900 hectares. Disaggregated by sex, 45,436 were males and 50,704 were females. The sex ratio was 89.5 per cent. The age structure of the town's population was typically that of a developing country. It is dominated by young citizens less than fifteen years of age. Of the total population, 36.6 per cent of inhabitants are under that age, a further 15.98 per cent are aged between 15 and 19; 21 per cent were categorized in the 20-29 age category. There were also 37, 213 economically active persons (19,200 were males and 17,953 were females), and 6, 035 unemployed persons (with experience or without job experience). There are also a significant number of street children, orphans, beggaries, and elderly people. Based on this census, however, the town's population was generally projected to be 134,062 in July 2000 (CSA 2001: 30).

Bahir Dar is predominately settled by the Amhara ethnic group. There are also Tigreans, Eritreans, Gurages, Oromos, Agews, the Woyito band and others. With regard to mother tongue, most residents are speakers of a distinct dialect of the Amharic language, *Amarigna*, and are followers of Orthodox Christianity. In addition, there are Muslims, Protestants, Catholics, and others. There are as well about 13, 3, 3, and 1 buildings for Orthodox Christians, Protestants, Muslims, and Catholics respectively. The Bible and the Quran are extensively preached in the town.

With regard to kinship, there are two kinds - through descent or blood or birth and through marriage. In addition, the community recognizes 'fictive' and 'ritual' forms of kinship as in adoption and god-parentage. An important basis of classification is the rules of descent, where it is traced either through the patrilineal or the matrilineal or both lines. Thus, Amhara kinship is predominately ambilineal and the majority of the Amhara live in nuclear families. Kinship generally extends to relatives within seven ascending levels of descent.

There are also different types of marriage in the area. The most common type is *semanya* marriage. *Semanya* literally means '80,' and is thus also called the 'eighty-bond marriage.' This refers to the oath, which includes the phrase 'May the Emperor die,' the breaking of which used to be penalized by what was then the enormous sum of 80 Maria Theresa Thalers. It is also called *baserat,* by contract. It is a contractual marriage between couples who occupy equal status with respect to property. It is legalized in the form of customary, municipal and/or religious marriage. Ordinarily, the couple, especially the girl, do have or do not have a say in the decision on whom to marry, and this is reportedly changing somewhat as couples are increasingly becoming acquainted and deciding on marriage beforehand. However, marriages arranged by parents are predominant. In any case, parents mostly pay attention to the character and blood line of the parents of the person their child is to marry, including traits that are expected to determine the income, industriousness, trustworthiness, responsibility, at times one's parent(s) native place/locality, and others. Potentially available endowment in the form of income, property and others from the in-law's family is another consideration in their choice. It is often said that this factor is gaining paramount importance, because of the tendency these days to show consideration for 'business' or economic factors. Nowadays, character and economic capacity are given more important consideration.

In Amhara society, kin-negotiations or go-betweens arrange such types of marriage. After both families have agreed to marriage and appointed *neger abbats* (lit. fathers of the affair) as

intermediaries, both parties will arrange a day for the wedding. On the eve of the wedding, the best men present wedding-rings, clothes, cosmetics and the like to the first bride. On the wedding day, the bridegroom, his best men and entourage come to the bride's residence. Then, the groom places the wedding-ring on the bride's ring-finger and the bride does the same to the groom, and the rings are worn afterwards to show that they are married. In the town, wedding-rings are usually worn on the second finger of the left hand, i.e., ring-finger. In what follows, there is feast and entertainment in the bride's house, at (public) park or a palace's compound or some other places. In addition, other types of marriage are *demewoz*, or *yechin gered,* and polygyny, especially among Muslims.

Demewoz marriage (lit. wage) is the temporary marriage, for which the man arranges to pay regular wages, *demewoz* to the woman. Most commonly the arrangement is from month to month, but may be for longer or shorter periods. The term is a contraction of 'demewoz' (lit.'blood-and-sweat') compensation. Her wages vary greatly from region to region. *Yechen gared* is literally the servant-maid of the thigh, meaning the servant-maid who embraces or 'broods' her master between her thighs, or the master puts his thighs on the servant-maid. Her status is thus lower than his wife and concubine. In addition, there is the Eucharistic church marriage or *Qurban* marriage, which is engaged in only by a minority of the residents. However, it has significance among members of the community.

Polygyny is type of marriage rule permitting a man to have more than one wife at a time. It is found especially among Muslims. Men can marry up to four wives. Polygyny as a cultural ideal is related to four reasons such as sterility/barrenness, continued sexual access during menstrual period, and maternity birth, and greater female to male ratio. According to my Muslim key informant, if a Muslim woman is not able to produce children or young, her husband can marry other woman instead of divorcing his first wife (divorce is possible only twice) or engaging in adultery. During menstruation, the man should not engage in sex with his wife. Menstruation is

disgusting or nasty event. He must be far from his wife. This is the case until she becomes clean. He is allowed to marry additional wife/wives in order to resort to have sex with these wife/wives during the menstrual period of his first wife. In addition, when the first wife gives birth, her husband should not 'have sex' with her until four months. During maternity, he could engage in sex with his other wife/wives. Finally, as it is expected that the number of females will be more than that of males through time (esp at the end of the world), the male Muslim is allowed to marry two or three or four wives in order to accommodate single women. This is as long as a male Musilm has wealth to administer four of his wives.

In Amhara society, marriage can take place between two persons who are not related within seven ascending levels of descent (Yared 1999:41). In contrast, divorce can occur between spouses due to one reason or another on frequent and temporary separations. The Special Zone Office provides birth certificates and marriage licenses.

Regarding education, there are six kindergartens/nursery schools, sixteen elementary schools, two high schools, three institutions for mentally retarded, deaf and blind pupils, one Junior Technical Training School, the Amhara National Regional State Management Institute, and Bahir Dar University with its Education Faculty and Engineering Faculty, and Faculty of Business and Economics. In the Zone, there are 12,059 school age youth, and 860 dropouts in the academic year 2000/2001. There are also two community skills training centres, two public libraries and about seven public places of entertainment. Moreover, there are eight NGOs in the Zone, which are carrying out activities in the educational sector (BDSZAO 2000: 7-146).

In the health sector, there are thirteen junior clinics, three moderate clinics, and one higher clinic. In addition, there is Felege- Hiwot Hospital, which has 170 beds. The ten top types of disease at the hospital are RTI (Respiratory Tract Infection), Bi-pneumonia (Inflammation of the lung parenchyma characterized by consolidation of the affected part, inflammatory cells and fibrin

and others. Most cases are due to infection by bacteria or viruses), Falciparum malaria, TB (colloquial abbreviation for tuberculosis), Intestinal obstruction, and others (HDO 2000). In the town, there is one Junior Health Assistants School, one Malaria Control Centre, one Ethiopian Pharmacological Dispensary Corporation, government and private pharmacies, one Ethiopian Red Cross Pharmacy, HIV/AIDS Council Secretariat Offices, and a few drug vendors. Likewise, occasional sanitation campaigns (esp on Fridays) in which the local residents take part and the municipality hires and provides garbage trucks and other sanitarian activities.

There are a number of government organizations (nine departments under the auspices of The Special Zone Administrative Office) and NGOs in the town. Bahir Dar also accommodates about six Banks and four insurance companies. The town has a big weekly market (holds on Saturdays) and daily back-street markets. In addition, there are more than 200 bars/hotels, night-clubs, restaurants, liquor houses, small tearooms and other businesses that are run without legal status. Here we should bear in mind that some of the local brewers and sellers are commercial sex workers.

Bahir Dar gets a 24-hour 72 Mega Watts of electricity from the plant of the hydro-electric power of the Blue Nile Falls. There are also five petroleum dispensaries and one petroleum tanker. The dwellers have access to mass media services on radio, TV, newspapers and others. The newspapers, include: the Amharic Newspaper, *Addis Zemen*, the English Newspaper, 'The Ethiopian Herald, *Bekur* (the Amharic Newspaper published by Bureau of Culture, Tourism and Information). There are also other privately published newspapers and magazines. The Amharic newsletter *Hulachinim* (translated as 'Together' in English is published jointly by CVM, and Bureaux and Zonal department offices in order to provide education on HIV/AIDS. The newsletter seems to have wider circulation in governmental organizations, schools, religious institutions, *kebeles*, and in Farmer Associations in the vicinity of the town, but it is quite superficial.

There are various cultural practices that put people at risk of HIV/AIDS. These include: circumcision of males and of females, tattooing, ear piercing, and health maintaining practices such as rubbing or scrapping of gums, cutting the uvula, piercing body marks (crossed or various decorations), cutting eye lashes, burning the body with hot metal objects, *wagemt* (the practice of cutting a blood vessel and taking out the blood by sucking with the mouth using a tool made of the horn of cattle, or cupping instrument) (Solomon & Kiros 1997: 8). Similarly the residents may share razor blades, knives, plaiting bodkins, safety pins, pliers, hawthorns, and others to take out jiggers or thorns without sterilizing them. However, some knowledgeable individuals sometimes sterilize the instruments.

There are also indigenous social institutions in Bahir Dar (such as *Equb, Eder, Senbete,* so-and-so *Mahber*, and *Tezkar*. *Equb* is a common rotating savings group in which the sum of members' regular contributions is given to each member, in turn, in a sequence to be determined by lot. *Eder* provides assistance to members when there is death in the family. Members of households pay a small sum to the *eder* on monthly basis. The very poorest in the community apparently may be members in an *eder* and receive benefits without paying a monthly fee. *Mahber* is a religious association which meets on a particular saint's day once a month to feast together at the house of members who take turns preparing the feast. The members form a sort of spiritual brotherhood and/or sisterhood. *Senbete* is similar to a *mahber* but meets at the local church instead of at members' households. *Tezkar is a* feast or banquet in commemoration of a dead relative, which is held on the 40th day after death - when the soul is believed to have its earliest opportunity to be freed from purgatory.

The residents of Bahir Dar are employed in the civil services, trading, small-scale industries (wood work, paper production, and so forth), handicrafts (such as weaving, sewing, basketry, making earthen wore and so on) and a number of other petty businesses. A large number of households also earn their livelihood by brewing and selling local beverages like *tella*, *areke,* and

tej. Likewise, there is cash crop such as *chat*, which is planted by 1259 *chat* growers in most of the town's *kebeles,* only 520 of whom are licensed. Although it is difficult to present exact figures on their number, there are many ex-soldiers in the town. Moreover, commercial sex workers, the youth, drivers and vagabonds are among the social groups vulnerable to AIDS (1997: 3).

Apart from problems associated with developmental patterns and other maladjustment, youth (20-24 years of age) in Bahir Dar experience a host of common problems related to their lack of occupation, affordable education, health and other psychosocial problems. Presently, the numbers of job seekers is growing fast (i.e. 1522 seekers in 1998) (ADA 1999: 1). Hence, this aggravates the existing social problems. The absence of affordable recreational centres in the town is another problem faced by the youth (1999: 2). There were 350 cases of beatings/assault(s), 265 cases of thefts, 130 cases of law negligence, 122 cases of burglaries, and others in 1999/2000, and a total of 1509 crimes in this year. In comparison, there were 1138 crimes in 2001. Most of the offences are committed by young males in the age-bracket 19-30 (BDZWPO 2001: 12). Thus, crimes seem to be on decrease in the town. This was because the Police Office employed community based crime prevention strategies in which the office taught residents about the nature of crime and mechanisms how to prevent it to teachers and students at schools, to *eder* members and officials during public and/or *eder* meetings, and to others who engage in other income generating activities (such as shoeshine boys, commercial sex workers, guards who work in governmental, private and other organizations).

Bahir Dar lies close to a number of major tourist attractions. The Blue Nile Falls are within an hour's driving distance. Furthermore, the town is connected with Gondar, Dessie, Mekele, Wellega, and Addis Ababa by an all-weather road. There are modern shops, tour and travel agencies, hotels/bars, restaurants, pensions, etc.

For administrative purposes, Bahir Dar is partitioned into two *woredas* and seventeen *kebeles*. *Kebele* 4 is the research site selected. The study *kebele* had a population of 5,910 of which 2,546 were males and 3, 364 were females (CSA 1995: 244). The *kebele* is located in the centre of the town where major economic and social activities take place everyday - the site is the town's commercial and business centre. The residents are civil servants, petty traders, businessmen and businesswomen, local beverage brewers and sellers, commercial sex workers, unemployed persons, daily labourers, street children and beggars. The latest population census further indicated that there were 1,188 households and 1,134 housing units in the *kebele.* The Special Zone Socioeconomic Profile (1993-1996) indicated that the *kebele*'s population density was 509 per hectare. However, The *Kebele* 4 Administration Office Socioeconomic Survey (March 1997) showed that there were 4489 households (The difference in number of households is due to the construction of additional houses, the presence of a number of self-employed commercial sex workers and others who have come from the neighbouring towns who live in rental houses partitioned from the main housing units in the *kebele), 5*33 government and 436 private housing units respectively. A majority of the residents do not have their own houses. Hence, many of them are living in crowded government houses and some of the residents are in arrears of rent. In the territory and around the *kebele*, there is a lack of pre-schools and kindergartens. Notwithstanding, economic constraints keep children of the poor out of school, for they are expected to make financial contributions to household earnings

There are government health facilities in the vicinity of the kebele, and private clinics, and medical laboratories are also operating within the *kebele*. However, each has its own shortcomings or restrictions. The government facilities, which are open to all residents at low cost or no cost, are reported to be crowded, poorly equipped and understaffed. Privately owned clinics likely provide better services, but are priced beyond the means of most households. In the study *kebele*, there are Health/Anti-Malaria Committees (distribute condoms and contraceptives

to commercial sex workers, and hand out leaflets on HIV/ AIDS), a Development Committee, and a Red Cross Committee, but there is no Anti-AIDS Committee or Club. Though there were no data on their incidence, malaria and other diseases such as TB, typhoid and AIDS affect all demographic and economic groups in the site. Health status is also threatened by crowded or polluted living conditions, harmful cultural practices and by lack of adequate latrines. However, there are five public toilets (some of them are without doors) and two garbage damp stocks.

In the *kebele*, there exist four 'self-help' associations, i.e., *eder*, to which members of households pay a small sum of money monthly. There are other social associations such as *equb, mahber* and *senbete.* Some small or informal credit institutions exist, but few have access.

The *kebele* (one of the oldest settlement areas) is said to have changed considerably during the past 25 years in terms of population growth, infrastructure development (housing construction, business and roads), and numbers of hotels, bars, night-clubs, shops and expanding trade. According to *Kebele* 4 Administration Office's official, there are now 68 hotels, 19 bars, 9 night-clubs, about 54 *chat* houses, about seven video rooms, few *areke* houses, many *tella* houses, seven juice rooms, two *tej* houses, few restaurants, pensions, and some other service giving institutions.

Generally, one could feel the deterioration of living conditions. Although all may feel the effects, the disabled, beggars and the chronically ill persons have desperate lives. In the survey study, many residents do not get enough food or are not in an economic condition to meet basic needs. A significant proportion of the residents (97 per cent) are destitute (with the exception of the rich and middle-income group, which comprises owners of garages, pharmacies, small shops, bars, big hotels and restaurants (Meyer *et al.* 1998: 13).

Poor households typically have petty trade as their main source of income, including sale of e*njera, tella, areke, chat,* charcoal or the collection and sale of fuel wood. During semi-

structured interviews with residents, additional economic activities were identified as being significant in the community. These include: making and selling charcoal, washing and/or ironing clothes, vegetable growing for sale and household consumption, vehicle repair, bicycle rental & repair, carpentry and other handicrafts. Children are also asked to make contributions to household income by shining shoes, fetching water, and by selling cigarettes, chewing gum, pea nuts, lottery tickets, lemons and so forth. The strategies undertaken by residents include: petty crime, selling labour in different constructions, borrowing money from relatives and/or friends, commercial sex business, migrating to other cities and towns in the country, etc.

1.5. Methodology

Two qualitative data gathering methods were employed - ethnographic research design (i.e. fieldwork which entails partial immersions/participant observations in the everyday life of the setting chosen for the study) and the case study method through in-depth interviews. I prepared myself for actual fieldwork by collecting information on the people and aspects of social life in Bahir Dar beforehand, practising observation and writing-up of various situations, preparing and testing out general research questions. Finally, I obtained letter(s) of introduction from the College of Social Sciences of Addis Ababa University, bought research supplies, and reached Bahir Dar town on July 24, 2000.

1.5.1. Fieldwork

The time I spent doing purely fieldwork added up to 100 days during which I mostly stayed in a residence in the setting. I conducted fieldwork from July 2000 through Jan 2001. This period was discontinued by trips to Addis Ababa and to Gondar in September and in December 2000

respectively. After I had come back to Addis, I started transcribing and translating tape-recorded interviews.

During my stay in Addis Ababa starting from Sept 17, 2000 through Nov 21, 2000, I held extensive and intensive session of discussions and consultation with my adviser from whom I gained constructive comments. In addition, these helped me note the gaps in the data that I had collected in the first phase of the research. I was also engaged in an extensive search for relevant literature from different sources. I then returned to the field in Nov 2000 in order to collect more data based on the comments and suggestions. I finally left the field in Jan 2001.

In the first ten days of actual fieldwork, I obtained formal permission from officials in the setting, learnt about social networks, and acquainted myself with the general socio-cultural and economic characteristics of *Kebele* 4 by touring the area with a guide, and writing-up my observations. I held casual conversations with the guides about numbers and types of places of entertainment, the socio-cultural and economic context of the *kebele*, their perception of and personal experiences in the context of the *kebele*, meaning(s) attached to the physical surroundings, and how youth passed their leisure.

After formal access had been obtained, I conducted informal and semi-structured interviews with *kebele* officials such as the chairman, the secretary and other members of the executive committee. Afterwards, I employed the 'snowballing' techniques and started intensive interactions with young members and/or participants of both sexes in order to learn social networks in the locality or locale. Here, to build rapport with them, I tried to show genuine concern for and interest in young and other residents, to be honest, to share their feelings, and adopted a role of partially immersed/participant observer. All these helped me establish credibility with my informants.

At the start of focused and selective participant observations in the locales, I had the overwhelming task of observing everything in each section of the *kebele* in order to locate 'red spot areas,' i.e., risk-prone areas in the *kebele.* Thus, I focused on locales that could give relevant data, and began the observations using my eyes, ears and other senses in the given context. I held informal discussions, writing memory triggers in a jotter, and/or taking 'mental notes.' I also held semi-structured interviews on various issues and tape-recorded. The jottings I took, were incorporated into a log-book in the form of direct observation notes. These were organized chronologically with a date, time, and a place on each entry both in the jotter and in the log-book. This was done for other data that I collected such as maps, diagrams, photographs, interviews, jottings, tape-recordings and the like.

Through participant observation, efforts were made to document aspects of social relations, interaction between sexes, significance and role of sex in social life, values about and attitudes towards sex, friendship, family, opposite sex, singlers, multiple partners, risk behaviour, and others. Key informants were identified with the help of guides and/or 'cultural brokers,' in a 'snowballing' technique that relied on the social networks of these young adults. Key informants' were chosen on the basis of their age, knowledge, beliefs, attitudes, education and other criteria, and their ability to shed light on young adults. The informants who often had a special ability to provide insights into conceptions of AIDS were potential conveyers of AIDS education or even distributors of condoms. Through key informant interviews, data were collected on the informants' background, aspects of changes in gender relations, patterns of sexual activity, young adults' conceptions of AIDS, etc. There was no overlap among key informants, cases and focus group discussants. When a situation dictated informal discussions with the informant(s), I carried out hour long interviews which are often gendered and flexible, taking mental notes and writing memory triggers in the jotter.

Regarding the case study method, a total of 15 young adult cases (7 males and 8 females esp focused on persons with high-risk behavior in the age-bracket 20-25), based on risk-prone social and behavioral contexts, were identified by my own efforts, and with the help of guides and/or 'cultural brokers,' and interviewed intensively about their personal history, knowledge of AIDS, conceptions of AIDS, sexual history, social relations and so on.

Case study interviews occurred after explaining to each informant, focus group participant and PLWHA's of their right to remain in silent or to withdraw from the study, and getting the informed consent of the cases who were assured of confidentiality by using pseudonyms, and lasted two hours on the average.

Access to PLWHA cases was negotiated through two NGOs (CVM and OSSA). In-depth interviews took place with the informed consent of PLWHA's who were assured of confidentiality and the right to raise any objections regarding the conduct of the interviews or withdraw from the study. In fact, no individual took up the opportunity to do so. Tape-recorded interviews were conducted with three PLWHA's (1 female and 2 males). In addition, informal discussions with the help of the jotter, and tape-recorded semi-structured and formal interviews were carried out. These included care providers and people who were part of social networks of people with HIV/AIDS.

Interviews and discussions with PLWHA's examined personal history, knowledge of AIDS, response to AIDS, social experiences, experiences with health care, etc. I paid informant allowances for the interviews, which lasted an average of 90 minutes. I used all pseudonyms in the thesis to keep their anonymity.

Like key informants, focus group discussants were located with the help of guides and/or 'cultural brokers' in a 'snowballing' technique that relied on the social networks of the adults in various informant categories. After pre-testing the prepared discussion research questions on topic guide with 7 young adults (4 males and 3 females) who are members of *Kebele* 16 reproductive health and anti-AIDS club, the actual focus group discussions were held with groups of 7 young adults (5 males and 2 females), who were selected on the basis of their knowledge, beliefs, attitudes and other criteria related to AIDS. In the discussions, as a facilitator, I asked a series of open-ended questions on a pre-tested topic guide.

At the very beginning of such discussions, some time was spent to establish a comfortable and secure environment for discussants at a chosen convenient venue and to develop rapport with them. During the discussions, where possible, I tried to keep track of who was speaking about certain topic(s), facilitated interaction between group members encouraged all discussants to share their views and to challenge each other's statements. On my part, I was quick to pick 'explored statements,' I also used probes, general and supplementary questions and supplied relevant information to gain clarification of answers and to get further information. All sessions were tape-recorded in their entirety and lasted on average 130 minutes each. Generally, data on the implications of the contexts of the *kebele*, opinions about community level phenomena, conceptions of AIDS, aspects of stigma towards PLWHA's, other issues, etc. were collected. Lastly, I employed document analyses to analyze newsletters, fliers, magazines, research reports and theses, official and unpublished documents in international, national, regional, and zonal offices, on-line database series, CD-ROM, and others on the topic under consideration.

