

**Socio-economic Consequences of HIV and AIDS for  
HIV-positive Women in Addis Ababa and their  
Coping Strategies**

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**Socioeconomic Consequences of HIV and AIDS for HIV  
Positive Women in Addis Ababa and their Coping Strategies**

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<b>Chapter Five: Consequences of Being HIV Positive</b> .....	53
5.1 Socioeconomic Consequences .....	54
5.2 Consequence on reproduction .....	60
5.3 Pressure on Marital Relationship .....	63
 <b>Chapter Six: Coping with HIV/AIDS</b> .....	 65
 Conclusion .....	 78
Bibliography	
Annex	

## **Acronyms**

AIDS	Acquired Immune Deficiency Syndrome
AAHB	Addis Ababa Health Bureau
E.C	Ethiopian Calendar
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NAC	National AIDS Council
NGO	Non Governmental Organizations
PLWHA	People living with HIV /AIDS
STDs	Sexually Transmitted Diseases
UNAIDS	Joint United Nations Program HIV/AIDS
WHO	World Health Organization

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## ABSTRACT

This research has focused on exploring the consequences of HIV and AIDS for HIV-positive women in Addis Ababa and their coping strategies. 15 HIV-positive women who were accessed from care and support organizations and associations of PLWHA were interviewed in depth on a range of issues related to the challenge they face.

Major factors which render women more vulnerable to HIV infection were highlighted. Different socioeconomic and cultural factors such as; poverty, less access to education, lack of employment opportunities and economic dependency are among these. Due to their low socio-economic status the consequences of HIV/AIDS on the women found to be severe. They also have fewer means to cope up with the impact of the epidemic. The women's socio-economic conditions had also changed considerably since their diagnosis as HIV-positive. Some women's husbands died due to AIDS as a result income disappeared. Moreover, some had children to care for and had to struggle to survive with meager resources.

HIV/AIDS appeared to be the object of stigmatization as a result the women do not only have to cope with their own anxieties, physical symptoms, and economic problems but also with the response or expected response of partners, family members, friends and the community. Due to fear of stigmatization therefore most kept their status an absolute secret. Some of the women who managed to

reveal their status however, noted the positive reaction they experienced. The fear seems to appear greater than the actuality.

The women made use of various coping strategies which can be classified in to emotion-focused and problem-focused coping. Seeking emotional and instrumental support especially from relatives, joining PLWHA networks, religion, and acceptance, positive interpretation and hope are some of the strategies. In particular, joining PLWHA networks and care and support organizations has been observed as a good means that helped most women in coming to terms with HIV status and actively cope with its consequences. PLWHA's associations and care and support organizations provide emotional and instrumental support to the women. By doing so they have created a safe environment for the women to share their worries and experiences with others who have the same problem. Religion was also another most important coping strategy which led most women to accept their situation and to develop hope.

# Chapter One

## Introduction

### Statement of the problem

Human Immune Deficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) have become a serious health problem in many countries around the world with social, cultural, economic, demographic, political and legal implications for society. HIV/AIDS has succeeded in joining people around the world in a common consciousness about its threats and implications. It has been responsible for the loss of many lives and remains a formidable threat for many more. It is changing not only individual lives but also the trajectories of whole societies (Barnett and Whiteside, 2002).

Although HIV/AIDS has been reported from every inhabited continent and from every country, the risk and the impact is distributed unequally between the poor and rich, between one place and another. Sub-Saharan Africa is the region most affected by HIV/AIDS (Barnett and Whiteside, 2002). The HIV/AIDS epidemic and its impact has reached catastrophic level in Ethiopia. It has become a major threat to the social and economic fabric of the nation (Pankhurst and Kloos, 2000). An estimated 2.2 to 3.0 million people in Ethiopia are infected with HIV which makes the country the third largest globally after South Africa and India in terms of the number of HIV infected persons (NAC, 2001; Ministry of Health, 2002). The cumulative number of deaths from the epidemic in Ethiopia up to the year 2000 is estimated by the Ministry of Health (2000) to be as high as 1.2 million. And 750,000 Ethiopian children were estimated to have been orphaned by the year 2000.

Societal vulnerability stems from the confluence of socio-cultural, economic and political factors that compound individual risk by limiting individuals' choices and options for risk reduction. These include discrimination and marginalization of certain groups of people, illiteracy and lack of educational opportunity, poverty and income disparity, lack of work or economic opportunities, law and the legal environment, political will to mount effective responses to the epidemic, and the states willingness to protect and promote the full range of political, economic and social human rights (UNAIDS, 1999).

All these factors hold true for the rapid spread and severe impact of HIV/AIDS on the Ethiopian society. Kloos and Damen (2000) reviewed the social, economic and demographic impacts of the epidemic in Ethiopia. They indicated that poverty, war, gender inequities, traditional practices, and political problems have been major factors in high-risk behavior and in averting an enabling environment for prevention and patient care/support programs.

As there are differences in the development of the HIV/AIDS epidemic between regions and countries the risks and effects of HIV/AIDS on women in developing countries show striking similarities. The reality for individuals is that, as with their chance of being infected, the impact of the disease will depend on their circumstances and the resources they can command (Barnett and Whiteside, 2002). Due to their low socioeconomic position women are disproportionately affected by the epidemic.