1.5.2. Data Analysis

Following the completion of data collection, verbatim transcripts and chronological files in the log-book were prepared. An initial reading of the data took place to check for completeness of coverage. I organized the field notes, and placed similar topics into folders. This was followed by a more in-depth analysis of recurrent themes and issues, which were later organized into logical categories. I also created a folder for analytical notes on conceptions of and meanings of AIDS, PLWHAs' experiences, how participants/members defined socio-cultural contexts, how young adults defined, justified and interpreted their verbal & nonverbal behaviour, PLWHAs' experiences and perception of PLWHA's by young adults, etc. Then, while writing-up the thesis, the researcher drew the themes from the folders, and contextualized the themes in light of socio-cultural aspects of AIDS among young adults in Bahir Dar.

1.6. Organization of the Thesis

The thesis consists of six chapters. The second chapter discusses the social context of the youth. This aims to examine the daily routine of young adults, their life-style and entertainment, aspects and nature of social relations, including gender and changes in such relations.

Chapter three narrates young adults' socio-cultural conceptions of HIV/AIDS. It describes awareness of the nature of AIDS, and 'folk' conceptions of and metaphors for AIDS, considering a narrative approach.

The fourth chapter on sexuality and risk behaviour discusses youth perspectives on sexuality, together with changing sexuality (changes brought about by AIDS). The chapter also describes social significance of sex, and youth sexuality and sexual risk.

The fifth chapter is on the social status and care of people living with HIV/AIDS, focusing on causes and their own reactions towards HIV positive status, stigma and attitudes towards PLWHA's, and care and support for them. These will be discussed by considering deviations from the sick-role model. Finally, the conclusion puts together the various findings of the thesis by way of shedding new light on the conceptions and social context of AIDS among young adults in Bahir Dar.

1.7. Limitations of the Study

All in all, the fieldwork was interesting and an excellent learning opportunity. However, the methodology I chose was not without its problems. For example, my age, gender, marital status, educational status and background, sometimes influenced my interaction with the youth, women, and normal social life. The gendered interactions, conversations and interpretations, the sensitivity of the topic, sexual taboo, and the exclusion of key informants and focus group discussants as case informants might affect what aspects of the setting I came to know, the interpretations of experiences, and might fail to locate and select potential female focus group discussants.

In addition, there was the difficulty of translating concepts in English to concepts in Amharic such as anthropological, sociological and/or biomedical concepts. There was also difficulty of translating informants' colloquial words or expressions, technical words, argot and/or others. I faced problems related to lack of funds in order to carry out the overall thesis research. As a

research fund was not released on time, I could not follow my research schedule. I used money from my own pocket in order to embark on actual fieldwork. When I came back to Addis Ababa from field, I requested refund of the costs of my research. Nevertheless, I have still not managed to get a refund since June 2001. Since I am severely short of funds, I have faced great difficulty and long delays in getting my chapters typed. Moreover, the disturbances on campus at the time have prevented me from using computers reserved for postgraduate students in the department. Because of such conditions, my employers have also terminated payment of my salary, which has severely affected my financial and living conditions. These challenges, uncooperative officials, etc. may contribute to the limitations of my thesis research work. The need to pay some informants in the research setting may challenge on my limited resources, and restricted the number of respondents.

Moreover, the focus group discussions failed twice due to Ethiopian Radio program pre-preparation for Christmas Day and meetings held for election of officials at *woreda* level (religious and political events), which added extra days. As the topic of HIV/AIDS was also extremely sensitive, I found it difficult to approach potential PLWHA's. Also, misunderstandings of my methodology by some who thought I was a journalist, political conditions and the security, and norms of social interaction in *chat* houses, night-clubs and bars affected the study in one way or another.

I was also not able to locate the few MA theses written on Bahir Dar town, because the School of Graduate Studies did not make them available in a timely fashion. I similarly had no access to an Ethnograph computer program for data analysis. I finally acknowledged shortage of money and time to work on computer (even though it was very challenging to get and use the machine without payment) in order to type and print each chapter of the thesis and edit comments. Having said these, it is now time to draw the themes from the folders and to

fit them to the social context of AIDS. I am getting in the discourse water myself, paddling around, and then contextualizing the themes in light of conceptions of AIDS.

CHAPTER TWO

THE SOCIAL CONTEXT

2.1. Introduction

Although HIV is the cause of AIDS, social factors are significant in the way the virus is transmitted. The virus obviously does not discriminate against people because of their sexual orientation, drug use or other. Social and cultural factors largely explain why AIDS has become so prevalent in some populations. Certain behaviours associated with particular groups and populations are major factors in the transmission of AIDS. Such behaviour is anchored in the cultural norms and social institutions of those groups and populations. It is therefore important to contextualize young adults' attitudes and behaviour by describing the community and the nature of social conditions within it. This chapter aims to examine young adults' daily routine, their life-style and entertainment, social relations, gender relations, and changes in these relations in response to prevalence of AIDS in a locality of Bahir Dar town. The chapter will also summarize the general themes.

2.2. The Daily Routine of Young Adults

The study of social life takes us into all kinds of activities and settings. Even in situations where one might think that nothing is happening, anthropologists see important processes of social interaction. For E. Goffman (1959), any group of persons develop life of their own that becomes meaningful, reasonable and normal once you get close to it, and a good way to learn about any of these worlds is to submit oneself to the daily round of petty contingencies to which they are

subject. This approach also requires a commitment to the idea that an adequate knowledge of social behaviour in a given context can be grasped when a researcher has understood the social world in which young adults live.

The context is one of the frameworks that must be considered as part of the process of describing the social world of the youth. Young adults in Bahir Dar are obviously able to develop forms of acquiring and assimilating social reality that provide them with many facets of sensory, aesthetic, emotional, interactive and communicative experience. However, we have to be aware that these adults develop their individuality in a social context that is insecure, unstable, and hardly accountable.

Only a few of today's young adults in Bahir Dar live in material wealth. These are able to realize many of their desires in the consumption and leisure field, desires that their parents could never have realized. Some of those adults are living their life on an independent economic basis.

Even though many of them are unemployed, young adults in the *kebele* are usually busy with 'business' (work). They are usually occupied with income generating activities in formal and informal sectors. They may engage in different building construction projects, car repair, bicycle repair and rent, 'illegal' economic activities, informal economic sectors and what not in order to earn some amount of money. In contrast to the past, young adults of both sexes do not belittle any type of 'business.' Nowadays, a man wins the respect of his peers and others not due to his being human but due to the amount of money he has, which is seen to give access to most things desirable. Similarly, it may prevent one from being knocked out of the 'sexual game.' This holds true for those who are employed.

A number of young people of both sexes are engaged in selling *tella*, *areke*, bread, eggs and other edible substances. Some young adults, esp daily labourers, shoeshine boys and others who belong in low economic categories also engage in petty trade, and other income generating

activities until 10:00 am in the morning and then go to *tella* houses, video rooms and/or *chat* houses respectively. Other young people do have other means of income like gambling, robbing, and so forth. In so doing, the youth manage to eke out a living by leaving no stone unturned to make money.

Due to their busy schedules, most young adults do not have much time for social interaction. When they come across each other, they typically say *aman new*? (Is everything going well?) And then ask each other where they have been until now. When two strangers meet across the road, they check up on each other's clothing, posture and general manner, while each modifies her/his own demeanour, because s/he herself/himself is under consideration. While engaging in a conversation, a board game or a joint task, young adults have close face-to-face interaction, competitive, conflictual, co-operative interactions and so forth. Generally, social interactions or activities may occur through language (using colloquial words or expressions, technical words, argot, and/or others), symbols, gestures, etc. Young people exchange meanings and have a reciprocal effect upon each other's behaviour. Young adults' relationships at the work place include: co-operation, competition, evaluation, conflict, cheating, stealing, mutual compassion, envy, pimping, persuasion, sanction, discussion, gossiping, respect or admiration, belittling, insulting, boss-subordinate, corrupt relationships (esp among assistant mechanics who use the term *ye-ayer,* meaning earning some amount of money by cheating both the owner of an automobile and that of spare parts) and others.

Within the same continuum, one may find differences among boys and among girls, and between boys and girls in terms of many characteristics such as leisure activities, social activities, style of clothing, sports, etc. in their daily life. Unlike the majority of the youth, some of them pass their time in the library, at home or away from risk-prone areas. A few of them engage in activities such as reading the Bible, writing poems, playing table tennis or billiards, or BINGO game, go out for recreation and appreciate nature, reading fiction books in Amharic and in English,

newspapers & magazines at public parks, and so on. In the evening, young adults of both sexes usually go out for walks along bright and asphalted roads. Many also visit *chat* houses and chew *chat*, smoke cigarettes and then go out for other aspects of entertainment.

2.3. Lifestyle and Entertainment

This section has two parts - lifestyle and entertainment. There are various influences on young people's way of life like video rooms, *chat* houses, etc. and influences on peers. In his capacity as a *ye-kebelew nechi bere,* meaning *kebele's* white ox *(*known by the majority of residents), a 28-year-old male adult produced such discourses from his thinking universe, which went as follows:

> Young people get socialized by video rooms, or TV programs. They imitate what they have watched in the videos and TV, but they are not in a position to be 'innovators.' The best examples are films whose characters are imitated by young people. Today, they earn a certain amount of money, chew *chat*, smoke cigarette and/or hashish, play Titanic card games; where they use words like *kezerawen, meaning* K, *shinikit wegeb, meaning* waist kept in good condition or kept fit (8), etc. and so on. Thus, they become 'slaves to their addictions.' Overall, their morals become churned up by educational and other policies, and by globalization, because there is no proper socialization and follow-up by the community. The community is responsible for the youth's morality to be churned up, because residents open *chat* houses, bars/hotels, night-clubs and what have you for the sake of making money or making their livelihood. Hence, the youth do not go to a library. If you ask me the why question, then it is because there are one hundred and one attractive and deceptive entertainment places a few footsteps from one's residence. Finally, the youth have no creativity, no vision, live in their own repetitive worlds - they are hopeless.

The narratives of a female case informant who resides in the same *kebele* also substantiate the foregoing discourse. The 26- year-old young dweller has this to say:

> The youth lead those life-styles because of unemployment. The government should do something like training in some skills or professions and should create job opportunity or help them create their own job opportunities (crying 30 times about AIDS is a futile policy). In addition, the community engages in the businesses such as the residents start *chat* houses, video houses, bars/hotels, night-clubs and what have you for the sake of money; as the government gives the licences and, in turn, collects taxes. On the one hand the government and the community are crying now and then that every one must combat the lethal pandemic, but on the other (hand) the former helps the latter contribute to the existence and continuity of these locales. Thus, both actions contradict each other, and also create favourable social conditions for the transmission of AIDS.

To the farsightedness of two of my key educators, the youth are not innovative, but they simply 'ape' the styles which they have watched on video shows and/or on TV and seen from other

people. Hence, the youth practice what they have observed in 'the fabricated and mystified world.' This expression could be illuminated by Rached Ghannouchi's discourses (cited in Burgat & Dowell 1993: 63). He has this to say:

> Our problem is that we have to deal with the West from a position of both psychological and material weakness. Excessively admiring it and paralyzed by our inferiority complex, we tried even harder to ape it and to take whatever it had to offer in every domain. Better, we took what was of little interest to us and we let go what we needed more. But, I maintained that... America or Europe did not need to renounce its values to grab from Africa or Asia or Latin America. **Why** should we be the only ones to taste the good things of modernity through the obligatory trickery of Descartes or Marx or what have you. To tell the truth, the only way to accede to modernity is by our own path that which has been traced for us by our history, civilization and religion.

In what follows, let me state an example of how youth also influence each other. David, a 29-year-old adult, a Christian, and a Civil Engineer who was one of my case informants stated:

> A male or a female does have one's idea of making himself or herself attractive. Such muffled feelings are reflected in and expressed to others by their clothing styles, hair- styles, hair-dyes, ear- rings, shaved eyelashes, specks of antimony dust on eyelids, nostril-rings, lipsticks, tattooed gums, golden teeth, make- ups, necklaces, bracelets, tinted fingers, anklets, tinted toes and shoe types. By so doing, young adults of both sexes influence each other or one another. Such endeavours may have implicit objectives for engaging in a good marriage or achieving positive state. Here we should keep in mind that an individual who appears in very nice clothing and who has direction may influence a person who is walking without any purpose in social life. Hence, clothing styles and what have you do have power and strongly affect young people who are not authenticated and developed intellectually. Thus, young people in the town are carrying out those actions without aim. In general, all these are inherent in each human being, which are manifested in her/his clothing styles, words or speech, movement or gait, the way of greeting people, of looking at others, of walking and what have you. However, all these are based on the imagination of the youth who have no well-established sense of dealing with the world.

Young male adults also wore necklaces around their neck, "borrow and wear ear pendants on their ear lobe(s)," according to Kidan, who is a 10th grade pupil at a high school. She said, "Oh, it is very interesting! I fall in love with such a male adult." In contrast, Aster argued that young male adults' clothing styles were awful. When two ladies observed a young male adult who had hair style like a lady's - curly hair, parted and tied by a plastic a string at the back - they said that they could not distinguish who was male and who was not. They strongly opposed such nonverbal behaviour of male adults.

Young female adults, on the other hand, appear in long dresses or miniskirts, in hats, apply lipstick and other cosmetics; put on ear-rings, and nose-rings; shave their eyebrows and line them with a black 'pencil,' and put a ring on their index fingers in order to implicitly indicate that they are in need of identification with or in a position to establish friendship with the opposite sex. Certain young ladies also try to catch males' attention by putting cloth waist-bands around their heads, which is traditionally put around one's waist. In so doing, they make a lot of effort to appear 'beautiful.'

While conducting an interview with a 21- year- old, 11th grade pupil of a high school and a shopkeeper in an Electronic Shop, I learned that the youth use certain fashion clothes, gait while walking along the road, and gestures in order to attract opposite sex. Zehara, who is a 24-year-old Muslim lady, and who is working in a government office on a fixed-term contract has to say the following regarding young female adults' general appearance:

> In the town, young ladies appear in very tight clothes which show their reproductive organs and in styles that might attract pedestrians (in their viewpoint). It is analogous to 'a rose plant, which is not hedged by thorns, and gets plucked by pedestrians.

Young adults also resort to various places at entertainment, some of which put them at risk. The following statement by a male focus group discussant, whose age is twenty-two, who graduated from secondary high school, works in private construction company, and who lives with his parents could be a good example of a stepping-stone on the path to chewing *chat,* drinking alcoholic liquors, etc. as sorts of entertainment. He narrates:

> If I want to read a book or to do something at home, then I am unable to do them, as the neighbourhoods sell *areke*, tea, and local beer, and thus there are music and noise. In addition, there are a number of youth whose parents are going about such businesses in the *kebele. I*n order to 'run away' from these conditions they go out a lot to chewing *chat*, drinking, etc. Hence, one of the young adults may come across 'healthy' or drunken persons, and then they go to *chat* house(s) or drinking house(s) or other 'evil places.' Thus, the young adult becomes subject to one addiction or another. Here we should bear in mind that different types of drinks may be on sale until midnight in his house. If he is a pupil then he is not in a position to pursue his lessons, because he comes from school and puts his exercise books and goes out; comes home late at night. Accordingly, most of the youth are cited as bad behaved ones in our *kebele*.

Another important activity that the youth have come to increasingly engage in is *chat* chewing which can influence them to engage in drinking strong beverages and in unprotected sexual intercourses with commercial sex workers and/or young ladies. In the words of a 26-year- old 'cultural broker':

Chat plays an important role on the youth's behaviour. They usually chew the drug, drink alcoholic beverages, get intoxicated, forget the 'protective value of condom,' (even if we have it in our pocket, and if we have our girlfriends somewhere), 'engage in' sexual intercourse with so-and-so. In the town, there are *nef*, many night school pupils who could 'lend their body for satisfaction.' To this end, we offer them *chat* (have puffed up our mouth with it, *meweter*) in a dormitory, and then we go ahead with our 'business.'

A 25-year-old 'cultural broker' around 'red spot areas' also teaches me enthusiastically with a laugh as follows:

Nowadays, young adults walk and are driven by the power of *chat* or their source of power of movement is undoubtedly *chat*. On such occasions, we feel like one could raise and discuss any issue we would like, and we could perform what we want to do (Oh, how could I tell you?). *Chat* is taken as one big 'culture' among young adults. This is because the youth are being 'vaccinated' by *chat* addiction! If there is a lady who does not chew *chat*, her friend encourages and trains her by convincing her to chew at least two leaves of *chat* (Here comes 'deviance by association,' because the girl has a *chat* addicted intimate friend). For example, if you say by mistake to a young girl you would like to offer *chat*, and then she says ok without hesitation. We are then likely to end up playing a 'game' of all sorts during our stay on the ' mattress and bed sheet.' In contrast, without *chat* we may be talking years without anything coming from it. Oh, a futile 'mental gymnastic.' Generally most youth pass their leisure by chewing *chat* and/or by playing card game, or with their girlfriends (which is also 'game'), and what have you.

Describing the intensity of *chat* use and associated sentiments, a 26-year-*old* BA degree holder educator narrates:

Most of the youth (75 per cent) usually pass their leisure or dawdle away their ample time in *chat* houses, at local breweries, in video rooms and other gambling or ordinary places. Day after day, even though they face economic problems, young adults are chewing 50 grams of *chat* or more, smoking cigarettes, and are playing card games. In addition, we raise certain 'empty hopes' and discuss about different means to leave for abroad and how to take out certain 'beautiful ladies' (although beauty is in the eyes of the beholder and our eyes are also easily deceived sense organs), how to get money and so on (There is no such a chat high up in the sky or in the heaven). In such conversations, we use certain colloquial expressions or argot.

Furthermore, some youth also smoke *atefaris* (hashish) at a famous *chat house*. *A*lthough they smoke it in secret, one could smell it at a distance. In this 'miniworld,' (small *chat* chewing room*)* there are good quality drugs, a complete CD-player, and several types of favourite or

classical music or 'mighty' music. Thus, one of the discussants goes on telling me that he finds very difficult to express the scenery in 'the earthly heaven' at the moment of the coincidence between *chat* intoxication and the music on the player.

After a session of chewing *chat*, they simply go out to drink local beverages and/or manufactured alcoholic drinks, depending on the amount of money in their pocket. They colloquially call it *merkana mesber* (literally, 'breaking one's intoxication') or *chabsi*. In the words of the degree holder:

> It is like something that comes next to something else. This can be analogically related to a person who goes to a big restaurant to have food. Before one eats 'hard food' like *doro aresto* or other food, he has to take soup or bouillon. Some youth call it *chabsi*. Here they underline that after they have chewed *chat*, they usually drink alcoholic beverages in order to 'break the intoxication.' All these happen either at local breweries or at night-clubs or bars/hotels.

The have nots drink seven or eight *tassa* or gublets of *tella* or *tej (*local brew) or cups of *areke* (local distilled liquor) and go to the pigeons' locales (where one finds young girls in glittering appearance such as night-clubs, and bars/hotels), entertain and disturb the haves who entertain themselves in night-clubs. In order to take part in the 'glittering locales of the night-pigeons,' one has to obtain money by hook or by crook. Some young male adults may obtain it from their families (if their parents are well-to-dos). Unfortunately, the poor ones may engage in petty crimes or in criminal activities like stealing, cheating, and engaging in gangsters' activities. Others may even sell their personal properties. The most unfortunate ones also stand around *chat* houses and ask politely for money from those who appear to be the haves – what they call *kefela*, to mean attempts to cajole the haves to give them money.

Having passed the rite of passage of acquiring money, one encounters the 'night-pigeons' (the young girls in glittering appearance) who are aged between 15 and 20 years, in night-clubs or bars/hotels. In the words of the 26-year-old BA degree holder informant:

Most of the time, if there is a 'beautiful pigeon,' then a young adult usually comes to the locale to dance, drink, and to entertain himself at least by looking at the catch-symbols, swaying gait and at her buttocks. Moreover, if the participants are human beings and their eyes get caught by her gait and/or her body and *asheka* (literally, act of decorating oneself) then the former may generate an 'electricity' between their laps and may covet her in order to provide care for the 'catch-symbols.' In so doing, they bargain with the pigeons' about implicit 'price,' and then 'purchase' the latter. Next, these 'care providers' may quarrel with the pigeons' about their condom use, various styles of sex, payment and the like. Here, we should bear in mind that the standard of night-clubs or hotels determines the 'price' of the pigeons in the town.

In the night-clubs participants are seen dancing, massaging or kneading and hugging each other, without mentioning the lethal disease. If a male desires a girl he invites her to have a drink and to dance with him. They do not talk about their living conditions. Such talk brings about loss of one's intoxication, *merkana yabeketal*.

Generally, the use of condoms at the locales is influenced by the amount of alcoholic beverage consumed, and/or that of money one could pay to the 'catch-pigeon' or to the self- employed commercial sex worker. Surprisingly, if one is a regular 'nurse' to the dove or has 'given care to her' for two or three days then the next day she may not require the use of condom - 'everything is possible by financial power.' On the average, according to the above-mentioned degree holder key informant, 25 per cent of the pigeons do not care whether their care providers use condoms or not (*bemelataw)*. Both sexes also may have 'the socks' (condoms) in their pockets and/or purses, according to most of my instructors in the field. Most of the 'pigeons' (self-employed commercial sex worker in night-clubs) they observe have adopted the use of condoms as their 'subculture' even if they get intoxicated. In the morning, when they get up, they have *makezekezha* (literally, coolants such as *tella* - the *korefe tella* or t*eray tella*). For the haves, cold beer and/or juice are their *makeseya* (literally, their 'cooler' or their 'refrigerator').

When young adults get intoxicated with such drinks, it is common to quarrel with one another in groups about ladies or about some other reasons at such locales. A 25-year-old key-informant who works as time keeper in a private construction company and a key actor at a *chat* house expresses the patterns of conflict and reconciliation as a fashion among young male adults by

saying *wend lej ena akomada sitaser ena sifeta newe* (literally, a young male adult and a leather pouch have been tied and untied for years).

In contrast, some young adults who do not run short of money ('whose pockets are not bald') may take boat trips with beloved ones on Lake Tana to visit historical sites. Some of them usually go to public parks on weekends. At Mango Park, for instance, young adults of opposite sex sit at the shore of Lake Tana*;* drink alcoholic beverages like *Dashin* beer and/or draft and engage in sexual 'games' (various styles of sex) under the cover of darkness. There are also a few public parks, where ladies are officially waitresses but through intensive interactions with them one finds that they are 'underground commercial sex workers' (but they live with their parents) and ask money for 'sexual services' in order not to be knocked out of the 'money making game or the peer competitive game.' This also holds true at certain *chat* houses.

Some high school students skip school to go to parks for sexual encounters, coming up with explanations for going home late. In relation to these entertainment places, a young male, who is a 25-year-old key-informant argued,

The chairman of the *kebele* has to close 'evil sites' in order to dry up the impulse to have sexual relations. Young adults should not go to these sites. In contrast, young adults should stay at their homes and watch TV Programs, and drink only one tin of *tella.*

A drama show at the Theatre Hall demonstrates that some mothers give protection for their children's misdeeds or deviant behaviour, 'the children being uterus of mother.' This holds true for very few fathers in the locality. Generally, however, the young adults do not pay attention to their parents' advice as to what is desirable, good, and important. The youth are thus living in 'risky contexts,' which may be a stepping-stone on the path to acquire HIV.

On the whole, the routine leisure activities of most of the young adults are: chewing *chat,* drinking local beverages, or manufactured drinks - and going to night-clubs and engaging in

dancing, massaging, hugging, kissing and in sexual intercourses which may put them at HIV risk, depending on the amount of money in their pocket. Next the author presents data on social relations, including gender relations.

2.4. Social Relations

Anthropologists study human behaviour in terms of persons acting in culturally defined situations and in systems of social relationships. There is a chain of social actions and interactions, which can be through social contacts that again can be various types.

Young adults engage in different types of social relationships, including familial interaction, interaction between seniors and juniors, sibling relations, very close and intimate friendships, and situational interactions. Their social interactions can occur in the context of entertainment, religious events, educational activities, the work environment, marketing or business activities, lending and borrowing transactions, etc.

Generally, one may find the following relations with parents: neglect, dependence and lack of autonomy, and harmonious and conflicting relations. In reference to neglectful relations, a 22-year-old construction worker has said:

> When the youth go out they do not learn good things. They mostly see, hear and do bad things. This is because their fathers or mothers give attention mostly to their own business (es). There are few families who ask where their children have been till then.

Concerning dependence and lack of autonomy in their relations with families, Tewodros' living conditions muddy the waters, as illustrated below:

> I am a 26- year- old single young adult, an economist, and live with my parents. Because of my addiction to *chat*, cigarette and liquors, I contribute meagre amount of money monthly. If I don't lend my parents a helping hand with 'business,' then they force me to leave the house. Oh, how a horrible and monotonous social life it is!

Unlike the aforementioned relations, Aster's relations with her peers can be an instance of harmony. She said, "I have intimate friendships with my peers." Aster's relations with parents and other family members, and with her kin can also be an illustrative example of harmonious and conflicting relations:

I was born in Gondar before 21 years ago and dropped out of junior secondary school three years ago. Presently, I am self-employed as an amateur musician and live with my elderly sister in the *kebele*. I had very nice relationship with my father. On the other hand, I had complete disagreement with my mother although I have a very nice and warm relationship with other members of the family. We have weekly meetings to discuss some issues about the well-being of the household. The same holds true more or less for my father's relatives.

As to the youth's relations with the community, the majority did not pay due attention to such relations. For example, *Kokebe*'s experiences can be an example of loose relations. She stated,

I came to this world more than two decades ago. Although I enrolled at different levels of schooling, I became a school drop-out at 8th grade. As I am from a poor family and become influenced by my friend, I joined the commercial sex business. I have relations with a few members of the community in terms of some affairs/matters like exchanging greetings, and work relations. For instance, when the residents came to work place, I had close relations with them during drinking alcoholic beverages and dancing and other affairs. Apart from these, nothing relates us. In addition, I really hate my neighbours because they are backbiters and envious people. Therefore, I don't pay attention to what they and others say. Succinctly, I usually ponder over my routines of daily life. Generally, I have baggy relations with community.

Gender relations are important to my research under consideration. The social and cultural position of women and the context of the relationship between men and women are crucial variables in understanding the way in which AIDS has developed in the setting. According to WHO and others (1995: 7), gender refers to widely shared ideas and expectations (norms) about women and men: ideas about 'typically' feminine and masculine characteristics and abilities and expectations about how women and men should behave in various situations. These ideas and expectations are learned from families, friends, opinion leaders, religious and cultural

institutions, schools, the work place and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

By the 1980s, the gap in anthropologists' knowledge about sexual behaviour became most pressing. Continued attention to gender relations and a focus on STDs, especially AIDS, led anthropologists to ask new questions. Many research projects began to explore the cultural or social construction of sexual practices relevant to disease transmission (Vicinus 1982: 880). In relation to AIDS, an understanding of sexual activity as socially constructed has thus refocused attention to... social persons integrated within the context (Gagnon & Parker 1995: 11). It is necessary to unpack gender relations and to locate women and men in the social relations (the interactions of both sexes and of different types of men and types of women in the context).

Although the distinction between male and female is one common to all male and female human cultures, the cultural attributes assigned to the masculine and the feminine, and the importance attached to these differences, all vary from culture to culture. Various scholars of gender relations have come up with two quite different line of argument in the 1970s. One maintained that neither female oppression nor exclusive male power was universal, while the other grew out of an assumption of universal male dominance and female subordination.

The use of the concept of gender to some extent freed the discussion of difference and inequality from biological referents. It was argued that it couldn't be assumed that all cultures represent difference in the same ways, or give sexual difference the same emphasis**.**

A social theory of gender is implied and required by current 'sexual politics.' Two main types of theory have emerged regarding gender relations - one emphasizing attitudes and social expectations, and the other presupposing the categories of 'women' and 'men' and focusing on power relations.

Some accounts of gender relations have emphasized the social construction of the categories of gender in terms of the work of Mead (1950), and Parsons (1953: 22-26). They synthesized

the field around the theme of custom and reciprocity. Mead and Parsons view gender relations as a social script, which people learn and enact. This perspective gives full weight to the social character of gender, especially the 'stereotyped' expectations. In role theory, the expectations reward one's conformity to the stereotypes and punish non-conformity, as *David* believed, "Boys are praised for being aggressive, and masculine but ridiculed for being girlish." Role theory thus assumes that customs are manifested in people's behaviour.

The theory on power takes men and women as already constituted categories, and focuses on the relations of power and of exploitation between them - 'sexual politics.' Its intellectual sources are Simone de Beauvior, Michael Foucault and so on.

Analysis of power can be a starting point for the theory of gender relations. Beauvior crystallized a number of important ideas of men and women for most purposes as already-constituted categories and she focused on power relations and exploitation between them - spoke of 'sexual politics,' 'oppression' and 'patriarchy.' She emphasized the social construction of the categories of gender, the ways they are learned, inhabited, and transmitted, and Beauvior treated it around the theme of the subordination of women. For her (1976: vii), since patriarchal times women have generally been forced to occupy a secondary place in the world in relation to men (i.e., the second sex), a position not imposed of necessity by a natural 'feminine' characteristics but rather than by strong environmental factors of educational and social tradition under the purposeful control of men. This has resulted in vitiating effect on the sexual relations between men and women.

David's words demonstrated that women are understood to be made of the same stuff as men, and also different, both more and less than men. He said, "Women must occupy a subordinate position in the world in relation to men. If I were the King or the President or the Prime

Minister of Ethiopia, for example, I would not install a female minister. In addition, I am not under the control of my wife because my mother has been teaching me not to become so."

Similarly, Foucault synthesized power relations around the theme of the 'modernization of power.' Michael Foucault (1980b) states that power is everywhere, not because it embraces everything, but because it comes from everywhere. Based on the modernization of power, Foucault (1979: 138) ensures the production of 'docile bodies' through self-surveillance to explore the ways in which women discipline their bodies in pursuit of ideal femininity (and the feminine body-subject) is constructed. By so doing, females produce a 'practised and subjected body, docile bodies.' Females' bodies are subjected in the sense that they are dominated and made productive and useful. This is achieved by a form of surveillance (which encourages them to watch themselves because they imagine themselves being observed by others).

An illustrative example of such surveillance is that of Yodit, the 26 years old female case informant. She stated:

> A woman's face must be made up - lips, noses, eyebrows, eyelashes, and etc. must be made 'catch-symbols' by caking lipstick, putting in golden ornaments and doing different styles of make-up. The woman whose mirror checks her make-up half a dozen times a day to see if her make-up has caked, who worries that such-and-such's may happen - a self policing subject, a self committed to a relentless self-surveillance. Such an action is a form of obedience to patriarchy. The surveillance is also the reflection in woman's consciousness of the fact that she is under surveillance in ways that she is importantly a body designed to please or to excite.

Discussions with men and women indicated that there is male dominance or female submissiveness in gendered relations among young adults. Kidan added,

> A young adult, like any man, is expected to be independent and dominant in any social relationship with women. There is male aggression against women because of the expectations that males should be tough, brave, aggressive, to quarrel, fight, or beat wives frequently on the one hand, and on the other hand that are characterized by accomplishment, leadership, responsibility to be head and financial provider of the households, etc.

Males according to the females in my research are all alike. They are naturally more aggressive, with no control, they do what they want to do, they think only about sex and want to take advantage of women, they are more suited to heavy work and the like. On the other hand, Zehara argued, "Females are characterized by gentleness, weakness, dependence, emotionality, responsibility for taking care of the house, and so on." Most of the girls seemed to agree that women should be polite, gentle, and well- mannered in every way.

The 25 years old 'cultural broker' has this to say about sexual relations:

> When choosing a boyfriend, girls use implicit criteria such as being a 'businessman,' being steady, honest, serious, having work, whether he drinks, smokes, chews or not, his general appearance, and what have you. The majority think that man must take the initiative for sex. A man always has to 'conquer,' or to 'besiege.'

In general, men are dominant and women are defined as submissive. This is due to shared ideas and expectations about men and women in the community. Zehara said,

> In the setting, daughters are socialized to stay home, to do household chores, to take care of their brothers and sisters, to participate in the community much less than sons, and what have you. The notion that good women should also be equipped with culinary skills, speak pleasant words, and be cautious in all manners was reinforced. Being born as a woman, one should realize that and behave as a woman. One should be conscious of her feminine characteristics.

Other aspects of power issues in gender relations are male aggression/violence and female vulnerability, and lack of female autonomy or inability to make decisions. A few young people regard pornography as an expression of the violence in male sexuality and a means of domination of women. Some young boys see rape as an act of patriarchal violence rather than sexual desire. One of my informants who was a well-off women in her 30's cited example of male aggression/violence and female vulnerability. She stated:

> In the setting, school attendance by girls is risky. There was a reported rape case of a young female by young male adults while she was coming along from a high school late in the evening. There has not been a drastic change in the reported rape patterns since that incident. In the community, a few young people have been accused of the act, usually, school drop-outs, or high school graduates - marginal, unmarried adults who are unemployed and who lack parental control.

Young ladies are not protected from sexual violence even along the road, in the *kebele*, or school or other places. Young female adults revealed anger, fear and vulnerability during in-depth and semi-structured interviews, and during focus group discussions. A 22-year-old focus group discussant had this to say:

> The *chat* chewer may come across a lady who has been sent by her family or parent(s) somewhere while he is on his way to a local brewery or night-club and what have you. He seizes her by force and has sexual relations with her. Following this, the lady gives up her hopes due to the forced relations she had at an unexpected place and time. Such an unfortunate occasion may pave the way towards prostitution.

Kokebe's narrative also demonstrates the same point:

> The young male adults in the *kebele* are very bad, because they have sexual relations with us, including me by force. For instance, I lost my virginity to a minishop keeper; I become a school drop-out at 8 th grade. As I am from a poor family and become influenced by my friend, I joined the commercial sex business. I usually have protected sex with 'multiple business partners' and with my boyfriend.

The following is an eyewitness narrative of a sexually violent episode in the locality:

> Once, I witnessed three young male adults carrying a lady to the dormitory. On the way, she cried and pedestrians asked them what was the matter with her? They responded that she got sick and they were taking her to the holy water. Afterwards, they were playing sexual checkers. \

Since our high school time, some male teachers have been known to be a hindrance to girls' education because of their lecherous activities. Regarding male power, a 28 -year-old key informant mentions that some teachers give high grades in exchange for sexual relations with female students. He added, "Both teachers and students have sexual relations with female students, chew *chat*, smoke cigarettes, play card games, have a game of billiards together, and other activities in their social life.

A case informant gave the example of a young woman, Chuchu as an illustration of female vulnerability.

Chuchu was born in this town 20 years ago. She lives with her beloved, but divorced mother. Unfortunately, Chuchu withdrew from 8th grade, and continued her schooling in the night-school program. However, her education was interrupted when she left for Djibouti. ...then she came back with a lot of money. She is madly in love with a young adult at a village. Hence, she and her friend were having sexual relations, chewing *chat,* drinking alcoholic drinks, dancing at night-clubs and passing the night there, and what not. In the end, she becomes addicted to the drug, cigarette, alcohol, etc. Surprisingly, her boyfriend went, to the war front without saying goodbye! Currently, she is addicted to the drug, cigarette, and alcoholic drinks and could not give them up!

As to lack of female autonomy or inability to make decisions, Aster's case provides an illustrative example:

She has a beloved boyfriend who 'has taken' her virginity. Even though she knows that he sometimes has sexual relations with others, she has relations with him without a condom - 'Oh, it is love! Which make me blind; what can I do?' She said, 'She could not tolerate the unpleasant odours of multiple partners.' She further dreams of becoming a famous musician and earning a lot of money in order to live in luxury with him.

However, male adults talked about such issues and considered as entertainment, according to the two focus discussants' words (22 years old construction worker and 20 years old student of Bahir Dar University). To my mind, all these discourses have implications of sex role theory and power relations in Bahir Dar.

There are also changes in gender relations. The changes in the conditions of life due to overall societal and economic changes have made the taking over of the adult role difficult. They have led to increased stress and tension for many young people. A 27-year-old young female Orthodox Christian key informant noted one of the changes as such - women being more forceful and the material basis for relationships. She argued,

The fact that a man had to take the initiative for love affairs and sex, a woman being ashamed to take the first move, has changed. The converse holds true. In the past, there was love among one another. Nowadays, however, young adults of both sexes established friendships in terms of benefit - due to our economic problem or our poverty, so to speak.

Finally, girls did not use to allow boys to 'caress' them in public in the past. However, presently, they are hugging, kissing and taking photographs and performing deviant acts in public, and at times along the roads or at public parks in the dark.

In summary, the social context is characterized by use of sociolingustically significant colloquial words or expressions, slang words, technical terms and/or argot, risk behavior, vulnerability, male dominance and female submissiveness. The social context is one of the frameworks that must be considered as part of the process of describing the attitudes and behavior. Participant observation in the setting gives the researcher the best chance of assessing the meanings behind verbal and nonverbal behaviors. All or most interaction activities occur differently in different social situations. The argument is that ongoing social contexts are the resources employed in daily life to see, discover, and know meanings. Interacting individuals, who must first interpret what is going on from the social context in which these events occur, confer social meanings (which direct human behavior) upon social events. Such events include: communicating with others using whatever colloquial words or expressions, slang words, technical words, argot and/or others young adults have at hand to 'get through day-to-day life' in different locales and/or situations. They use these features of language to be different, to be picturesque, to escape from clichés, to induce intimacy, to show that one belongs, exclude others, to be secret, for ease of social interaction and so forth. The daily routines of young adults' conversations are full of sociolingustically significant colloquial words or expressions, slang words, technical words, and/or argot.

There are various influences on young people's way of life like video rooms, *chat* houses, etc. and influences on peers. The youth visit to video rooms and simply imitate the styles which they have watched on video shows and/or TV and seen from other people. Hence, the youth practice what they have observed in the world which surrounds them. Young adults also resort to various places of entertainment. Many young people of both sexes visit *chat* houses

and chew *chat,* smoke cigarettes and/or hashish and then go out for other aspects of entertainment. These can influence them to engage in high-risk activities which may put them at risk of HIV infection such as they drink local and/or manufactured alcoholic beverages, get intoxicated in local breweries, night-clubs, and bars/hotels, forget condom use and engage in sexual intercourse with commercial sex workers or 'pigeons' or 'birds.' In addition, the youth do not pay attention to their parents' advice as to what is desirable. Generally, the daily routine lifestyle and entertainment of young adults are high-risk prone behavior.

Gender relations are important to understand the reality of the phenomenon of HIV/AIDS transmission. The social position of women and the context of the relationship between men and women are crucial variables in understanding HIV/AIDS in the setting. The attitudes and 'stereotyped' expectations assigned to the masculine and the feminine in the setting result in male dominance and female submissiveness. Males are praised for being aggressive, expected to be tough, brave, to quarrel, fight, or beat wives frequently that are characterized by accomplishment, leadership, responsibility to be head and financial provider of the households. On the other hand, females are characterized by gentleness, weakness, dependence, emotionality, responsibility for taking care of the house and so on. Women should be polite, gentle, and well-mannered in every way. Therefore, men are socially or culturally dominant and women are defined as submissive. The chapter has shown that the social context of youth life as characterized by risk behavior, vulnerability male dominance and female submissiveness.

CHAPTER THREE

CONCEPTIONS OF AIDS

3.1. Introduction

This chapter attempts to provide insight into the different theoretical and descriptive concepts, which are used by young adults to conceptualize AIDS. The organizing framework of the chapter is scientific versus 'folk' conceptions. In medical science, unlike folk/metaphorical conceptions, disease reflects biology more than culture (Ackerknecht 1971: 151). Many societies, however, do not conceive diseases by their biological properties at all. Even in 'rationalized societies,' societal reactions may reflect conditions of society more than they do the biological attributes of disease. Indeed, some scholars therefore conclude that physical pathology exists only if a condition is socio-culturally conceived as a disease and that disease has no reality apart from socio-cultural context. In attempts to describe how the youth conceive the disease, the author has organized their conceptions of AIDS under two themes - scientific conceptions of AIDS and 'folk' conceptions of AIDS. One mode of conceptualizing the socio-cultural conceptions of HIV/AIDS is the considerations of young adults' awareness of the nature of AIDS in light of Arthur Kleinman's theoretical concepts. Other forms of the conceptions of AIDS require looking into their narratives using descriptive concepts such as folk/metaphorical conceptions of AIDS. These include moral, social, and behavioral/individualized conceptions of AIDS. In so doing, I am mainly going to use a narrative perspective.

The following sections narrate young adults' socio-cultural conceptions of HIV/AIDS. The first section describes youth's understanding of objective characteristics of AIDS. The next part will examine their conceptions of and metaphors for AIDS. Generally, it is also shown that AIDS is presented as a complex and multidimensional phenomenon which requires use of narratives to understand this.

3.2. Theoretical Considerations

In recent years, a narrative approach has taken root in the social sciences. This trend recognizes that the important human phenomena are not strictly speaking natural events like the movements

of clouds, but that they are personal, social, cultural, and historical events (Kugelmann 1997: 254). Individuals can and do talk about the important events in their lives, reflect upon them, act upon their understandings, and so forth. We make and tell stories of our lives and this is of fundamental importance (Mattingly 1994: 811). Through narrative, we try to make sense of how things have come to pass and how our actions and the actions of others have helped shape our history. In narratives, the representation and interpretation of experience is guided and shaped by shared socio-cultural understandings, and narratives therefore transcend particular histories and life circumstances and become representative life circumstances and become representations of shared socio-cultural models. Thus, narratives are interpretive devices which give meaning to the present in terms of location in an ordered sequence - they enable us to see the present as part of a set of relationships involving a constituted past and an anticipated future (Brumer 1986: 139).

There has been an intensified interest in narrative as a mode of thinking. Narrative theory has been increasingly utilized to study the subjective experience of illness (Kleinman 1988: 49-50; Mattingly 1994: 811; Hassin 1994: 391; Frank 1995: 115). Significant treat whenever it occurs in life gets woven into narratives that reflect and influence how people explain, treat and make sense of their lives, their worlds and others. Medical anthropologists have made significant contributions to the narrative approach to chronic illness. Thus, what people are actually articulating when they associate AIDS with something else is a narrative about order, disorder and respect for existing rules and values of the community. The narratives should be seen as part of an active constructive process in which people develop a shared understanding of AIDS. When talking about AIDS, young adults associate it with 'evil,' or something bad. A close investigation shows that this association is not the result of categorical thinking, but rather of narrative logic. Although through education, a certain understanding of AIDS is communicated (usually the narratives of the 'North'), elsewhere in the world, people have chosen other alternatives. Paul Farmer (1992: 11; 1994: 801) provides an example of how

rural Haitians have chosen to see AIDS as a disease caused by witchcraft, i.e., they give meaning to AIDS through a narrative of witchcraft, or 'a narrative of accusation.' Such alternative narratives of AIDS should be seen as part of an active constructive process in which they develop a shared understanding. Generally, the researcher will use narratives to conceptualize young adults' socio-cultural conceptions of HIV/AIDS.

3.3. Awareness of the Nature of AIDS

The section considers the narratives that express young people's understanding of AIDS. This section has two parts - awareness of the nature and transmission of AIDS, and conceptions of 'how.'

A common belief about AIDS in Bahir Dar is that the disease does exist. Almost all informants and discussants no longer doubted the existence of AIDS but one female case informant. *Aster* had not believed in the existence of AIDS until I met her and took my time to conduct the research.

The other problem is that some young adults are in a dilemma. According to the words of a 22-year-old focus group discussant,

> Many people usually talk about people with HIV/AIDS, but we only see two or three of these people living with AIDS in public in Bahir Dar. Moreover, we observe that the so-called educated persons are carrying out risk-prone activities at places of entertainment. Thus, we are inclined not to believe in the existence of AIDS.

Most young adults in the study believe that AIDS results primarily from promiscuity or having many sexual partners, from punishment by God, from prostitution, from homosexual practices, and from sexual or other contact with animals that have the disease. Most frequently mentioned by informants and discussants were sinners (persons who do sinful deeds such as violating God's

words with respect to sexual union) as causal agents. When asked especially about the types of people who might acquire HIV, informants and focus group discussants responded that those persons who have unprotected sex with one partner or with multiple partners, who give great value to sex, or who have positive attitudes to sex, are careless in their social life, have sexual relations before they get married, have sex with CSWs, lack creative power, are ignorant of modes of transmission, and young female students who consider themselves as `decent' and share menstrual clothes and pants with intimate friends.

Based on scientific facts about AIDS, young people of both sexes had the following narratives. Unprotected heterosexual intercourse was identified by all informants and discussants as the main mode of HIV transmission, followed by the use of contaminated needles, razor blades, knives and so on. HIV is passed from an infected person to an uninfected person through the body fluids of the person with the virus. These include: semen, vaginal secretions, and blood.

As Gluckman (1956: 83-84) has observed, every misfortune involves two questions: how it happened, and why it occurred at all. A common-sense empirical observation answers the 'how' question. In the case of other modes transmission of AIDS, all informants and focus group discussants but *David* seems prepared to accept the mass media campaign proposition that person A can catch the diseases or 'can get fire' from person B through sexual intercourse. However, even scientific explanation cannot fully explain why the disease transmission does not always occur, i.e., does not occur in every case of intercourse between an infected and an uninfected person (Green 1992: 1462). Thus the 'why' or ' why a particular person question' arises.

On the other hand, both informants and focus group discussants do have enough understanding of the long incubation period of HIV, which ranges from one year to more than ten years. However, three female case informants fail to say something about the timing of

onset of symptoms. Yodit's case calls heart-felt attention. She said, "I do not know the timing of onset of symptoms, because my mind has no space to accommodate it. I don't want to talk about and to listen about such matters. If my mind slips into the matter, then I get very frustrated. I usually chew *chat* so that I may not think about it and get frustrated. Then I go out for `business."

The signs of AIDS are different from person to person. They include major and minor ones. The major signs are: (1) the person gets thinner and thinner;(2) S/he has frequent, watery stools, in and off or all the time, for more than one month;(3) S/he feels cold while her or his body feels hot for longer than one month, and (4) S/he feels very weak and tired all the time.

The minor signs are: (1) a bad cough lasting for more than one month; (2) headache and vomiting; (3) dizziness;(4) lack of appetite; (5) itchy skin rashes; (6) thrush or yeast infection in the mouth and throat;(7) swollen glands anywhere in the body, and (8) sores that do not go away with treatment, especially around the genital or buttocks. If a person has two of the major signs and one of the minor ones at the same time, s/he probably has the disease. The researcher asked informants and discussants about signs of AIDS. Almost all of them were able to describe the major and minor symptoms of AIDS. A few know that TB is a particular problem for PLWHA's in the town. Here I share such findings of Dear's research.

AIDS is considered as a severe opportunistic infection and active illness. Persons whose immune systems are compromised by HIV infection are susceptible to other infections and illnesses not caused by directly by HIV. These illnesses are called opportunistic infections. They have been used as the diagnostic criteria of AIDS. David's statements may exemplify scientific conceptions of AIDS.

He believes that HIV causes AIDS (that grotesque and stinking disease). When the infectious virus attacks a person's body, his/her immune system releases white blood cell to fight the infection. The virus inactivates the system and destroys its ability to produce these cells. This condition makes the body helpless against a variety of infectious diseases. The infection does not immediately result in AIDS. After some time, he/she will develop diseases like TB, typhoid and so on.

Regarding appropriate treatment for AIDS, most informants and all focus group discussants believed that the condition has no cure. They said it was possible to consult a doctor for diagnosis and perhaps advice about the disease, even if they believed that doctors could not provide effective treatment. Only two case informants, for example, heard about the presence of very expensive medicine, which could prolong the age of people with AIDS. Also, only five case informants believed that holy water and/or prayer could cure AIDS.

Aster's case is an illustration of such treatment for AIDS. The disease can be cured by holy water. She said so because one young girl at her village won a DV lottery of USA, while testing the girl's blood for HIV/AIDS, it was found to be HIV-positive. In what follows, she went to *Shenkora Yohannes* Church and drank and got baptized by holy water. In the end, she was diagnosed HIV-negative.

Another belief that has been expressed more than once is that AIDS is not considered as a unique and newly created disease. That is, it has been around for long time, but with a different name, *amenmen (*making thin/emaciated which means a person with HIV/AIDS gets thinner and thinner over time).

To reiterate, the research participants were able to correctly state the main modes of transmission and those, which could not transmit the virus (insects, saliva, causal/social contact, sharing eating/drinking utensils and so on), but there was at least a misconception in air. The researcher observed very specific example of knowledge of HIV/AIDS transmission in a multi-purpose mini-room in the *kebele:*

In the room, five young assistant mechanics were drinking *areke*, talking about their young colleague. This person usually has sexual relations either with married women, widowed women or with single ladies without protection ('he does not give value to his life, for he is against 'Hiwot Trust'). He also has anal sexual relations. Those young adults maintained that unprotected anal sexual intercourse could not transmit the virus because HIV is most often passed through unprotected vaginal intercourse.

However, it is argued that the accepted starting point to attitudinal and behavioral change is knowledge. As discussed above, the level of awareness of HIV/AIDS was high among the informants and the focus group discussants. It is a paradox, which creates a space to think in my mind. Finally, I should go beyond youth's scientific understanding of AIDS and consider their thoughts and language in order to understand what they are learning, reading and experiencing have something about their socio-cultural conceptions of HIV/AIDS.

3.4.Socio-Cultural Conceptions of HIV/AIDS

Strauss & Quinn (1997: 6) believe that what something (a word or an event) means to somebody depends on exactly what they are experiencing at the moment and the interpretive framework they bring to the moment as a result of their past experience. To call it a socio-cultural meaning, which also includes cultural/symbolic dimension is to imply that a different interpretation would be evoked in people with different characteristic life experiences.

Concepts, including scientific concepts are mental constructs reflecting a certain point of view and focusing upon certain aspects of phenomena while ignoring others. Thus, the four letters concept (AIDS) expresses the medical condition, which is called disease. Medicine conceives of AIDS or any other disease in terms of pathological and neuro-physiological processes that have natural, emotional - mental and epidemiological aspects. The scientific medical conception is only one framework. According to this conception, disease is a biological phenomenon with natural, internal and external causes over which the individual has little control. As science aims

for universal generalizations, which do not vary by cultures, conceptions of disease vary less between societies where medical science provides the dominant conception of disease (Rushing 1995: 132). In scientific medicine, a recognized disease retains its identity wherever it occurs, regardless of the socio-cultural context so that the scientific taxonomy of disease may serve as a 'trans-cultural reference' for diagnosis of disease (Lieban 1977: 21).

Such a position is not tenable in this extreme form. For example, AIDS has been variously defined as a God-inflicted disease, gay disease, green monkey disease and so forth. Such differences in conceptions do not change the underlying biological reality. Regardless of how the physical state is defined, AIDS consists of a syndrome of physical pathologies deriving from an immune system that has been impaired by HIV. However, a person responds to his/her disease definition rather than just to (and sometimes instead of) the physical aspects of the disease. Thus, those differences are reflected in conceptions of disease. Most socio-cultural conceptions of disease fall in folk and/or metaphorical conceptions.

Throughout history, most people thought that spirits, witches and/or sorcery caused disease. This folk conception is widely prevalent in the world, including Africa (Murdock 1980: 26). In many instances, folk conceptions form the idea of disease as punishment for bad behaviour and the breaking of cultural taboos (Hallowell 1941: 871; Ackerknecht 1979: 16; Murdock 1980:26). Disease is frequently conceived in moral terms. The sick person is considered responsible for being sick, and blaming the victim is typical (Rushing 1995: 132).

Susan Sontag (1978) extended the folk conception with the idea of 'illness as metaphor.' Illness is conceived as an example of its use to indicate social deviance though related in some way(s) to the literal meaning. Disease is conceived as a metaphor for immorality. A sick person is a person shunned for moral or social reasons. More generally, sick people have frequently been (and

continue to be) viewed as morally polluted. Their social worth may be questioned, and they are treated as deviants or despised outcasts.

Moral conceptions of HIV/AIDS are widely prevalent among young adults. Perhaps the most widely hold belief is that AIDS is God's punishment for sinners. In fact, most case informants are more inclined to believe that the disease is a curse from the Almighty God. Kidan has this to say about conceptions of AIDS as punishment:

> Unlike scientific argument, when we see all the symptoms of AIDS and its modes of transmission, it seems that the disease is a curse from our LORD. The Bible tells us that we have to have only one sexual partner and it also forbids premarital sex, however, we violate God's rules. In addition, the disease has no appropriate treatment. All these force as to believe that AIDS must have been sent as curse from God.

In general, my findings confirm to that of Ayalew Gebre and Wolde-ab Teshome *(*1995: 16). HIV/AIDS is indicated as being caused by biological agent and as being sent down from God in the form of punishment. Among young adults in Bahir Dar, there is a predominant notion that fatal illnesses like AIDS are the expressions of divine wrath against gross human immorality and perverted behavior.

Identifying and understanding the metaphors of AIDS prevalent in the community are essential to effective AIDS intervention and prevention. David speaks of moral conceptions of AIDS:

> When I conceive of AIDS, sex and condom come into my mind. Sex is natural, prestigious and holy; this is undeniable fact in each of us. In the world, sex cannot be made inactive, for at least one adult person may have sex with one partner or multiple partners once in a blue moon. In order to protect himself from HIV infection, he may use a condom. Needless to say, since the world of HIV outfights that of sex, I argue that condom use cannot be a way out. I believe that premarital and/or extramarital sexual intercourses are very bad behaviour and against God's words. For his immorality (violation of God's words or unhealthy/deviant practices), he gets God's punishment in the form of HIV infection or sickness. The sick person is responsible for his sickness.

Metaphorical conceptions of disease may reflect other aspects of the community besides conceptions of morality. For example, hated marginal or outcast groups may be scapegoated and accused of causing a disease, in which case the disease is a metaphor for divisions in the social

structure. Nevertheless, the general point is that as a socio-cultural metaphor, a disease is conceived in terms of a condition of the community rather than of the biological organism.

Zehara who is a twenty - four year old young lady cited somewhere in the previous chapter, implicitly views AIDS as metaphor for social categories. She has this to say:

> As known, the community is relatively speaking poor. There are also a number of unemployed young adults and self-employed ladies in commercial sex business. Similarly, there is 'sexual game' (engaging in multiple sexual relations) based on multiple sexual partners and abandonment of one's partner and then turning to others in the youth life-styles. Likewise, young people who are not ready for permanent relationships within wedlock are vulnerable to repeated and unprotected sexual relations in their need for experimentation, learning about love and so on. We, women also find ourselves at risk of HIV, because of our lack of power to determine where and when sex takes place. We should bear in mind that the disease comes from promiscuity, adultery and/or other risky socio-cultural practices. In sum, there are sound reasons to categorize these groups of people as susceptible to AIDS. This wildfire is conceived by most residents as the disease of the poor, unemployed young people and prostitutes in the *kebele.*

AIDS can be seen as a spotlight for society's problems. Medical anthropologists find it useful to use specific images to express the metaphor of AIDS as a finger in the dike enlarging the crack and exposing the weaknesses of the wall. It can be viewed by some educated people as a searchlight that increases the visibility of problems in the health care and social systems, or as a spotlight that shows up specific problems. This metaphor can also provide a framework for dealing with larger, underlying problems within the community, the family, the medical system, and even in human society.

The following is an illustration of AIDS as a symptom of social problem. In Bahir Dar, AIDS removes 'invisible curtains or coverings' from various problems in the community such as poverty, commercial sex business, gender inequality, and misuse of the mass media.

One of the key informants in his late twenties has this to say regarding HIV as one of the facets of poverty. In his words,

> Most residents of Bahir Dar lead a low standard of living that lasts long enough to undermine their health, morale, and self-respect. The AIDS crisis has also erupted in the town at the very time when everything seems to combine to bring bad news such as drought, famines, structural adjustment, population control and others. As known, OSSA and CVM provide each person living with HIV/AIDS with fifty birr per month. Nowadays, persons who are left destitute, go to Felege-Hiwot Hospital in order to have a blood test for HIV on a voluntary basis. When the result of their blood test was found to be HIV-negative, they asked that what does it matter? If the virus was found in our blood, then we could receive money and other support from those benevolent organizations monthly and would live on the earth for a limited time.

AIDS is similarly conceived as associated with commercial sex work. Sophia's experience is a case in point.

> I am 24 years old, 10th grade school drop-out, live next door to my widowed mother, and have one son, whose father has deserted me and his only son and gone to Sudan. Having waited for one year, I become self-employed as 'night pigeon' at night-club or in commercial sex business, where I could at least earn 300 birr within four or five days. Within the narrowing of opportunities for me in the labour market, I actually encourage myself to 'trade' sexual favours for money and gifts as a way to provide for my family. The sale of sexual services is often the only resource at my disposal. Despite the pervasiveness of prostitution as a means of livelihood, most members of the community do not consider it as societal problem. Before the eruption of AIDS, for example, women in her village used to talk about prostitution as 'lucrative business.' As my neighbours are aware of the main mode of HIV transmission is engaging in sex without using condom and the presence of some prostitutes, who engage in such a sex with 'well-to-do clients' to earn additional payment, I am considered as 'HIV mother.' Thus, the neigbours conceive 'my profession' as a serious problem and then me.

A male panel discussant in his mid-twenties argued that AIDS reflects or symbolizes gender inequality in the setting. He strongly said,

> Women are expected to carry out most household chores, go through pregnancy, childbirth, lactation, rear children, and to provide care and support for their siblings, for sick member(s) of their families or for persons with AIDS in the households. In contrast, men are expected to control women in most aspects of gender relations, which are supported by cultures. Thus, there is female submissiveness, exploitation, vulnerability, and male dominance. Such women's low social status and power may restrict their possibility of controlling their lives in relation to HIV/AIDS. In addition, we are told that more females are HIV-positive than males in Bahir Dar. A slogan of the International AIDS Day on the first of Dec 2000, i.e., 'Men make a difference,' which was emphasized in controlling transmission of HIV/AIDS in the setting at least reflected or symbolized the presence of gender inequality. Thus, AIDS can be conceived as a reflection or symbol for gender inequality among members of the community.

AIDS may be seen as a media and educational product. My observations may say something. On 24th Dec 2000, a panel discussion was held at The Amhara National State Hall, which was sponsored by CVM, OSSA, Health Bureau, The Region State and DKT- Ethiopia. The aim was to narrow the gap among twelve reproductive health and anti-AIDS clubs in the town, GOs, local and international NGOs. A discussant's statements may shed light on one of the socio-cultural terms for AIDS. In a young male panel discussant's view, AIDS is *ye-hedar besheta (*influenza), because the concerned bodies usually assemble and discuss about the disease once in a year - on the International AIDS Day (Dec 1 in the European calendar or November 22 in the Ethiopian calendar). Such a media and educational product may serve as mechanism of social control.

HIV/AIDS may be associated with other social problems such as income inequality, labour migration, the inefficacy of health care system, school drop-outs, shortage of human and social capital, the dependency ratio, the youth's life-styles, orphans, street children, cultural practices (multiple partners, circumcision, clitory mutilation, tattooing, etc.), impact of TV programs, video shows (of pornography), and of globalization on the youth's behavior and attitudes, drug addiction, alcoholism, unemployment, educational policy, and lack of affordable places of entertainment.

Yonas' case is more or less an example of AIDS as metaphor for promoting social control and self interest. As he has 'mental notes' on the topic, let us read them as text. The notes are read as:

I have been living on the earth for 23 years. I am single and live with a pensioner dad and a self-employed local brewer mammy. After I had graduated from natural science stream of Tana Haik Comprehensive Secondary High School, I held a certificate Diploma in Metal Work from Bahir Dar Technical Training School. Presently, I am employed as welder at a private metal workshop. Concerning the topic under consideration, AIDS is conceived as biological product in a biological science laboratory. Such biological phenomenon is created to serve as a policeman with a biological armament (who forces me to use condom), as an effective and reliable birth control. In addition, the devastating impact of AIDS never fails to impress foreign innovators. Indeed, AIDS is a 'biological axe,' which shortens life. Therefore, the ingenious virus is conceived by some young people of both sexes in terms of its dual purpose - to affect some persons and to serve as source of income for others. Regarding the municipality, for example, AIDS creates work for sanitary department, esp which has to do with lavatory. As persons with HIV/AIDS have frequent, watery excrements all the time and when they use their latrines, the latrines become full within short period of time. In contrast, as AIDS is accompanied by TB and/or typhoid, some health professionals at private clinics prescribe very expensive drugs for the symptom even when a patient is clinically diagnosed as person living with HIV/AIDS.

One may note the following critical themes in this quotation. Some young educated people conceive AIDS in terms of its social functions in the society. Foreign innovators have created AIDS to serve as an effective and reliable birth control, to control population growth, to create work, and to be source of income.

AIDS may also be considered as naturalistic population control mechanism. This is the case in Africa and India where we find genuine overpopulation problems. With regard to naturalistic conception of AIDS, let me give this opportunity to Tewodros:

Malthus formulated a theory of population growth, holding that population tends to increase in a geometric ratio, whereas the food supply augments in an arithmetic ratio. Malthus saw disease and famine as the two main checks on population growth. In recent years, there has been a renewed interest in Malthus, as world population, esp Third World population has grown at an unprecedented rate. AIDS is a prepared life-plucking disease and flare fire, which is intended to kill human species. To my knowledge, some scholars from different disciplines consider this disease as one effective mechanism for reducing population as Malthus has thought of. That is why there exist a number of reproductive health and anti- AIDS clubs and advertisements for family planning and Hiwot Trust condom in light of the severity of AIDS in town. [The lethal disease, together with the practices of family planning, of abstinence, faithful one-to-one sexual relations, and the use of Hiwot Trust condom to prevent the transmission of AIDS can be viewed as effective demographic and/or human design to control overpopulation].

AIDS is thought to be associated with self-destructive behaviour. Zehara has this to say:

Young adults of both sexes are chewing *chat*, drinking brewed and/or manufactured alcoholic beverages, smoking cigarettes or hashish and going to night-clubs. At such locales, they are eliciting each other using attractive, but deceptive words, and employing their 'symbolic power' in order to attract each other. In so doing, they leave no stone unturned and may acquire the AIDS - the *joker,* the owner, Addidas, the lazy, the weight loss agent or the flamed & killer fire.

AIDS is similarly considered as self-inflicted joker who can be evaded by wearing condom*s.* An example of this metaphor is the following:

Abbi, whose parents died, lives with his elderly sister. He mentions that the joker, or the jorkef is a unique and a new disease whose whereabouts are unknown. The joker is an extra playing card used in certain card-games, and it can be arranged with any card in a game which may help a player who draws the joker win the game. Moreover, the joker *i*mplies a foolish person, an irresponsible person or a person who does not value his life, and a person who is not socialized seriously. Following from the same argument, a person who engages in unprotected sex or 'unsafe sex' with multiple sexual partners or in extra sexual relations (aside from his partner) without condom may get the HIV infection. As the joker can be pulled or drawn by chance during a card-game, the person who engages in many sexual relations may get infected with HIV by chance. Such a foolish person does not give value to his life. While having sexual relations with commercial sex workers or 'pigeons' or 'birds', Abbi buys and puts on condom - the lord's socks or *mekod* (defender or gallant which can prevent one from HIV infection) in order to protect himself from the *j*oker. For example, he had Dr. Condom's (an American) innovation in his pocket during an in-depth interview session. Abbi is fearless of AIDS, because he has sexual intercourse with multiple partners so many times. However, the main thing is that the condom (the defender) should not break or tear up.

Such conceptions weaken the essential empathy and compassion that health care professionals must bring to their interactions with patients and clients. For instance, I went to Felege-Hiwot Hospital once in order to acquire data on seropositivity of blood samples, where there was a nurse who was counseling people living with the virus. The researcher and PLWHA's were told to wait for our turn outdoors. Eventually, the nurse used another door and left the room, although

we were waiting for her permission to enter. Later a janitor told us that 'nurse' had gone somewhere and she was there to clean the room.

Sex is itself identified with HIV/AIDS or vice versa. HIV infection is linked in people's minds with sex. During a question and answer session held on the first of December 2000, one female panel discussant in her 20's was asked about the first report on AIDS episode in Ethiopia. She then responded, "Unprotected sex." Despite diverse sources of transmission, the metaphor of sex and sexual behaviour has become locked in her mind as the principal image of AIDS. When the issue of AIDS was also in air, most discussants appeared in decorated shirts and in caps with condom pattern.

In what follows, AIDS is associated with a romantic/desirable form of death. Yonas' case provides an illustrative example of such a metaphor. He said, "If one is going to clothe oneself in fashionable clothes, they should be jeans; If one wants to have a meal, it should be roasted meat; .If one is going to drive a good car, it should be a DX; If one is to die, s/he should die of the golden AIDS." This type of idealization of HIV/AIDS may arise from idealized young adults' life-styles, living conditions, sexual behavior, and significance of sex in their social life.

For Landau-Stantan and Clements (1993: 13-15), the disease experience thus shares something with the social and cultural response to TB in the eighteenth and the nineteenth centuries. Dying with TB became highly romanticized and eroticized, the disease making the individual more heroic and sexually attractive in the public's mind.

Speakers of Amharic use language in special ways when they talk about AIDS and its effects on their social life and other. They draw on code words and phrases when identifying HIV - illnesses and describing signs. The speakers adjust word order, disguise subject reference, and make other changes in sentence and paragraph form when discussing the socio-cultural conditions, which encourage risk- taking. Sometimes, when AIDS is the topic under discussion,

people explore their thoughts and feelings in great verbal detail; other times, they make their thoughts and feelings known by saying nothing at all. All discussions of AIDS are rule governed speech events to express what the speakers understand about the pandemic, and its effects on their lives help them choose the features of grammar and discourse which are relevant to the messages they convey in such settings. For many young adults, AIDS is a metaphor for evil, and this gives it socio-cultural meaning and interpretation that they could understand. For example: AIDS is the flamed fire which sets a house on fire, the ferocious animal who is against us in the locality, the vicious symbol that symbolizes a savage and dangerous creature, is a devil who knocks at everyone's door, dull (does not understand love), the joker (the disease which effects all sections of a population without discrimination), *amenmene* (brings about thinness or slimness, since an individual with HIV/AIDS gets thinner and thinner over time), Addidas (the disease of the generation and the words are the same as AIDS), and *fendis* (lethal disease which is without curative medicaments).

3.5. Conclusion

This chapter is about the narratives that express the youth conceptions of AIDS, which are conceptualized by using different theoretical and descriptive concepts. In such attempts, I have been concerned with the understanding of AIDS. The disease is to a much larger extent part of everyday life. Young men and women in Bahir Dar are knowledgeable about the nature of the disease and its transmission. However, there is discrepancy between awareness of HIV/AIDS and behavioral change. This gap has to do with young adults' socio-cultural meanings and interpretations of AIDS. Individuals respond to their disease definition rather than to the physical aspects of disease. Thus, these differences are reflected in conceptions of disease. Such

shared socio-cultural conceptions of AIDS direct behavior. It generally appears that increasing level of knowledge does not in itself lead to a change in behavior.

My research in Bahir Dar leads me to conclude that as the phenomenon of AIDS is complex and multidimensional, this requires the use of the narratives to understand this. Youth conceptions of AIDS incorporate scientific understanding but go beyond that to include moral, social and individualized/behavioral notions - complex. In attempts to describe how the youth conceive the disease, the author has organized their conceptions of AIDS under scientific conceptions of AIDS, and 'folk' conceptions of AIDS. One mode of conceptualizing is the considerations of young adults' awareness of the nature and transmission of AIDS. The youth understand 'objective' characteristics of AIDS. If the levels of awareness of AIDS were high among young adults, it would be a paradox, why the majority of them engage in risk-prone activities which may put them at risk of HIV infection. Young people know scientific causes but also have their own 'folk' explanations.

It is also shown that AIDS is presented as a complex and multidimensional phenomenon which requires use of narratives to understand this. In narratives, the representation and interpretation of experience is guided and shaped by shared socio-cultural understandings. Narratives therefore transcend youth's awareness of the nature and transmission of AIDS and become representations of shared socio-cultural conceptions of HIV/AIDS among young adults. Thus, these narratives are interpretive devices which give meaning to youth's socio-cultural conceptions of HIV/AIDS as moral, social and individualized/behavioral notions - complex. Generally, one needs to go beyond the scientific understanding of AIDS to consider 'folk' conceptions of AIDS such as moral, social and individualized/behavioral conceptions of AIDS. Folk conceptions of condom include mixed notions such as condom is conceived as against males' natural, prestigious and holy behavior; against youthful sexuality; the lord's socks to serve as a ploy to reduce the rate of inflow of creative and economically active young Ethiopian populations in general; 'modern'

contraceptive sheath as device for America's globalazing effort, innovated by Dr Condom (an American); but it is the defender which does not completely eliminate the risk of HIV transmission. The promotion of condom use has always been a problem, both for family planning reasons and for preventing HIV infection.

Having driven home a gnosis *(*a kind of secret knowledge), let me use another window within this framework of AIDS discourse, and discuss sexuality and risk behaviour.

CHAPTER FOUR

SEXUALITY AND RISK BEHAVIOUR

4.1. Introduction

Youth sexuality and risk behaviour are critical to the understanding of social or cultural or contextual aspects of HIV/AIDS transmission. So, progress in understanding the sexual transmission of the HIV/AIDS requires data about their perspectives on sex and sexuality. Youth sexuality has multiple dimensions: social, cultural, economic and others. It is worth giving attention to the meanings of and the expressions of sexuality in different social and cultural contexts relevant to disease transmission.

The chapter will discuss youth perspectives on sex, together with changing sexuality (changes brought about by AIDS). This chapter also describes social aspects of sex, and sexuality and sexual risk. Finally, the conclusion will restate the major themes in the chapter. All these attempts will be in light of the sociology of sexuality and interaction theory.

4.2. Youth Perspectives on Sexuality

The individual member is imbued with the beliefs, values, norms, and expectations of his or her social reference group. Community attitudes about sexual activity influence young adults developing attitudes (Hayes 1987). Three of my informants, for example, have positive attitudes to sexuality. They state that sexual activity is necessary for health and sanity and any person who does not have sex within a certain time interval will suffer from various illnesses. Zehara further argues that sexual activity is the cornerstone of marriage. It is necessary for the union of man and of woman. She considers sexual activity proper for husband and wife to have at night. This is the expected attitude towards sexual activity between a man and a woman. Some consider that it is desirable to desist from sexual activity before marriage, especially in the case of women. Thus, marital sex and virginity are viewed as desirable. A female key informant in her twenties said:

> Young adults usually emphasize sex differences from birth in their speech - a boy is *balekachil* (one with a small bell); a girl is *sentik* (split/ fissure). Unlike sons, girls are expected to remain chaste, virginity intact until formal marriage. An important part of the wedding ceremony is the formal 'test' of the bride's virginity by the groom himself. The hymeneal blood, staining white piece of cloth is considered as a sign of her virtue. Her proven chastity reflected upon her own honor and upon that of her parents, siblings and relatives. These symbolize the ideal of feminine status in Bahir Dar.

However, according to Yacob, such attitudes to virginity are no longer influential. Regarding virginity, he said:

> Virginity and small-pox in the town 'went astray' many years ago. Nowadays, we are reading about virginity and true love in newspapers, magazines, and we even see them in playwrights and scholars who look at the world with their love-eyes.

There also appears to be a contradiction between girl's preferences to remain virgins and what actually turns out to be true. Generally, Zehara said, "Virginity for unmarried girls remains an important value before they experience sexual activity within marriage, but its realization is far from universal." To continue on the same theme of chastity and reality, although discouraged by public morality, church teachings, health educators and reproductive health and anti - AIDS clubs, premarital sexual activity is part and parcel of growing up for many boys and girls. Certain

attitudes towards sexual adventure oppose the stress on chastity implicit in the above statements.

For her, many young people of opposite sexes view sexual activity as an important part of youthful adventure. Some young boys in Bahir Dar are often anxious to enhance their prestige among their peers not only by having many sexual relations, but specifically by deflowering virgins as well. For instance, young male adults commonly and jokingly comment on the relative size of one another's genitals using colloquial words such as *manabello, ya -mukechcha lej* (the child of mortar to express its length which has 'social value' among themselves in terms of love making with opposite sex and making money), and *zenezena* (pestle to indicate that relatively short but voluminous penis is valued for sexual satisfaction). One is presumed to be 'more male' in having a larger penis, *manabello.* Likewise, males boasted among themselves about the number of girls they 'had taken out,' the number of virgins ('first - breaks'), they had disvirgined, and the number of *kebeles* in which they had made connections through their 'girlfriends.'

In comparison, virginal status is undesirable for boys. "A boy who is thought to be a virgin is humiliated or insulted as 'priest' or as a castrated bull by his peers. Such a status does not have important implications for ways in which their bodies function and is more of a source of embarrassment for boys," said Yonas.

A common youth perspective is to look at sex as a natural impulse. The following youth present typical attitudes:

An illustrative example of such conception as sexuality is that of Kidan. Sex is the grace of natural force that makes her to conceive the fact that she could not force back her sexual nature. Therefore, she believes that she is unable to live without the opposite sex and his love. Sex remains as the natural force in her body, including other humans.

A copulation or coitus between a man and a woman is natural, because 'having sex' is biological fact of human life and exists throughout human societies, including the animal kingdom. He also argues that male dominance and female submission are biologically determined and inherent in heterosexual relations. Therefore, one has to try again and again to understand his partner's sexual impulse through experiences. By so doing, this man should devise how to arouse in his partner a certain 'emotional condition, ' which may lead her to 'fall in love with him.' Here the partner has to admit that his sexual demands are natural and inevitable and that the couple could only achieve sexual satisfaction by consenting and enjoying her submission to the partner whether one calls it civilization or not. David said, 'This is the right way to enjoy sex, within marriage. One should not look for other partners as a substitute.'

On the other hand, sex drive may be seen as a negative force that required social control.

Tewodros′ statements are an illustration of uncontrolled sexual behaviour and its control.

Sex has become an almost important motif in representation of my daily life. Sex is also a combination of fascination, and it also resides in me. At present, however, sex has become a source of fear and embarrassment. Owing to civilization, most young people are misdirected in their sexual expressions. Such sexual acts may reflect incestual desire. If such sexual desire is not socially controlled then they may have sex along the streets (in darkness), with one's relatives, may rape and have sex by force, and even may challenge the well-being of the community. Such sexuality is animalistic. The community should devise informal and/or formal mechanisms of social control. Such prohibitions should become embedded in cultural frameworks and expressed in our value judgments.

In addition to such conceptions of sexuality, some informants also agreed to the empowering effect of sexuality. This is the case for David who heads a family of four. He said:

Sex is a holy and prestigious human behaviour. Because of this, it should be accomplished to gain power, as sex has power above all things which are created by man in the world. If a young boy or a young girl has great understanding about sex, then he or she can derive power from the sexual act. While s/he is 'having sex,' one should not ejaculate at climax of sexual excitement (at the achievement of an orgasm), but s/he must interrupt the sexual act at that moment. Such a sexual act endows her or him with power [s/he becomes a person who is embodied with power]. Eventually such a sexual act makes her/him very powerful person.

For some, the attraction of sex changes with familiarity. Aster stated:

I have a beloved boyfriend who lives in Dangell*a*. My beloved 'has opened the gate to the sexual world by the right key.' While entering the world, I have experience of sexual pleasure that makes me as happy as the day is [very happy]. I was never bored when my much-loved boyfriend is 'having sex' with me. You will be surprised, but now what we call sex makes me bored and I have developed abhorrence for the sexual act. Nevertheless, I don't know why it happens. Sometimes, I wept bitterly and regret for starting sex, even if my beloved one politely requests 'having sex.' In sum, sex is a beautiful act if it is with one's lover. When it is done repeatedly, sex becomes boring and a hated physical exercise - a good-for-nothing act. Thus, as we get gradually accustomed to each other, sex has made me very embittered. Finally, I imagine sex to be different in men and women.

Some young people believe that knowledge or maturity is needed for sexual involvement.

David's words are illustrations of such a conception, when he said:

In understanding human sexuality, our first focus is on coming of age - 'maturity.' The journey to sexual act begins with the maturity of a man and a woman (In God's concept, sex is for man and woman, not for boys and girls) in the sense of education, finance and/or other. It is awkward to think of 'having sex' when one is unemployed. Otherwise, sexuality can make him or break him! If one generally understands and properly applies his knowledge, it is good for him and for the community.

My observations in Bahir Dar lead me to conclude the co-existence of contradictory notions about sex, which suggest the retention of fears and anxieties about sexual desires. Aster's case provides an illustrative example of fearing sex - linkages with pregnancy:

Aster has a beloved boyfriend with whom she has developed abhorrence for sexual acts with time. Sex is very problematic in her thoughts, which may result in pregnancy. Aster does not want to conceive and to give birth to a child, because the child would take her love. The beloved boyfriend therefore would show little love towards her. Eventually, heterosexuality in this form creates many problems in a household.

For males and females, in sum, fairly permissive sexual attitudes are generally found in Bahir Dar, because some young people regard sexual activity as pleasurable and good for health. It also enhances strength and gives power. Similarly, there is conflicting aspect of sex such as need for control of sex, and fears about sex.

Therefore, there are reactions to programs on AIDS which have to do with sex. To restate their words, when there is advert on radio on something of a one-to-one relationship to prevent AIDS, they usually say what chattering talk it is and put it off. For example, there is one thing. Let us assume that a journalist or a physician advises, "Don't smoke cigarette or chew *chat*;' but s/he does not do herself/himself." By the same token, young members of reproductive health and anti-AIDS clubs are out crying repeatedly to be faithful to one-to-one heterosexual relations in order to prevent the transmission, but the majority of young residents do not pay due attention to the lesson, because the educators themselves fail to act as such.

Even if the youth have such perspectives on sex or attitudes towards sex, some people change towards safe sex due to awareness creating education about HIV/AIDS and its prevention given by GOs, local NGOs, international NGOs, reproductive health and anti-AIDS clubs, and others.

AIDS has an impact on sexuality. The lethal disease thus discourages lovers not to engage in unprotected sex. Most informants, except two, say that AIDS has an impact on their sexuality. The following statements can be an illustration of the impact of AIDS on sexual activity and life-styles:

> In the past, because of unemployment, young males waited for females along the roads to have sexual intercourse by force with them. Moreover, after the youth had chewed *chat,* they were drinking strong liquors and had sex with prostitutes or other ladies in completely unprotected way to dawdle away the available times of idleness in those days. However, thanks to AIDS, we resorted to life-style colloquially known as *mirkana maragaf.* Although their number is relatively small, young adults go out for walks, drink juice(s), and take a bathe in order to 'unload *chat* intoxication,' and to be able to get some sleep well after they have received the 'message' from the chewing act.

Such changes affect the living conditions of young prostitutes. Because of the lethal disease, many of their customers are refraining from having sexual relations with them. This can be illuminated by responses from most of the cases. For example, *Yodit* is a 26-year-old 'modern prostitute' who hunts her 'care providers' at tourist standard hotels in the town. Her abhorrence about AIDS goes:

> AIDS has great influence on our business because of conflicts about unprotected sex between the customers and the commercial sex workers. This results in a lower frequency of visits by our customers and a reduction in our income. We are therefore short of bread and money to pay house rent.

A 23-year-old male key insider's commented that some young male adults had sexual relations in freedom in the good old days. Previously, young adults went to kiosks in order to 'purchase sex.' In addition, they resorted to girls standing outdoors with 'their labelled price,' who wear tight trousers, carrying their bags full of exercise books on their shoulders while walking along the asphalted roads, pretending that they are night-school pupils who are coming back home. The male adults may 'purchase' and 'have sex' with these girls - who are colloquially speaking- *kuda, kemis, shele, sitawa*, etc., along the roads. At present, however, the male adults have abandoned such acts and switched to drug addiction, drinking and what not.

A 25-year-old young adult who works as time-keeper in a private construction company and a key actor at a *chat* house made the following statements**:**

> In the good old days, we secured opposite sex by force in order to have sexual relations. We were doing these without thinking about THE FOUR LETTERS, because we ridiculed the notion that AIDS could appear in a dress; no one was fearful. Nowadays, we have changed 'the game' and the discourse, especially the ridicule.

He expressed the change as follows**:** *'edis enkwan kemis lebsonewe suri lebso bimetas manim ye-minekaw yelem; merwarwat enji! angenagnim*! This meant, "Let alone AIDS dressed in women's dress, even if it appears in trousers no one touches it, but we run away - we never meet!" The modification of the youth's behaviour consists of - the forced use of condoms. All these are changes brought in response to AIDS. It is just some people that are changing towards safe sex.

Changes in social attitudes towards multiple sexual partners may reflect actual changes in social values to sexual pleasure, or a new ideal about what should constitute sexual behaviour. *Sophia*'s case is an example of the latter:

> In the past, young male adults were waiting for us at the gate of a school to have sex forcefully. By so doing, anyway we had sexual pleasure without thinking of and talking about AIDS and condom. However, those boys who had such acts, for example, changed their mind. Males and even females have condoms in their pockets and purses, respectively. By so doing, most young people leave aside sexual pleasure for interested professionals to be chronicled or written. Condom use impinges upon our expression of sexuality. Condoms (the lord's socks) are also seen by a few of my 'business sexual partners' as wasting sperm, belittling the sperm by obstructing its entry into a partner's organ, preventing flesh-to-flesh contact, reason for raising a question of satisfaction, and human design against social means to create close and intimate relations. Generally, unlike those who seek sexual pleasure (a few young adults of both sexes), some of my 'business sexual partners' use two or three condoms at a time. Nevertheless, they invest quite a sum of money to 'purchase' me. I usually think, 'Is this sex with me or with my insurance (condom), so to speak?'

There are already indications that puritan agendas are being stimulated by public discussion of HIV infection. Monogamy (long-term monogamous relationships) is presented as the ideal safe sex behaviour. This was the case for *Kidan*. She said,

> My peers who think of themselves as 'modern' usually have sex with multiple sexual partners, depending on the protective ability of condoms (the plastic). In my opinion, they should establish and maintain faithful one-to-one sexual partnerships in line with the Almighty God's words in the Bible.

4.3. Social Significance of Sex

Sexual acts can communicate closeness and affection, where sex is viewed as an interpersonal relationship (Hopkins 1977: 67). Interaction theory has been used to interpret data on the sociology of sex. The theory assumes that individual behavior is to be described and/or explained in terms of the interaction between persons engaged in the construction of social events (Seymour-Smith 1986: 154). When an individual starts interacting with his sexual partner in construction of social events, they create social relations around sex. Sex is at once an act of individual intimacy and of social significance (Hawkes 1996: 6). From a sociological point of view, the biological division of function between male and female is elaborated into two major statuses upon which behaviour is differentiated in all societies. The sexual relationship is a social relationship, and is organized only partially around biological sexual needs. In all societies, social needs for acceptance, companionship, approval, and affection, as well as economic needs, are very closely tied to the conception of the sexual relationship. Even the more purely biological aspect of sex is never a simple expression of a physiological drive. The individual derives the significance and functions of sex and meanings attached to sexual relations from the customs and definitions of his/her culture or subculture and his/her unique social experiences.

Now let me present data to illustrate the above discussions. Community ideals of sex differ from youth ideals: "In Bahir Dar, the cultural values about sex dictates that sex is socially significant if the holy and prestigious union of two people of opposite sexes is carried out within marriage," according to *David*. In contrast, many youth see their sexuality as central to their youthful identity, even outside of marriage. Abbi's case is also an example of sex as symbolic of youth status.

> Privately, at least, I see sex as an important part of my youthful behaviour. Copulating with 'birds' (ladies) is associated with expression of youth, of masculinity, one's personality, and so forth. We usually hold conversations among one another and the

great agenda for the talk is sex (even such an issue spices the chat). We consider sex as one basic thing and it has special & great position in our social life. Therefore, sexual relations are standards of youthful behaviour.

*Y*oung adults also conceive of sexuality in light of its social function. *David*'s case is an illustrative example of its function in reproduction and maintaining social relations in addition to personal expression and satisfaction.

The world of sex is extremely complex. Sex has multi- functions such as: reproduction in order to replenish the society with new members, as a source of happiness, joy, and spiritual satisfaction. Sex creates and maintains love, establishes social relations and so forth. In general, sex has very great importance and function for the continuity of society.

Regarding social status relative to reproductive sexuality, the above-mentioned informant also asserted that sex is associated with vitality and power, and with the political advantages that accrue to any married man by virtue of sowing his 'seeds' far a field and thereby creating many branches of his descent line, through different sets of offspring. In general, any male prestige that accrues through reproductive sexual activity comes through active expression of sexual impulses rather than their suppression. Through sexual prowess, according to male focus group discussants, males may gain prestige and even power among peers.

More to the point under discussion, let me cite examples of the role of sex in maintaining self-identity, as source of affection, approval, companionship, etc. Sexual identities have a special place in the statement of identity. *Zekarias* said,

Sex is important to my identity. For example, I am male, have a fiancee, and am heterosexual. In comparison, I sometimes hear a few foreign tourists like to say who they are by telling of their sex: homosexual or lesbian. In the town, the residents also identify so-and-so as *fenafent*, hermaphrodite; a female who appears like male in her overall appearance as *kebe*. Therefore, sexual identity identifies practices and codes of behaviour.

Sex is considered as basis of social relations. As to the role of sex as a source of affection, David has this to say: "Sex, especially sexual compatibility is one and major source of feeling of fondness or love, happiness and fulfillment in social life." The same case informant further argued that sex is a source of acceptance, as he said:

Sex is good or acceptable or satisfactory activity in social life. Good sex or pleasurable sex through orgasm and/or sexual compatibility is the basic fact for getting and keeping one's wo/man, while her/his ability to give such a sex may imply one's successful membership of the ' world of sex' and, in turn, genuine members of the community may give their acceptance. In sum, sex is one decisive source of approval or consent between married partners.

It is similarly worth drawing attention to the way in which the role of sex is conceived as a source of companionship. Tewodros' views are an example of such a conception.

There may be possibility of friendship or relationship between these young persons who go with or spend much time together. Sex can be a mechanism for creating intimate friendship. Generally, sex is viewed as a big communicative tool and source of strong and 'unseen threads' which become the underlying basis for relation between friends or sexual partners.

Sex appears in various ways in the compartments of young people's day-to-day lives and overtime. For instance, sex can be a tool of exploitation. The following focus group discussant sites an example of exploitative aspect of sexuality. A 20-year-old focus discussant 9th grade drop- out mentioned:

Most of the prostitutes have come from neighbouring towns. As there are fearsome young boys in the *kebele* and these boys may hit the prostitutes, the latter become fearful of the boys. The 'birds' do not refuse if those boys swindle them using deceitful words and convince the 'birds' to copulate with them. Then, these shrewd boys by hook or by crook make the 'birds' fall in love with them.

Thus, the boys start 'milking their American cows.' They become share-holder and use ' her price' selfishly and unfairly for their own good life.

For some young adults, the material/commercial significance of sex is conceived as an almost of its social content. For example, *Tewodros* stated, "For persons with characteristics sexually desirable by others, sex has exchange value, and so can function importantly in individual strategies for personal advancement and/or economic survival as in the case of prostitutes."

Most young people, however, are not interested in creating complex relations around their sexual partnerships. *Yacob's* is a typical example.

I do not think that the interaction with my sexual partner in the construction of sex as a social event creates social relations with her parents and/or relatives. For me, for instance, sexual act is the manipulation of muscles. Moreover, it is the time during which I play a game of 'sexual knock out.' Therefore, I don't see any ground for the association of having sex with the establishment of relations to her social networks.

In summary, when one reads the research on sexuality that has emerged during this epidemic, s/he gets an extremely impoverished and naive view of what sex is. In comparison, for the

youth in this study, sex is a complex social phenomenon that is basic to identity, reproduction, prestige, acceptance, affection, companionship and livelihoods.

4.4. Youth Sexuality and Sexual Risk

Risk behaviour is the result of individuals' knowledge, beliefs, as well as interpersonal interactions (Kane 1991: 1037; Gabe cited in Rhodes & Quire 1998: 157). Quoting the National Research Council of United States, Rushing (1995: 104) states that the transmission of HIV infection and consequently, AIDS, is the product of human behavior enacted in social contexts. Both the behaviours and the circumstances in which they occur are conditioned and shaped by culture and the larger social structure. This entails that the transmission of HIV should be the study of the behaviour of vulnerable social groups, in this case the youth. In this section, the different themes associated with patterns of sexual activity, risk perception, and risk behaviour are described.

High levels of risky behaviour characterize the sexual lives of young people in Bahir Dar. Aster has this to say about young girls who study in Bahir Dar:

Young girls who study in Bahir Dar educational institutions, including junior, secondary, and tertiary levels (extension programs) are promiscuous. The girls tell their parents that they are going to school or the library or night-school, but the girls are actually going to their 'boyfriends,' for these girls are fascinated by chewing *chat*, and going out for walks along the asphalted road. A few of them have abortions while they are in schools and others even have to quit schooling because of their unintended pregnancy.

For a minority of young people, adventurous attitudes about sexual activity extended to *ledama* 'group sex' (a group of two or more males are engaging in sexual intercourses with only one female by turns), although there was no evidence that these practices were widespread - according to most of the discussants. Abbi and Kidan related an increase in sexual activity among young adults of opposite sexes to the availability of methods of contraceptive pills and condoms. These methods give girls and boys more freedom in the enjoyment of sex for themselves without worrying about getting pregnant and infected with HIV.

One of the focus group discussants in his early twenties has this to say about risky sex or sex activity.

As a prostitute lives in the neighborhood in a hired house, any way my ears do not say 'we do not want to hear.' They have been hearing too much talk about her customers. To mention one, although a young boy does not want to use condom and he pays extra amount of payment; for the girl feels that she misses out, she engages in unfrocked sex (It is an act of atrocity). This may be due to the need for sexual satisfaction, her external beauty and/or her deceptive odours. Therefore, this 'sexy boy' enters a game of sex, but if chance ignores him then he can pull the joker (AIDS) during card playing game or in game of checkers. Thus, the boy could get fire (AIDS) and appear in 'a shirt labelled as number 13, i.e., unlucky number' - he is one who is ill-starred.

Activities such as chewing *chat*, drinking alcoholic drinks and the like can be regarded as risky because they substantially endanger the health or safety of an individual. According to Abbi, these are risk behaviours that cluster together among some young adults:

> Chewing *chat*, smoking cigarettes, drinking very strong and numbing drinks, having unprotected sexual relations with a trusted girlfriend, drinking and having sex with a prostitute with condom, 'knock out' of one's sexual partner, engaging in various positions of sex with a commercial sex worker (even using condom), having unprotected sex with multiple partners or with commercial sex workers, sharing needles and sharp equipment, touching another person's blood and wounds, having sex out of wedlock, obstinacy with one another to have sex with someone's 'bird(s)' are behaviors and life-styles that may expose young people to AIDS.

Risk perception and behaviour is the outcome of the interplay of factors at the individual, and the interpersonal level (Giffin 1998: 151). Although most decisions in life may involve some degree of risk, in many cases the perceived probability of loss is so low, or the consequences of loss are so slight that the decision would not be classified by most as risky.

The literature however tells us that young people who participate in risky behaviours tend to underestimate the risks associated with these behaviours. Resistance to condom use, inside or outside long-term relationships, may also be rooted in men's attitudes about sex. Research from Mexico and Brazil finds that some men believe that they cannot turn down any opportunity to have sex, even if they do not have a condom with them (UNAIDS 2000: 8). UNAIDS (2000: 11) argues that boys who are brought up to believe that 'real men don't get sick' may see themselves as invulnerable to illness or risk. When they actually fall ill they may put up with the sickness or seek health care only as a last resort. One of my informants has views on reckless pursuit of sex and perception of risk. To paraphrase him, if real youth do not fall ill, then it is not 'youthful' to worry about avoiding *chat*- and drink-related risks or to bother with condoms and others.

Generally, young adults of opposite sexes in Bahir Dar have their own mechanisms for managing risks. Some young people put on one or more condoms at a time. Some others consider the physical appearance of a partner, or avoid 'slim girls,' douche immediately as the condom breaks, engage in prayer and use condoms, and even a few employ the evaluation of their partners' attitudes towards condom use. Finally, most young boys evaluate their partners' sexual history in retrospect in order to manage risk.

Different social and behavioral contexts define/condition sexual activities of young people that may be risk-prone. One of these socio-behavioral contexts is public places and places of entertainment where young adults actively pursue sex. Young adults of both sexes are at times 'hunting' for sexual partners either along the asphalted roads while they are out for a walk or at public places of entertainment or at any encounter(s) in daily life. As peanuts are assumed to arouse sexual interest, according to most young adults, it is usually common to buy it while opposite sexes are out for walk and/or are going to public parks. Some young people are often chewing *chat,* drinking alcoholic drinks, and practicing deep kissing, hugging, and cuddling at such places (especially in the dark) - according to the researcher's observation and the male key informant in his late 20's. At Mango Park, a few young females somehow manage to establish and maintain friendship with opposite sex, and might convince males to engage in sex for payment (either in cash or in kind). This male informant said, "Public parks are places where we find fire and *teff* straw."

In addition, two of my key educators added, bar ladies or divorced or widowed women go to such locales in order to 'catch' the attention of the opposite sex by gaiting, wearing clothes of different sorts and by using other 'catch symbols.' In so doing, a few may use *astekuash* (one who serves as go-between for commercial sex workers to convince their 'care providers' to spend a lot of money in care provision) *o*r may employ *mestafakir (*a sort of black magic which has power of apparently using supernatural forces to influence people's spirits in order to come by mysterious results*) i*n order to convince males to engage in sexual activity.

Other people may have patterns of sexual activity that result from chewing *chat,* watching pornographic films, together with others. Zekarias' words can be an example:

When I get 'intoxicated' by chewing *chat*, 'breaking many bottles of beer' or drinking a combination of two or three beverages (*panechi)*, breathing in smoke of hashish, watching pornographic films, and/or when my sight gets 'colonized' by some females' soft body or lap, *mekemecha* (bottom or buttock which is their 'symbolic resources or capital - socially valued among young males), general appearance (esp their beauty), I usually engage in sex.

Some other young people have somewhat different patterns of sexual activity. Tewodros′ observations at *areke* house(s) can be a case in point.

Some young people mostly drink *areke* because its price is cheap. They sometimes put Asprin in a vessel filled with *areke*, a combination of *areke* and tea and drink as well as invite prostitutes to drink. By so doing, they cannot restrain their sexual impulses due to the excitement of the strong drink and therefore they engage in sexual activity.

According to the paraphrased statements of Sophia, she usually engages in sex when she chews *chat,* but does not drink any type of drink or when she drinks *Bedelle* beer, *Dashin* draft and/or Gordon alcoholic beverage. This is also an example of drinking/*chat* and multiple sexual partners.

Abbi's case is an example of intoxication and sex, as he engages in sexual activity twice a week. After Abbi has chewed *chat*, smoked cigarettes, and gulped alcoholic beverage(s) down, he engages in sex with his 'resemblance' or 'peer,' who can be a prostitute or a 'bird,' depending on the amount of money in his pocket. *Abbi* manages risks that may come from drug use, alcoholic drinks and multiple sexual partners by the use of condoms (his *allegnigneta*, moral support which implies that he gives due value to the protective quality of the contraceptive sheath). "In the presence of condom, why I should worry about AIDS, " said Abbi.

In the past, because of rampant unemployment young male adults generally used to chew *chat*, drink alcoholic drinks and had sex without condoms. As the disease that is said AIDS has come, some young people lose their cordial friends due to the lethal disease. They also experienced that addiction to *chat,* hashish, alcoholic liquors and others can remove one's self- control over risk-taking. These individuals believe that they should show sympathy towards one another in such circumstances to inform the addict of safe sexual practices. The 25 years old time-keeper in the private construction company adduced, "If young boys enter prostitute's house in order to have sex one young boy among drinkers in the house says that 'my brother' if you don't have *chinbel or kalsi* (condom), take this and enter the bed room, and put it on before engaging in sex."

My observations in Bahir Dar reveal the prevalence of involvement with multiple sexual partners among young people. Tsehay's statement can be a case in point. She said,

> Presently, young adults do not confirm to the biblical sexual activity between Abraham and Sara. If one thinks that young people abide to this law, then s/he must be foolish, because they don't value singlers. Instead, the youth prefer multiple sexual partners to one partner. Surprisingly, these partners are even chosen based on financial benefits that can be earned from many male partners - the sexual game is based on 'knock out.' No one is forced to engage in the auction. Therefore, some young people abuse sex and engage in sexual activities with multiple partners in regularized ways. To my mind, all these are from my experiences and observations in the area.

Young male adults, particularly government employees have patterns of sexual activity with their *puttings,* meaning mistresses who sit and wait till their lovers come in order to have illicit but regular sexual relationships with them. These girls are mostly young bar ladies and they usually go to their customers' residences and pass the night there on weekends, to paraphrase Yacob's words.

In no case there is evidence for the economic determinants of risk behaviour clearer than it is for sex work. Evidence from all regions of the world has suggested that an overwhelming motive behind the exchange of sexual services for the provider is economic opportunity (Thant 1993: 135-139). Whereas this is often a desperate survival strategy for some, it can be a lucrative business for others. For example, the coercive exploitation of young girls by older men, including those offering 'sugar daddy' gifts. Chuchu's words are illustrations of the use of sexual services for economic return.

> I know a married girl who has gone through a bad patch or difficulties in her social life. Her husband has no permanent employment and is not a well of income for his household! However, the wife has an old white man or foreigner as her sugar daddy. When the daddy comes, the married couples are in the happy position of never having to worry about money. With the husband being aware of the matter, she has been staying with the sugar daddy for many days. The daddy is a source of many benefits such as house furniture, jewelry, clothes, savings in a bank and so on. Thus, her sexual services become a profitable business.

Romantic relationships are another context of sexual activity. Aster's case is an example of romantic of sexual activity. In her words, she has this to say:

> Although I drink strong liquors, watch pornographic films and what have you with my beloved boyfriend, I don't get feelings for sex. However, while I am sitting alone at a bank of a river or a lake, or at Public Park, I get absorbed in those 'plays' of love with him. Then, I have 'sex problem' i.e., feeling of sexual desire. In addition, while I am in bed and singing my favourite Ethiopian music, especially using Ethiopian lyre, engagement in sexual activity comes in my mind.

Romantic relationships may put some youths at risk for HIV/AIDS because women may not feel they have sufficient control because of cultural norms that make negotiation for condom use very difficult. Women as a social group also present difficulties with condom use. They may not be in control of the decision to use condom, because of love, cultural and/or gender issue(s).

> Aster's case is an example of romance and sex and negotiation about condoms, as she does not use condom while engaging in sex with her beloved boyfriend. Either she or he does not raise the issue of condom use, because they do not want to suspect each other. If she is told that he 'has AIDS" she will live with him (she swore an oath once and started love with him, because of this she wants to die as soon as he dies). Moreover, 'after all, at least, as death is unavoidable,' it is not necessary to use condom - to be considered sex there should be a real relation between penis and vagina. In her mind, the use of condom is like sucking a candy with its sheath and like taking a shower in one's trench coat.

However, not all youth sexual activity is risk-prone as some also engage in abstinent, safe behaviour, and single partner sex. Zehara's words express abstinent behaviour. She argued,

> Although a single Muslim at her age is unpopular**,** one should abstain from sexual relations before marriage or during one's youthful time. The concept of prevention of the deadly disease leads to abstinence from sexual relations. I am strongly in favour of this. In so doing, I engage in fasting, spend time in prayer, adoration, and reading religious books in order to get spiritual strength and control my sexual desire. Contrary to present fashionable belief in extensive sexual relations among young people of opposite sexes, I employ abstinence to avoid HIV infection. To put succinctly, to be on the safe side of a continuum, one has to hold her/his sex organ tied up.

Similarly, Kidan's case may demonstrate the general existence of safe behaviour. She said,

> As much as possible, I try hard to be afar from practices, contexts, lifestyles and what have you that may put me in the category of risky behaviour, *asgi bahari*. Thus, after a blood test for HIV infection, I want to establish faithful one-to-one sexual partnerships, I also abstain from premarital sex, chewing *chat*, smoking cigarettes and hashish, from certain cultural practices and from lending to and borrowing from neighbours sharpened objects in order to be safe from HIV infection.

Another patterns of sexual activity may take place in the form of single partner sex. As mentioned, somewhere in this chapter, Aster is a case in point.

In summary, many people engage in risky sex due to faulty risk perception and management, and risk-prone social and behavioral contexts. The transmission of HIV infection and consequently, AIDS, is the product of human behaviour enacted in social contexts. Young people who participate in risky behaviours tend to underestimate the risks associated with resistance to condom use, reckless pursuit of sex, belief that real youth do not fall ill and should not worry about avoiding risky activities and so on. Young adults of both sexes have faulty mechanisms for managing risks such as they consider the physical appearance of a partner or avoid 'slim girls,' douche immediately as the condom breaks, even employ the evaluations of their partners' attitudes towards condom use and evaluate their sexual partners' history in retrospect. In addition, different social and behavioral contexts define/condition sexual activities of young people that may be risk-prone. These socio-behavioral contexts are places of entertainment, public places, any encounters in daily life and romantic relationships. In these contexts, young adults are often chewing *chat,* drinking alcoholic liquors, making love and actively pursuing sex. Therefore, they engage in sexual intercourse in these risk-prone social and behavioral contexts.

4.5. Conclusion

This chapter is about youth attitudes towards sex, together with changing sexuality, social dimensions of sex, and social context of risk. For males and females, fairly permissive sexual attitudes are generally found in Bahir Dar, because some young people regard sexual activity as pleasurable and good for health. It is also thought to enhance strength and give power. Similarly, there is conflicting aspect of sex such as need for control of sex and fears about sex. A common youth perspective is to look at sex as natural impulse. On the other hand, sex may be seen as a negative force that required social control. Owing to civilization, most young people are misdirected in their sexual expressions. Such sexual acts may reflect incestual desire. If such sexual desire is not socially controlled then the youth may show animalistic sexuality. The community should devise mechanisms to control sexual activity. Although sex is an important motif in youth daily life, sex has presently become a source of fear and embarrassment. Sex is associated with HIV/AIDS infection and pregnancy. Even if the youth have such perspectives on sex or attitudes towards sex, some people adapt towards safe sex due to HIV/AIDS awareness creating education.

Sex appears in various ways in the compartments of young people's day-to-day lives and overtime. Thus, sex is a complex social phenomenon that is basic to identity, reproduction, prestige, acceptance, affection, companionship, and livelihoods.

High levels of risky behaviour characterize the sexual lives of young people in Bahir Dar. Young adults of opposite sexes in the town have their own mechanisms for managing risk such as they put on two or more condoms at a time, consider the physical appearance of a partner, avoid 'slim girls,' douche immediately as the condom breaks, engage in prayer and condom use, employ the evaluation of their partners'

attitudes towards condom use, and evaluate their partners' sexual history in retrospect. However, not all youth sexual activity is risk-prone. Many people engage in risky sex due to faulty risk perception and management, and risk-prone social and behavioral contexts. Generally, the chapter indicates the significance of and the need to pay attention to the social and cultural contexts of youth sexuality.

CHAPTER FIVE

THE SOCIAL STATUS AND CARE OF PEOPLE LIVING WITH HIV/AIDS (PLWHA's)

5.1. Introduction

As the thesis is about socio-cultural and behavioral aspects of HIV/AIDS, part of this is the social status and care of people living with HIV/AIDS. Quoting Hampton, Anannia (2000: 92) sees living positively with HIV/AIDS in daily life consisting among other things of maintaining a positive attitude toward oneself and others, not blaming others, not feeling guilty or ashamed, following medical

advice, continuing to work, if possible, occupying oneself with non-stressful activities, socializing with friends and family (members), and using condoms during sex and avoiding pregnancy.

The chapter describes the central idea - perceptions and care of PLWHA's (health institutions and others). A self-help model appears to be applicable to the PLWHA's in Bahir Dar. This chapter will examine the perceived causes and reactions towards HIV positive status, focusing on PLWHA's conceptions of events that led to infection and initial reactions (conceptions of self) to HIV positive status. The next section will consider stigma and attitudes towards people living with HIV/AIDS. In what follows, I will be concerned with care and support issues such as health care, family care, and association and support. The chapter finally pulls together the various themes in the aforementioned sections by characterizing the social status and care of people living with HIV/AIDS in the community.

5.2.Causes and Reactions towards HIV Positive Status

Poverty, migration and crisis are closely related in the day-to-day lives of the inhabitants of Bahir Dar. It cannot be emphasized too strongly how central the daily experience of poverty and associated uncertainty and precariousness in describing how PLWHA's in the town have been coping with HIV/AIDS. In this section, I have tried to address PLWHAs' perspectives on causes and status of HIV infection, focusing on their conceptions of events that led to infection and initial reaction (conceptions of self) to HIV positive status.

Turning to my male PLWHA case informant, I present the following story of John, who has been diagnosed to have the virus in his body. The case particularly shows the challenges that may be involved when he is left without any one to lend him a helping hand.

On 6th of Dec 2000, I woke up early in the morning in order to hold semi-structured interviews with one of the staff members at OSSA, Bahir Dar Branch Office. After I had finished the interviews, the staff member introduced me to John, who expressed his willingness to share his life experiences with me.

Case One: John

In a conference room that was arranged for us, I commenced the in-depth interviews and asked him to 'share his story.' John said, "I was born in South Gondar about four decades ago. I abandoned farming to join The Ethiopian *Milisha* in 1978. Following my military training, I went to Harar in order to fight with Somalian insurgents, where I earned twenty birr monthly as pocket-money, which was increased to ninety birr in 1983/84. "

During his thirteen year military service, John drank up to eighteen or nineteen bottles of beer, a few vessels of Gin, *areke* and other liquors in every weekends, smoked cigarettes, chewed *chat* and had sex with multiple partners (because there is no idea of keeping it till tomorrow in 'military house'). Even though John had sex with different women, he lost his heart to a woman, from whom he had his nineteen-year-old daughter.

With the change in the Ethiopian Government in 1991, he left for Jimma and engaged in coffee trading business with the money he deposited in a bank. Unfortunately, although John heard about AIDS on the radio and during health education sessions in military service in 1986, he never gave up risky behaviour. In 1994, John got sick and had signs of bloody diarrhea, fever and vomit. He went to a health center in order to get a treatment. John

underwent the treatment and felt better for some time. Then, he came back to his native place. However, after a week, he sickened again. John continued,

> Since I underwent the treatment at Gondar Hospital and at health centers in Jimma town, I could not get cured. If the disease is different from AIDS, then I may be cured. The signs of my symptoms are quite like that of pieces of information I have heard on a radio for years. Therefore, I convinced myself that the illness was AIDS. Because most of the coffee trading business was mostly on credit and my debtors refused to pay their debts, my livelihoods as trader was bankrupting business deal. Then, I wrote on a sheet of paper that I was HIV-positive and started begging on Sunday. Pedestrians found the condition new, because they had not come across this. Any ways, I collected eleven birr in total. I also sat at the gate of a commercial bank like a person who deposited money. Seeing me there, some depositors became depressed and others said that he appears in good clothes but he is begging. The latter also asked, 'Is he sick?' However, I got quite a bit of money. Surprisingly, while pupils were coming from a school, a female pupil read what was written on the paper and put twenty- five cents on it (she was afraid to put the coin in my hand).

My case informant admired the female student and then expressed:

> I came to know the presence of OSSA in the compound of Saint George Church with the help of the woman who gives support to PLWHA's. Following this, the head of the branch organization asked, 'where did you get the blood test?' John responded, 'I did not get the test, but the disease has become severe and I have no money to buy medicines. Hence, I asked help from pedestrians as if I were a person living with HIV. Whether I got the test or not, I believed the signs were the same as that of AIDS I had heard on the radio. My illness is undoubtedly AIDS.

John received ten birr and a letter from the above-mentioned organization. On the next day, he went to Felege-Hiwot Hospital and took a serological test for HIV. After three or four days, he came back to the hospital for the result. John said, "I was first diagnosed in December of 1994 with HIV infection, when a physician reaffirmed my initial impression. The doctor advised me not to be afraid and anxious, and to take care of others, including myself."

Finally, the researcher asked whether he blames anybody (for having HIV) or not? John replied, “No, not at all, you know, I got the virus because of my actions. You know, I lived as a tied and an untied dog, and the consequences of that brought on the virus." Yet, when John described his feelings about promiscuity, he indicated (that) while it may be a life-style acceptable to most soldiers, for a few it was immoral. Later in his narrative, John reiterated the biblical censure of promiscuity as a sin. When asked, "Do you feel that it is in any way a

punishment?" John replied, "Yes, sure, I do believe that HIV/AIDS is from God and that He is cursing the transgressors. I believe that LORD God is using the pandemic to let people know that it is a wrong life- style and that they are living in sin."

John attributed him with an acceptance of AIDS as retribution without treatment warranted by his past behaviour he had lived. 'Perhaps, this is my punishment from God. Yes! That is what it is," he admitted. Generally, the themes that emerge from his case are his reactions such as degraded status, moral judgements, self-blame, and retribution from God. Following his heart-breaking conversations, let me turn to the second informant.

Case Two*:* Ruth

A female counselor had promised to introduce me to a woman who lives with HIV/AIDS. However, she failed twice in her attempts to do this. One day, I was visiting OSSA's Office, and unexpectedly met Ruth in the counselor's office. Subsequently, the counselor tried her best to convince Ruth to be my case informant. Nevertheless, Ruth refused, giving many excuses. The counselor said, "If you do not volunteer, I will try to find another one." Ruth changed her mind and said, "As I don't want to hurt any one's feeling, I agree to your request." My informant and I went to the room, where I tried to create a more pleasant atmosphere. Ruth played down the disagreement and the interview turned out to be quite successful.

Ruth is a woman in her early 30's who has been living in a military base with her husband and her two children. Her dreams were about improving her living condition. Ruth's life changed dramatically when there was change of the Ethiopian Government and her husband dashed away to Sudan. In an attempt to deal with financial problems and her loneliness, and not yet

ready to start another permanent relationship, Ruth had several casual encounters with men she met at her local brewery. Unfortunately, she soon began to witness signs of HIV.

Ruth mentioned,

> At the age of one, my son began to experience a bad attack of diarrhea, wounds on his head, fevers, night sweats, and a weight loss. At first, I attributed these signs to viral illness, resulting from the turmoil following the displacement. As it was only when my neighbours said that his illness persisted and he was suffering from pain, I then accepted that he should have medical attention and took him to the Felege-Hiwot Hospital. After diagnosing him, a physician prescribed tablets and injections. However, these did not cure him. Once again, my son undertook treatment but the illness did not get healed. Afterwards, he took a blood test for HIV - infection and was pronounced HIV - positive.

In the confusion caused by the result, Ruth claimed:

> The doctor informed me about the presence of OSSA, which is a foundation that supports needy people with HIV/AIDS. He wrote my son's blood test result on a sheet of paper and sent us to the organization. The organization then assigned a counselor and I was given pre-test counseling for HIV. I prepared myself psychologically and went to the hospital. I was told that my blood test turned up HIV-positive in October of 1993.

After being informed about the test result, Ruth was unable to discuss her concerns about HIV/AIDS with anyone except a few employees in the organization. She added,

> I felt shock, numbness, confusion, despair, anger, guilt, anxiety, suspicion, withdrawal and so forth. Thus, I was thinking about or attempting to take many measures against myself, including suicide. I was so afraid to step outside my four walls because of the fear that people recognized my condition. They may take one look at me and know my status. I have looked at myself in the mirror one hundred and one times. I don't look any different, but I know that they see it. It is as if the word HIV, with all its taboos, were branded on my forehead. No, I cannot leave my mini-room. Once they realize that I have the virus, they would lock me up, never come near me. Suddenly, although I interrupted the selling of tea, *areke* and *tella*, and prostitution a few weeks earlier and done my best to erase HIV from my mind because it was rearing its ugly head. This made it impossible for me to be with other people or out in public. I thought because I could not erase this evil spirit (ghoul) from before my eyes, and they must see it, too. Therefore, I was too ashamed to even think of attending religious services and others.

In her explicit narrative, Ruth generally was not aware of AIDS until October of 1993, knew it came from her ex-husband's reprehensible acts, and thought that she would not stay alive beyond 1994/95. Eventually, she underlined, "Thanks to an unforgettable assistance and counseling from OSSA and from CVM, I plucked up the courage to share my life experiences

with the residents." Thus, one can draw from this case such themes as her emotional reactions, fears about social reactions, shame of taking part in social services and then finally getting the courage to share her experience.

In the wake of this discourse, I switch to another young person living with HIV/ AIDS.

Case Three: Ezekiel

Ezekiel is a twenty-seven-year-old Orthodox Christian male deacon from an outlying district. He lives alone in a rented house, but has married parents in the countryside. He worked in a grain-trading job when he was at a religious school. Ezekiel had money, drank and got intoxicated and engaged in sexual relations. Ezekiel adduced, "I gulped down any type of drink such as beer, *areke, tella,* and other drinks as human beings and plants drink water. Meanwhile, I had unprotected sex with many prostitutes. Next, I gave up religious services in a church and pursued trading."

Signs of swelling around his neck appeared after sometime and then developed into 'scrofula of neck' (disease causing swelling of the glands, probably a form of tuberculosis around neck) and also had a bad diarrhea. In what followed, Ezekiel's skin developed rashes and wound. He complained that there was not a part of his body left sacrosanct. Ezekiel was devastated at the realization of what a mistake he had made, and felt guilty and incompetent in trading and become extremely depressed. He had realized soon after his signs began that he needed blood testing. Ezekiel then went to Felege-Hiwot Hospital. It was then that he learned he had the virus. Ezekiel said:

> When the result I dreaded was confirmed, suddenly darkness descended; the ghost of my grand parents who had worshipped their guardian spirits came back to haunt me. I was embarrassed and ashamed to stand with people. I felt dirty, undesirable and frightened that I would be separated from my parents because of the illness. My anxiety, frustration and what not grew as the signs worsened. Since the doctor at the hospital counseled me how to cope with these problems, then 'arrows of the wicked spirits' left for the atmosphere, and I became settled.

In response to my question about his previous awareness of AIDS, Ezekiel voiced,

> I did not know about the disease and the virus. However, I believe that as we live against God's words and laws, God becomes vexed and He gives sinners to the devil to be punished. AIDS comes as chastisement in order to exterminate us. For me, it is surprising to think of a medicine, which can cure this lethal disease, albeit we have heard its invention on radio news. However, I have no mind that fantasizes about such medicine. Well, I believe AIDS is chastising disease and I understand the disease has no treatment. It is reluctant to release me and will kill me. I live by bearing these facts in mind. In my opinion, death is death. Until my death, I am ready to give service to the community. Above all, AIDS is that ugly and horrible illness.

Reactions to knowing about his seropositivity status include: feeling that he was in darkness and being attacked by the wicked spirits; as well as feeling embarrassed, dirty, anxious, undesirable and frightened. Moreover, he felt separated from parents, like a sinner to be punished by the devil, fatalistic death but also exhibited a readiness to give service to the community.

On the other hand, youths have their imaginations how PLWHA's become HIV-positive and also express their attitudes towards them. Kidan's words can be example of negative and judgemental attitudes towards PLWHA's. She said,

> These persons have been engaging in unprotected sex with many women. They do not take care of themselves. The virus infects them. These people are loading or unloading the virus. Thus, I consider PLWHA's as evils or killers. I show very negative attitudes to persons living with HIV.

To summarize, one can draw the following themes from this section: self-blame, a sense of being punished and a lowered self-image/social value. Finally, it is now time to discuss PLWHA's encounters in the community.

5.3. Stigma and Attitudes

This section focuses on two aspects of PLWHA's. From the beginning, HIV/AIDS epidemic has been accompanied by an epidemic of ignorance, fear, and denial, which has led to stigmatization of PLWHA's, their family members, and caregivers. Stigma is a multidimensional concept whose essence centers on the issue of deviance. A stigmatized person is regarded negatively, for having violated rules. Stigma usually represents a construction of deviation from the ideal or expected form of behaviour. Others are stigmatized for being the sort of people that have traits that are not highly valued (Birenbaum & Sagarin 1976: 33).

In Goffman's perspective (1963: 2-5), stigma is a powerful, discrediting and tainting social label that radically changes the way individuals view them and are viewed as persons. When individuals fail to meet normative expectations because of attributes that are different and/or undesirable they are reduced from accepted people to discounted ones.

Finally, stigma creates social boundaries between the normal and the stigmatized. Drawn from the foregoing discussion, the essential meaning of stigmatized people are a category of people who are pejoratively regarded by the society, and who are devalued, shunned or otherwise lessened in their life chances and in access to the humanizing benefit of free and unfettered social interaction (cited in Anannia 2000:79).

The 'unhealthy,' 'contagious,' 'sexually deviant,' and 'addicted-minority' other - all are condensed in the negative symbolism of HIV/AIDS. PLWHA's can be considered stigmatized because their status is thought to be contracted via a morally sanctionable behaviour and therefore thought to represent a character blemish, perceived as contagious and threatening to the community, associated with an unaesthetic form of death, and viewed

negatively by health care providers. In this respect, let me describe "the external labels" attached to them.

Case One: John

John's comments illustrate fears of contagion. He recalled,

> At the beginning, after I have taught members of the community about AIDS, the majority of them start thinking of the disease like a lance which can be thrown at them. Hence, they are stigmatizing me. In our daily routines, those people who come across me along the road think that our eye encounters could transmit AIDS. Others use very awful words to insult me, go away from the street, find a shortcut and they don't want to look at me. Some others don't like to have me called to a coffee ceremony in my neighborhood, do not have me haul water, do not rent me housing, denigrate me and don't want to exchange words with me. To put succinctly, the majority of them consider my eyes as ammunition fired from *shaebiya* (EPLF) soldiers. As there are 'labels' which are stacked to and fixed to my body, I always meditate these labels and others. Oh! How can I walk upright in public?

Ruth also identified feeling shunned as an aspect of stigma among the community. She said,

> For instance, one day, I taught about AIDS and shared my own experience with the participants at Mulualem Cultural Center. After I had finished the lesson, I wanted to have a seat. While going in between seats my clothes touched theirs, and they were feared of it. If this was the case in villages, they pinched and washed that part of their clothes. Before I exposed my HIV status to the public, I was a housemaid on daily labourer basis. These people for whom I worked did not want me to bake *enjera* (Ethiopian bread) or they fired me from such household chores. My employers said, 'Oh! This would expose us to the virus. '

One of the group discussants said,

> Someone with AIDS should be isolated. There should be a specific place to put her/him, but s/he should get care until s/he dies. S/he is a threat to the rest of the community. In order to protect the community, s/he should be stigmatized and isolated for the sake of the others. It is generally better to isolate them rather than put the majority at risk.

The following three quotations from Ruth exemplifie*s* social isolation. She angrily said,

> Not even I stay at home in bed due to sickness. As I appear in public to teach about my health condition, I encounter so many problems. Those persons who know my situation tend to exclude me from many social interactions or ostracize me. For example, I had to discontinue taking part in a coffee ceremony in neighbourhood three years back. In olden times, when some people commemorated a religious occasion in the name of one of the saints, they invited me during the day. However, those persons currently don't invite me to take part in such occasions. At night, a neighbour provides me with food and drink by her housemaid. Here what is funny is that the vessel is immediately taken. Similarly, other acquainted persons who have been inviting me home do not provide me with *enjera* (Ethiopian bread) with sauce of spiced pepper; this is not because of their greediness, but because of their fear of people's backbiting, veiled insults, and criticism.

Ruth went on,

> Acquaintances used to kiss my cheeks and greet me, engage in playing, dancing (with leaps) and romping with me in the past. All these are left for memory; they dislike to see and to present verbal greetings. I was also thrown out of *equb, eder* and other self-help associations.

Generally, from the above discussions one observes social exclusion that is one aspect of stigma. Fear, social distance and suspicion (self isolation) are another aspects.

> Sometimes after I have taught about AIDS to the community for their own sake, I feel afraid. I have an uneasy feeling or fear that the members of the community may strike me very severely. Moreover, I could not sit at a table with people except for employees of OSSA and of CVM, including trained counselors. My neighbours also suspect that I taught the community for the sake of money. Then, they asked, 'Is it true I live with the virus? Is this the reason that she doesn't have to work?'

Ruth furthermore talked about her ejection from her house. She stated about social rejection and displacement.

> In the past, I lived in a rental house. The first time, I taught about AIDS in public. When I came back home, the owner fired insults at me and I was expelled from the house for exposing my status. In addition, as soon as I left the house, the owner brought a daily labourer in order to daub the dirt floor with dung and then to sprinkle it with *malatayen* so that the virus may not infect members of the household. Thus, there is a conspiracy to insult and hit me.

The wish to forget often became the need to start a new chapter in life. Ruth also maintained, "I had better look for a smaller house where I can go to live away from those neighbours, for this is not my house. It belongs to the *Kebele*'s Administration Office ... I have always felt ashamed. This is the state of things and I can't help it!" This case exemplifies another result of stigma - being forced to move.

The following statement by Ruth is an illustration of the abuses and insults that stigmatized PLWHA's experience. Ruth continued, "Currently, as I reside in kebele's housing, I hear insults which have me deeply. For example, they insult me by referring to me as the one with

AIDS, who is organized under an umbrella association for people living with AIDS and limited to it, and the one who has been staining so many people in Bahir Dar."

Ezekiel shared his experiences of prejudice against and abuse of PLWHA's. He strongly argued,

> My publicity brings about prejudice. For example, there are some 'healthy,' but mad persons who insult me using insults, which may penetrate even to dividing my bone. There is a pregnant woman who always insults me whenever she comes across me. She said, '*ante edesam*, you, a person with AIDS, live in aid of government finance. However, you become arrogant and you can do nothing to me. Because I have fat and quick- tempered sons who, could hit you. ' Nevertheless, as I could do nothing I prefer to be quiet - I think that the woman is not resocialized about AIDS, so she usually defiles me.

Families of persons with HIV/AIDS also experience social stigma, which may result in suffering of heart, mind and soul, with serious longer-term consequences. Ruth recalled, "... But I dislike a lot of young people's lack of understanding, because, you see, they start saying, 'your brother has died of this, your husband lives with it and you also have it *(edesam),* and perhaps you are from a family of AIDS.' Thus, I don't want that for my children."

Family members often hide the HIV status of PLWHA's. For example, they give pretexts such as s/he is sick of TB, typhoid, cold, and so on. Another form of ambiguous behaviour has to do with the process of information control in order to ensure someone else's provision of support for the PLWHA's. In the course of the study, at least one case was identified where the family assigned a domestic worker from a rural area to look after a PLWHA. However, the worker was not fully informed about the conditions of the person she was caring for, according to my eyewitness. Both the above two paragraphs are examples of how families of PLWHA's cope with stigma.

In contrast to such negative attitudes to PLWHA's, some youth's have positive relationships with them. Two focus group discussants shared such positive attitudes towards PLWHA's in addition to feeling of ambivalence.

We have had food and drink with a female who lives with the virus. We also visited her at her home. At times, when visiting her, some people in a neighbour suspected us as of being in love with her. One of them asked, 'Up to now, we have been taught many pieces of information about

AIDS. However, to what extent each of us performs the lessons in our day-to-day activities of social life, we may use our mind to evaluate this - the majorities do not implement the lessons. '

The other discussant adduced,

I have shown kindness towards PLWHA's when I find myself in distinctive atmosphere that seems to have their problems in the air, esp during panel discussions about PLWHAs' conditions usually hold in Mulualem Cultural Center. Nevertheless, I don't know why everything vaporizes into the atmosphere and I simply pay Ethiopian sign of humanity, lip- service to their problems, but 'we' still do not show our humanity in real sense.

The researcher further heard humanitarian words from Sophia regarding people living with AIDS. She described,

In my *kebele* urban setting, I have a friend of mine who lives AIDS. I, including my intimate friends are friendly to her as much as possible. We always chew *chat*, drink coffee and smoke cigarettes with her. I was educated about PLWHA's and did not want to stigmatize her. Thus, she leads a relative happy life. In contrast, there is an unpleasant surprise. Even though we provide care for her and tell her about her HIV status, she does not show great care for us. She has been attempting to infect us many times by cutting her finger deliberately and then holding a cup with her hand on which there is the injured finger when there is coffee ceremony at her home, using my lipstick, and by borrowing and using sharpened equipment.

Along with the above-mentioned positive attitudes towards PLWHA's, a few young adults also feel responsible towards them. Yacob has this to say,

When members of the community visit PLWHA's, they should use words which are filled with hope. In addition, the young people should show commitment for providing care to people living with HIV/AIDS. We should not insult PLWHA's using very bad words because God holds them by the wrists. The youth should be responsible for providing psychological support, taking them to entertainment places and teaching them. We thus have to use our eyes from the humanitarian perspective. Young people should generally be responsible for PLWHAs' care and love.

His justification for the need for responsible attitudes towards PLWHA'.s was:

In the *keblele*, there are many people living with HIV/AIDS other than those persons who have exposed their HIV status to the public. Here we must believe one thing. Basically, PLWHAs' spirits have already been broken and such spirits must be renewed. There are many obstacles in one's life development such as car accidents, illnesses, financial problems, etc. Therefore, we may be in their shoes in the future. Young people, including other members of the community must believe that the disease is like any disease in one's body. For example, TB patients and PLWHA's are in one campus. The latter live in line with their inherent behaviour and think about the virus, which is without medicine. Against this view, PLWHA's work, play, entertain, etc. like us. Thus, there are a hundred and one persons in the community who live with HIV although they don't go to the hospital for confirmation. Accordingly young people should be responsible for PLWHA's.

In comparison to the many residents in the town, who are judgemental of the persons living with AIDS, Yodit's words can be an illustration of non-judgemental attitudes towards them.

The public judge the persons living with AIDS from sin perspective. However, I do not run away from them. For example, there is a young female who lives with the virus. She owns a bar, but no one enters to entertain himself. Therefore, she started a *chat* business, but no customer came. They think that she may infect them with the virus. In contrast, I don't want to judge her by her misdeeds. Such conditions may happen by accident. Thus, I advise her, do some chores for her, and eat food with her in the same vessel. Generally, I should not judge persons living with the virus from as sinners, but I should judge them by putting myself in their position.

The reactions of PLWHA's towards their HIV and social status can also affect their relationships with others as well. *Sophia*'s experiences can be a case in point.

I know that my childhood friend got infected by HIV. My friend and I usually chew *chat,* take part in coffee ceremony and smoke cigarettes together. However, I don't drink coffee with the same cup; there is a cup for her use. While chewing *chat* I do not share cigarettes with her. When there is coffee ceremony at her home, she usually cuts her finger deliberately to provoke me. She then holds the cup with her hand on which there is the injured finger. Therefore, this condition places me in dilemma. On the other hand, without my consent, she uses my lipstick. When I opposed her action, she said that this action would not transmit the virus. I therefore cut the tip of the lipstick with a razor blade and give it to her for use. She often tries to contaminate me. By so doing, she wants to equate me with her status and she keeps on doing this whenever she finds convenient conditions. Formerly, the girl was mischievous. In the end, I decided not to drink coffee in a cup which has been poured in my absence, because I think she may draw a blood out of her vein with syringe and needle, and pour it in the cup. All these fearful and supportive interactions and relationships are due to the fact that I get convinced that PLWHA's should not be stigmatized and isolated from the community.

Along with young people's social norms, let me describe negative reactions of PLWHA's.

Zehara said:

People living with AIDS have firm beliefs that members of the community insult them using awful words, and nonverbal communication, i.e., gestures, facial expressions, etc., which conjure up unpleasant memories and hatred for the rest. In addition, the majorities see PLWHA's from very bad point of view. As persons with the virus believe and know this, they become malicious persons. They develop vindictiveness and start avenging the remaining members of the community. Until

their death, the persons with AIDS engage in unprotected sexual relationships with many women. For instance, there was a rumour in *kebele* 13 in the town. Some persons got HIV test at the hospital, but the results delayed for weeks. Then these persons drew out their blood with syringes and injected others.

On the whole, the social status of PLWHA's can be characterized as stigmatized - where they experienced hostility, abuses and insults, social isolation/self isolation, displacement, etc. Stigma is contextualized and there is variation in time, situation and space. However, there are instances where youth are accepting of PLWHA's.

5.4. Care and Support

In this section, I will describe health care, family care, support for PLWHA's, and their association. It is important to recognize that illness is not a private phenomenon. All people are involved in one or more social networks. When they fall 'out of sorts,' the modifications of their behaviour will eventually affect others in those networks. Illness may therefore be said to be a social and psychological concept.

a) Health Care Institutions

Whenever PLWHA's receive health care and assistance from health professionals, there is a social relationship, of whatever duration, between PLWHA's and caregivers. There is a referral system in the town between the hospital and centers such as the Organization for Social Services for AIDS (OSSA), and Centro Volontari Marchigiani (CVM). The former is an NGO for providing care and welfare, counseling, education and training for PLWHA's, and for funding HIV/AIDS projects. CVM is also an international NGO engaging in care and welfare for PLWHA's, community outreach, education and training, income generating

activities, information and communication, patient care, and research on best practices. The centers are generally places whereby PLWHA's who require ongoing counseling and social support are referred to. The centers are open from Monday through Saturday, when counselors will be assigned to see and counsel their clients. These counselors are either employees of the centers or train counselors from other organizations in the town. At OSSA, a file is kept on about 150 clients along with their letters of reference from the health institution.

Meetings between doctors and patients are frequent and regular occurrences. At Felege-Hiwot Hospital, such meetings occur between general practitioners and their patients every working day, while a large number of consultations also take place at (private) clinics. The success or otherwise of these medical encounters is often influenced by the nature of the relationship between doctor and patient. Central, to medical diagnosis and treatment, for example, is the exchange of information between doctor and patient. However, unless PLWHA's feel at ease and are encouraged to talk freely, they may not disclose the 'real' problems that are troubling them or express their concerns, which may thus remain 'hidden' (Scambler 1991: 47). In what follows, the PLWHAs' experiences with the health care system of the hospital will be described.

Case One: John

According to one of the officials of OSSA in Bahir Dar, the disease as a health problem requires a level of medical treatment and personal care that extends beyond the range of services available in a patient's residence. His organization facilitates the referral of such cases to the hospital in order to help people living with HIV/AIDS. From the standpoint of the official, the PLWHA has adequate access to health care. Here let me give this opportunity to John.

The case informant recalled,

After I had been diagnosed as HIV- positive, I went into a long explanation about my HIV status with a health professional at the hospital. Whenever I feel illness, I usually go to the card room where I receive a medical treatment chart - like other patients. Next, I wait my turn sitting on a bench beside a physician's office to get a diagnosis and treatment. I recognize particular bodily signs such as pain, a high fever and others, and then I express them well to the doctor. On his part, the respected physician welcomes me warmly with a smile. In addition, he listens very carefully and makes his diagnosis, and finally the doctor either prescribes drugs or writes a request for a laboratory examination.

However, John further expressed his abhorrence for some health professionals in the system by saying as:

After that, I take the prescription to a dispensary where I encounter many difficulties, because of my HIV status. Like persons in the card room, a female pharmacy technician belittles me and she does not consider me a human being. I find it belittling to be criticized by those who are so much younger than me. For example, her mood changes in the twinkle of an eye. In these workers' eyes, I am like an old piece of rag, which is torn and discarded. Moreover, I am like a rubbish bin in rubbish damp. However, I am not surprised at their actions. Such foolish acts don't astonish me, because the officials of the town do nothing for their citizen and brother, albeit they have allocated sites for the rubbish bins. Leaving all these aside, I request my God for His forgiveness for what they have done wrong - they do these either knowingly or unknowingly.

In an explicit articulation of his experiences in the health care system, John, without worrying too much, added:

The pharmacy technicians and the laboratory technicians are very very problematic persons. When I take the prescription to the pharmacy at about lunchtime (esp twenty or thirty minutes to midday) the pharmacy technicians take in the paper and read it. If it is from PLWHAs' physician or counselor or nurse, then the technicians postpone the dispensation during the evil time [to their mind] to the afternoon. In contrast, the technicians also say that those patients who come from Room Number 49 bring very great problems. These acts bring about misunderstandings with me. Consequently, the delivery of a drug or a tablet is postponed for tomorrow. Thus, the technicians and workers in the card room are problematic persons.

John further said, "Let alone non-relatives, even my mother may get tired of care provision for PLWHA. I felt very sorry and depressed in being separated from my family, relatives and from my only daughter."

John finally concludes that these reactions are due to his HIV status and his experiences with the health care at Felege- Hiwot Hospital are very interesting, for he has very good relations with his physician and his counselor. Notwithstanding this, John’s relations with workers at lower level of the institute are full of hostility, delays, etc. These relationships may primarily

emanate from their lack of awareness and belittling attitudes. He continued, "I leave aside both the speakers and their words. However, I usually present these problems to the Medical Director of the hospital who gives solutions to the encounters - there is a chief for chiefs."

Within the same narrative framework, the female informant will reflect on her experiences in the hospital.

Case Two*:* Ruth

Ruth has this to say:

> Owing to my husband's faults, our son and I are affected by HIV. If this is a life, then I live with the virus and I am temporary customer of the hospital's out patient department. When I have a splitting headache and/or wounds on my skin, I usually go to the hospital in order to get necessary treatment. Even though the disease cannot be cured, the physician gives treatment for illness related to HIV/AIDS. In any event, praise to God, my health is well. My body weight is in good condition. In addition, I have blood tests during certain intervals of time.

On the other hand, Ruth has no problems with gate - keepers/guards and with janitors. Ruth said,

> Mostly, I take my wound case to the physician who prescribes ampoules [small sealed containers holding a liquid especially for injections] for seven days. If they are not within reach, the doctor writes a referral to Bahir Dar Health Center where the ampoules are usually available. When I am not so lucky, I simply praise God and ask for His help.

Ruth tended to play down her complaints regarding the health care system. However, her experiences with the health care at the hospital are not without challenges. Ruth also expressed,

> When I find myself uncomfortable mentally and physically, I wake up early in the morning and go to the hospital in order to have my treatment chart from the card room. If I am lucky enough to come across those workers in the section who are educated about HIV/AIDS, then they give the chart to me immediately or they present it to the physician as soon as possible. It follows that the doctor diagnoses and gives a prescription. Oh! It is really annoying to go to the pharmacy to get the prescribed medicament. The technicians usually refuse their help because they are angry with PLWHA's. To my mind, they cut off their noses to spite their faces, meaning they hurt themselves in trying to take revenge on us.

She continued,

> Surprisingly, there was an instance of great disagreement with the technicians. I argued that almost all necessary medicaments, drugs and what have you had been made available by the Ethiopian Government. However, the technicians become a very reluctant helper. They did not want to give the prescribed medicine(s) to me. I told all these to one of them, and I even asked, 'Do you think the state is poor?' In addition, one day, the pharmacy technician read a prescription without looking at me and set a price. Needless to say, when he was counting a medium - sized spoonful tablets, he recognized me at a glance and claimed unfairly that you the one who is victim of AIDS, you are useless (*ye-mmatrebi),* worthless (*waga-yellesh)*, and are inferior to others (*ye-hullumm betache ye-honesh).* In addition, he expressed a veiled insult (*asemur)* and said that you the one who has been a thorn in mud (*ye-cheka eshoh),* said we became bored by your frequent visits to the pharmacy, that you the one who is bushfire among the community, and other very awful words which I don't want to recall. Afterwards, he said that the drug was not available, but I presented the prescription to an administrator. The official helped me (to) obtain the tablets. Thanks to the boss the technician eventually received a formal warning.

In conclusion, similar to the previous case, one notes a difference in her perceptions of Medical Doctors (MD's), on the one hand, and pharmacy technicians, on the other hand. Ruth perceived MD*s'* care provision as faithfulness to their oath, whereas she viewed the acts of the technicians as breaking their promise to the public.

Next come Ezekiel's experiences.

Case Three*:* Ezekiel

He stated:

> For many outside observers, I don't worry too much and remain outside the difficult health care system at Felege- Hiowot Hospital. In 1999, I heard the awful news about the presence of HIV in the blood at the hospital. Then, since I need to go to the hospital regularly, I start living close to it. I have frequent therapeutic encounters with a physician, male nurse counselor, and a male psychiatric nurse. However, there is a female guard who creates untold problems, which are difficult to express in words. For example, one day, when the same guard handed out a result of a blood examination, she stashed away the paper more than once. She said, 'Even if you keep on taking blood tests, you cannot be cured indeed! You are at death's door (I became a fish out of water). Then, the guard added, 'Why do you drain governmental resources and influence on our health care plan performance or the health professionals' care providing activities? [There is no smoke without fire, meaning there is always some reason for a rumour].

According to the chief medical officer, they have good relations with PLWHA's. He argued that when he considered the supplies, counseling service, provision of care for admitted cases, and care for orphans, the professionals did their best. The hospital has received aid in terms of medicines and other medical supplies from CVM and other 'benevolent organizations' for

people living with HIV/AIDS. However, the cost of caring for PLWHA's in the hospital has serious repercussions on the institute. When asked about problematic workers, he responded, "It is due to their lack of awareness of AIDS and to their fear and suspicion of PLWHA's [*ye - kerb asallafi gorebettun yegodale*, a waiter who is near to one will hurt his/her neighbour]."

In conclusion, PLWHA's face unexpected challenges at the institute. They are considered as 'different' patients in the institution. PLWHA's get support from one physician, two nurses and other health professionals who don't experience difficult problems apart from scarcity of surgical gloves. The PLWHA's I interviewed were not happy with workers in the card room, with laboratory technicians and the pharmacy technicians.

b) Family Care

In addition, it is important to discuss family care for people living with HIV/AIDS. This is from the importance of understanding the most immediate context, the family, in which for many people HIV-related illness evolves.

With this background, let me proceed to the discussion of PLWHA's care in their familial networks. The family care for persons living with AIDS is delivered through existing kinship structures and gender relations. The majority of care in Africa are given to PLWHA's by blood relatives. For those who are married, spouses have also been major providers of care. Studies in Uganda conclude that PLWHA's are cared for by their families, with most of the burden borne by women, including wives, mothers, sisters, aunts, and grandmothers (Caldwell *et al.* 1993: 241). In this study, I collected data on the types of care providers for PLWHA's and the problems and issues they faced in caring for them.

In Bahir Dar, most of the married PLWHA's I observed were given care by their wives. In the community, support for PLWHA's was characterized by great demands on one's time and

physical and emotional exhaustion of providing care, leading to near burn out in some cases. The tiredness that comes from having to provide near constant home care to PLWHA's has consequences for the family's own rhythm of life. New activities have to be accomplished without neglecting daily chores. Yacob's words can be an illustration of a young boy who has been receiving care from his mother and sister. He said,

> I know a friend of mine who is living with HIV/AIDS. He received care from his mother and his sister. My friend used to say, 'My mother, I am vomiting now, or 'this diarrhea just doesn't go away,' or 'massage my back' or 'turn me this way and that and lay me down on my back or on my right or left side to sleep. He used to ask for different things frequently. Meanwhile, his mother had to brew a local beverage as a means of livelihood. For her or her daughter, caring for him was a time consuming and irksome routine activity.

Similarly, mothers and/or grandmothers undertake the provision of care for certain PLWHA's. Sophia's experiences can be an example. She said, "I know a lady who is living with AIDS. At times, when she gets sick, both her mother and her grandmother stay at her bedside." Older children are also taken out of school, not only to reduce pressure on the family budget, but also to help with the care of the sick member of the household. For instance, Ruth has her only daughter as care provider at home.

The range of individuals who are giving care to PLWHA's is often wider than the immediate family. Moreover, HIV/AIDS has created a set of circumstances whereby unusually wide ranges of individuals are providing care for PLWHA's. Ezekiel, for instance, receives heart-felt care from non-relatives. He emphasized,

> I have no relatives in the town. At present, I live in a rented house. The owner is a priest in an Orthodox Christianity Church. He and his household members provide care for me. For example, they provide food, drink, pocket- money and a bed. Surprisingly, as the householder is a dedicated Orthodox Christian, I am present at all family meals on the same dining - table, even though, the priest, including his family members are not my blood relatives.

Some relatives were unwilling to provide care however: Ruth's interaction with her maternal aunt can be a good example:

My son was getting thinner and thinner. By that time, however, I was struggling to survive by selling tea, *areke,* and *tella*. Things were not going right. I was also fighting a lot with myself; because I was having sex only with my husband - I thought my son's father was in denial. After I had tried my best, I went to my aunt so that she could help me with my two children. I stayed a few days with her in a kitchen. I had no money. Needless to say, my aunt despised me and was reluctant to see me at her house. I used to look at my children and cry. I asked myself, ' what do we mean by relative (s)?'

On the whole, the Amhara traditional health care approaches reflect the centrality of the family. At the nuclear family level, women are the primary health care givers. Although socio-cultural patterns change slowly, the arrangement whereby the burden of care rests with the family is expected to remain the norm rather than exception. This is likely to be the basis for the current trend in the region - to situate AIDS care at the home and community (Ankrah 1993: 13). This is likely to apply pressure on women as primary caregivers in the family to withdraw from paid employment.

Research on care giving conducted in other areas has also found consistently that family members most often serve as caregivers. Specifically, women - wives, mothers, sisters, middle - aged daughters, aunts and at times, grandmothers - are most likely to take on the care giving role. Thus, patterns of family care are deeply embedded in the kinship system. Care at home provided by family, friends, neighbours or paid workers are not without problems. Very few of the care providers have ever had any training in looking after sick people. Many of them were not concerned about their lack of awareness and skills. They might also not be concerned about getting infected.

Along with the above, the natural progress of AIDS can lead to deterioration in PLWHAs' condition which may frustrate efforts to provide care. The impact on family members severely drains their will to provide support and confronts them with dilemmas of whether or not to provide care, how and to what extent. Yacob's observation of a young person living with HIV/AIDS, a next-door neighbour, is a case in point. Sadly, he said,

Believe me, he was all bones. It was horrible bathing someone like that...Hadn't he been her brother it would have been very challenging... - you get shocked. She is mostly thinking about her brother's condition and her futile endeavour to provide care for him. However, as she uses gloves while providing care, she does not reject her brother due to fear.

Moral judgements on the part of a person caring for someone with HIV/AIDS may also influence the level of care that is given. Here one should bear in mind that the care provider may believe that the person has become infected through misdeeds. As a result, the care provided may be kept at minimum. I have witnessed negligence of PLWHA's by family members. According to a female care provider in her late 20's who cares for her elder brother:

I take care of him, but I abominate him. It is the disease, which he himself has contracted from going round and about. If I thought that he had got it from a needle or another similar mode of transmission, I would sympathize for him and would take care of him. Since I know that my brother used to go around (being promiscuous), I will give him what he needs. However, I will not spend too much time with such a morally corrupted brother.

Generally, Bahir Dar community seeks to consolidate the values, which have traditionally conferred on the family; it can ill-afford to ignore the still viable kinship structure in its search for channels through which to confront HIV/AIDS. In order to receive support and care from care provider(s), an individual needs to let them know about his or her HIV status. Given the stigma associated with HIV/AIDS, it is not uncommon for those affected to want to keep their HIV status a secret. The difficulty families had in explaining to themselves and to others the problems of having an HIV- positive member was directly associated with the interest that PLWHA's had in controlling the information flow about their own status. This dilemma to tell or not to tell, may compel PLWHA's to resort to often-complex information control strategies (Goffman in Castro *et al*. 1998: 1477). However, attempts to control this information are limited by the physical signs of HIV/AIDS - slimness -which has become the sign of PLWHA's in Bahir Dar.

c) Self-help Association

In attempts to understand how PLWHA's cope with their problems, I have been also concerned with their self-help association, Megbare Hawariat Association, which is another source of social networks and support for PLWHA's. It is founded by PLWHA's and their supporters and has quite a few members involved throughout all levels of the organization, including the leadership. Its mission is mutual self-help, and PLWHA members take responsibility for controlling the Community-Based Organization's strategies. The majority of the members are PLWHA's, including social sector workers in OSSA, Bahir Dar Branch Office. Thus, PLWHA's may act simultaneously as service beneficiaries and providers.

The self-help Community-Based Organization, Megbare Hawariat Association (MHA), is often quite visible within the community as an HIV/AIDS organization. "In order to be able to speak out publicly as a PLWHA we have to be financially independent, and our families (if any) must be prepared to put up with the criticisms that will be made against us," said an official of the association. Ruth's and John's earliest experiences of self-help activities came when they were encouraged by OSSA in order to join up with one another and establish the association for people living with HIV/AIDS. "After being diagnosed, we felt we had nowhere to turn," recalled Ruth and John. The need to share our thoughts and educate ourselves about the disease impelled us to correspond regularly with MHA members. About four years ago, with the support from OSSA, thirty- five PLWHA's from different *kebeles* of the town came together under the single umbrella association, MHA. Ruth added, "The presence of members as PLWHA's underlined the fact that we, PLWHA's, needed to push our insecurities aside and to help other members of the community in the town. In so doing, we might get help from them - we reciprocate help or give and receive help in return." She was elected as an official in the association. The hope was that it would encourage more women living with HIV/AIDS to come out publicly to work together in solidarity. The association

membership has responsibility for care provision to the PLWHA's who have associated with MHA.

The members of MHA meet on the third of each month, which is *Bata,* the date that commemorates St. Mary on the Ethiopian Calendar. When the members had meetings, they raised issues such as how to prepare their association procedures in order to get legality from Bureau of Disaster Prevention and Preparedness of the Amahra National Regional State Administration; how to give home based care services, psychosocial support, and HIV/AIDS awareness raising education for members of the association and the community at large. The members also discussed about problems encountered and their solutions (if any) and the association's future plan. Because the majority are poor and uneducated persons and they could also not get professional assistance from the 'officials' to prepare the procedures, the PLWHA's were not able to get legality. On the other hand, although the members of MHA did not pass 'the rite of passage,' they gave care for bedridden member PLWHA's. Attempts were also made to involve family members and other volunteers in such services, but the attempts were not that much successful. Moreover, the members tried to give massage, dress wounds, help doing physical exercise, educate about personal hygiene, help purchase drugs for weak PLWHA's, take the patients to health institutions, and others. In their capacity, the members gave bits of advice to some people living with AIDS in order to help them cope with the problems associated with the disease. These pieces of advice helped a few of them develop the courage to live positively, share their HIV status for others, give their personal testimony for the public at large, develop positive attitudes towards others, and withstand the burden of the 'labels' attached to them by the community. Generally, it is those who have no access to afford their basic needs who disclose their HIV status and join the association. However, MHA could not provide members with social support (food items, clothes, house rent payment, drugs, and so on). Therefore, the activities of the association were weakened by

lack of support and assistance from GOs and local NGOs. Thus, the association was at risk of disintegrating. Ruth confirmed,

> We find ourselves in destitution. We have tried voicing our concerns to 'officials' who sit in very comfortable positions at GOs and local NGOs. However, they responded by saying, 'Come with your association procedures. ' We could not get assistance, even from OSSA officials. Thus, our efforts are going to waste.

Without great surprise, I recorded the aforementioned statements and resorted to an official of OSSA. According to this official, every person living with HIV/AIDS had a trained counsellor of the same gender. When s/he gets sick, the counsellor, who is their employee, provides care at home. However, PLWHA's strongly argued that when one of them got sick, it was members of the self - help association who provided care for him/her. For example, Ezekiel has a voluntary counsellor from Tana Haik Comprehensive Secondary High School who does not

help him that much in terms of counselling him. He said,

> My counsellor visits me once in a blue moon. Sometimes, when I go to his office for some advice, I cannot trace his whereabouts. Therefore, he does not provide me with substantial care and counselling. However, when I face certain problem(s), I usually go to the CVM Office (as MHA has no office) and get a solution.

Generally, the self-help association is good initiative but has weaknesses. In sum, there are strengths, liabilities/weaknesses and resource shortages in institutional, family and self care of PLWHA's. The facets of institutional care include professionally considerate treatment, and social biases because PLWHA's are considered as 'different' patients and faced problems such as hostility, delays, etc. due to some workers' lack of awareness and belittling attitudes. Moreover, there is scarcity of surgical gloves in the institution. Family care is strong but weakened by social blame. The family care for PLWHA's is delivered through existing kinship network and gender relations. The majority of cares are given to PLWHA's by blood

relatives. Women under great demands of their time, physical and emotional strain, also care for PLWHA's. However, moral judgements on the part of caregivers may affect the level of care provided. The self-help is characterized by strengths and weaknesses. The self-help has accessibility to people living with HIV/AIDS but cannot provide them with food items, clothes, drugs, etc. due to shortage of resources.

5.5. Conclusion

This chapter has dealt with the experiences of HIV/AIDS and those of people in their social networks. These are stories/life experiences or narratives about causes and reactions towards HIV positive status, stigma and attitudes towards PLWHA's, and care and support of PLWHA's in different socio-cultural contexts, also considering deviations.

Youths state that PLWHA's become HIV-positive because they live in risk-prone areas, engage in risk activities and perform certain sinful acts which are against God's words and laws. PLWHA's also admit these as causes of HIV infection.

PLWHAs' reactions to their HIV status vary from person to person - ranging from resort to begging, moral judgements, self-blame, and feeling that they are experiencing retribution. Others experience such reactions as being unable to discuss one's concerns about AIDS with anyone except concerned people, shock, confusion, despair, anger, guilt, anxiety, social withdrawal, being afraid to out of one's house, and suicidal intentions.

PLWHAs' social status is characterized by stigma, with its different facets - including hostility, abuses and insults, social isolation/self isolation, displacement, etc. Stigma is contextualized and there is variation in time, situation and space. However, they also experience social acceptance by the youth. Institutional care for PLWHA's is mixed due to

social biases and judgements. The facets of institutional care include professionally considerate treatment, and social biases because PLWHA's are considered as 'different' patients and faced unexpected problems such as hostility, delays, etc. due to some workers' lack of awareness and belittling attitudes. Moreover, there is scarcity of surgical gloves in the institution.

Family care is strong but weakened by social blame. The family care for PLWHA's is delivered through existing kinship network and gender relations. The majority of cares are given to PLWHA's by blood relatives. Women under great demands of their time, physical and emotional strains also care for PLWHA's. However, moral judgements on the part of caregivers may affect the level of care provided. Generally, my research findings have indicated that the types of individuals who provide care for PLWHA's include women - mothers, sisters, middle-aged daughters, aunts, grandmothers, friends, neighbours or female paid workers or spouses (for those who are married).

The self-help is characterized by strengths and weaknesses. The self-help has accessibility to people living with HIV/AIDS but cannot provide them with food items, clothes, drugs, etc. due to shortage of resources. Generally, PLWHAs' psychosocial status is characterized not only by social isolation, hostility, moral judgements, and emotional breakdown but also by acceptance, professionally considerate treatment, and self-reliance.

CHAPTER SIX

CONCLUSION

This thesis has been concerned with socio-cultural and behavioral aspects of HIV/AIDS among young adults (in the age-bracket 20-29) and people living with HIV/AIDS (PLWHA's), in *Kebele* 4 Administration of Bahir Dar, Northwestern Ethiopia. I have argued that the social context is one of the frameworks that must be considered as part of the process of describing youth attitudes and behaviour. Young adults in Bahir Dar are obviously able to develop forms of acquiring and assimilating social reality that provide them with many facets of sensory, aesthetic, emotional, interactive and communicative experience. However, we have to be aware that these adults develop their individuality in a social context that is insecure, unstable, and hardly accountable. The chapter on the social context of youth life has shown that it is characterized by use of sociolingustically significant colloquial words or expressions, slang words, technical terms and/or argot, risk behaviour, vulnerability, male dominance and female submissiveness.

The discussion of youth conceptions of HIV/AIDS has shown that young men and women in Bahir Dar are knowledgeable about the nature of HIV/AIDS and its transmission. However, there is discrepancy between awareness of HIV/AIDS and behavioral change. The use of youth narratives has shown that their understanding of HIV/AIDS is complex and multidimensional. Generally, one needs to go beyond youth understandings of the characteristics of AIDS and should consider 'folk' conceptions of AIDS, which include - individualized/behavioral, moral and social notions. In this

regard, AIDS is associated with self-destructive behaviour, a romantic/desirable form of death, as a self-inflicted joker, as well as sex itself. AIDS is similarly a symbol for moral failing and a form of God's justice. AIDS also represents certain social categories such as poverty and commercial sex business (work), and symbolizing gender inequality. AIDS is finally conceived in terms of its social functions in the society - in serving as an effective and reliable birth control, controlling population growth, as a source of work and income. Folk conceptions of condom include mixed notions such as condom is conceived as against males' natural, prestigious and holy behavior; against youthful sexuality; the lord's socks to serve as a ploy to reduce the rate of inflow of creative and economically active young Ethiopian populations in general; 'modern' contraceptive sheath as device for America's globalazing effort, innovated by Dr Condom (an American); but it is the defender which does not completely eliminate the risk of HIV transmission.

The reality of HIV/AIDS is intimately intertwined with youth sexual attitudes and behaviour. It is therefore worth giving attention to the meanings and expressions of youth sexuality and risk behaviour in different social and cultural contexts relevant to disease transmission. The thesis has demonstrated that youth sexuality is a function of three components: sexual attitudes, social significance of sex, and risk perception and risk-prone behavioral and social contexts. For males and females, fairly permissive sexual attitudes are generally found in Bahir Dar. Some young people regard sexual activity as pleasurable and good for health, as well as strength enhancing and a source of power. These notions coexist with contradicting notions that emphasize the need to control sexual urges and also with anxiety about sex. We also see that some young people are adopting safe sexual practices due to HIV/AIDS awareness creating education.

Sex appears in various ways in the compartments of young people's day-to-day lives and overtime. Thus, sex is complex social phenomenon that is perceived by youth to be basic to personal expression and self-identity, and a means of replenishing society with new members, acquiring respect, creating social relations, and constructing livelihoods.

High levels of risk behaviour characterize the sexual lives of young people in Bahir Dar. Not all youth sexual activity is risk-prone. Many people engage in risky sex due to faulty risk perception and management, and risk-prone social and behavioral contexts. Young people who participate in risky behaviours tend to underestimate the risks associated with resistance to condom use, reckless pursuit of sex, believing that real youth do not fall ill and should not worry about avoiding risky activities and so on. However, young adults of opposite sexes in the town have their own mechanisms for managing risk. Young adults of both sexes have faulty mechanisms for managing risks i. e. considering the physical appearance of a partner or avoiding 'slim girls,' douching immediately if the condom breaks, even employing the evaluations of their partners' attitudes towards condom use, and evaluating their sexual partners' history in retrospect. The transmission of HIV infection and consequently, AIDS, is the product of human behaviour enacted in social contexts. Different social and behavioral contexts define/condition sexual activities of young people that may be risk-prone. These socio-behavioral contexts are places of entertainment, public places, any encounters in daily life and romantic relationships. In these contexts, young adults are often chewing *chat,* drinking alcoholic liquors, making love and actively pursuing sex. Such contexts may encourage them to have sexual intercourses that put them at risk of HIV/AIDS.

The thesis also discusses the psychosocial status of PLWHA's. This thesis has shown their rationalization of how they become HIV-positive. People living with HIV/AIDS admit that they have achieved this HIV status because they live in risk-prone areas, engage in risk activities and perform certain sinful acts which are against God's words and laws. PLWHAs' reactions to their HIV-positive status vary from person to person - ranging from resort to begging, moral judgements about their past behaviour, self-blame, and feeling that they are experiencing retribution. Others experience such reactions as being unable to discuss one's concerns about

AIDS with anyone except concerned people, emotional reactions such as shock, confusion, despair, anger, guilt, anxiety, and social withdrawal, as well as suicidal intentions.

The social status of PLWHA's is characterized by stigma. They experience hostility, abuses and insults, social isolation/self isolation, displacement, etc. but also acceptance. . Stigma is thus contextualized and there is variation in time, situation and space. The institutional care for them is mixed due to social biases and judgements consisting of professionally considerate treatment, but also social biases by health workers who consider them 'different' patients, which results in hostility, delays, etc. due to some workers' lack of awareness and belittling attitudes. The scarcity of resources such as surgical gloves in health institutions is also a serious problem.

The family is a primary source of care for PLWHA's. Women, especially under great time, physical and emotional demands are central in caring for PLWHA's. However, moral judgements on the part of caregivers may affect the level of care provided. Fear of social stigma forces family members to control information flow about PLWHAs' status. PLWHAs' Self-help association is important because of their accessibility to PLWHA's, but they are weakened by shortage of resources.

This thesis has therefore argued that understanding the reality of HIV/AIDS among youth requires the need to incorporate a broader social and cultural perspective on the reality of HIV/AIDS among the youth, in addition to moral and behavioral perspectives. This is important because the reality or significance of HIV/AIDS among youth is comprised of the social context of their daily lives, their socio-cultural notions of HIV/AIDS, socio-cultural dimensions and context of youth sexuality, and the psychosocial status of those who are HIV-positive.

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APPENDICES

Appendix A: Notes on Case Informants

List of Young Adult Interviewees (Case Study)

Sex	Age (years)
1.F	24
2. M	24

3. M	26
4.M	26
5. F	20
6. M	26
M	29
8. M	23
9.F	26
10.F	24
11.F	21
12. F	20
13.M	20
14.F	27
15.F	21

List of PLWHA Cases

Sex	***Age (years)***
1. M	***40***
2.F	31

3.M 27