HIV in Africa is predominantly transmitted by heterosexual activity. One of the groups at greatest risk is young women. They are infected at a significantly younger age than men (WHO, 1994). Several complex socio-cultural factors make women in Africa more

vulnerable to HIV. These include low power to make decisions on sexual matters and relatively less access to adequate services and information due to relatively low levels of education, migration of husbands to urban areas to look for jobs (often to return with HIV or another STD), poor nutritional status, poor hygiene, and the necessity to use sex as an economic resource. Moreover, girls become sexually active at younger age than boys, and marry younger; their older partners may also be riskier. Too, sexual abuse, including incest and rape, affects more girls than boys (de Bruyn, 1992; Schoepf, 1993).

Initial states of individual health, nourishment, degrees of physical exhaustion, mental state, work conditions, residential location all influence susceptibility to infections (Farmer, 1996). With specific relation to HIV/AIDS, how the disease progresses, its outcome, is also an expression of social and economic inequality. Thus inequities in the socioeconomic positions of men and women make women more vulnerable. Besides the psychological and social burdens associated with the pandemic is greater for women than for men in similar situations (de Bruyn, 1992).

As in many developing countries similar situations prevail in Ethiopia that facilitate women's susceptibility to HIV/AIDS and their lesser socio-economic ability to cope with its consequences. As a result young females have become increasingly infected in Ethiopia during recent years. Females now have significantly higher AIDS rates than males in the 15-24 age groups (MOH 2002). Of the estimated 3 million people who are living with the Virus across the country, 2.9 million are adults and the number of adult women who are infected with the virus is 1.6 million which is more than the number of adult males (UNAIDS, 2000; NAC, 2001).

In Addis Ababa, an estimated 300,000 persons live with the virus (AACAHB, 1999). According to the report of Addis Ababa City Administration Health Bureau, the HIV prevalence rate among blood donors' women was 6.9% in 1999 higher than that of men (6.4%). In any case, the data available for Addis Ababa and other regional towns indicate that the epidemic has affected a sizable proportion of women in a number of ways.

All these factors reveal that the risks of acquiring HIV and its consequences are particularly great for women and the situations indicate that women require special and urgent consideration in the response to the HIV/AIDS and related problems. However, despite the increasing number of HIV infected women, there is a paucity of research on the consequences of HIV/AIDS for them and their coping strategies (Annania, 2000; Converse et al. 2003). Besides, what support they needed and provided is an area which is neglected. Until recently the government and other agencies that have been working on HIV/AIDS, and research works have been focused on prevention and less attention has been given to care and support for People Living With HIV/AIDS (PLWHA) (Annania 2000; FHI, 2000; Converse et al. 2003; Kloos et al. 2000). Therefore, this study intends to highlight on the consequences of HIV/AIDS for HIV-positive women in Addis Ababa and the way they cope with these consequences. How do the women live with HIV/AIDS? How do they cope? What support women needed and received?

## **1.2 Objectives of the Study**

### ***General Objective***

The general objective of the study is to explore the consequences of HIV infection and AIDS for HIV positive women in Addis Ababa and the way they cope with these consequences; and to assess their need for care and support.

### ***Specific Objectives***

1. To investigate the challenges being faced by women with HIV/AIDS and to assess how the disease confronts women's expectations and hopes.
2. To identify the cultural and socio-economic factors which render the women vulnerable to HIV infection.
3. To assess the women's need for care and support.
4. To assess the different coping mechanisms they employ during the different stages of the disease.
5. To assess the type of relationship the women have with their partners, family members, friends and other members of the community in order to examine the differential impact of social network on the women incoming to terms with HIV and cope with its consequences.
6. To explore the relationship and attitudes HIV positive women have with other HIV-positive persons (PLWHA).

### **1.3 Significance of the Study**

Women require special and urgent consideration in response to the HIV/AIDS pandemic. Considering the impact of HIV infection on women of a particular area may give insight about the many other women with HIV and AIDS. Insights into the consequences for women with HIV/AIDS in the study area and a deeper understanding of their individual coping responses including the role of support will help those responsible providing care and support to HIV positive women to involve the women themselves fully in the development and implementation of activities and to design a better care and support and prevention mechanism.

### **1.4 Methodology and Ethical Considerations**

HIV/AIDS is a social disease that still requires a lot of research from social perspective to develop meaningful and effective interventions. However, research on social aspects of HIV /AIDS need to operate, as far as possible, within the framework of ethical principles, guiding biomedical behaviors research (Pool, 1997). Given that HIV/AIDS is a disease resulting mainly from sexual intercourse, issues about it become very difficult to discuss openly. Sex in many African cultures is a delicate and hidden issue which demands that it should be studied in socially acceptable manner (Pool, 1997; Schoepf, 1993). Of great use in these kinds of studies are the more interactive anthropological methods such as participant observation, narratives, life histories, ordinary conversation and focus group discussions (Pool, 1997). Studying matters as delicate as HIV/AIDS therefore, calls for a qualitative, exploratory approach.

Research participants of studies addressing HIV/AIDS would largely be people infected and or affected by HIV /AIDS. As HIV/AIDS is an object of stigmatization, they risk

confidential information about their HIV status and their social networks to the researchers that can certainly lead to their discrimination in social places, employment, educational institutions and even divorce if it happens to leak out. AIDS is not only a lethal disease but also one which stems from a highly stigmatized condition. Therefore, utmost care should be taken to ensure that ethical issues are given due consideration in all aspects of the research from initial contact to a release of findings.

The methodology I employed in order to gather the required information for the study falls into such a framework. The study was conducted in Addis Ababa and the actual data collection period lasted from mid of October 2003 to mid January 2004. The study is based on case studies of 15 HIV Positive women that were identified from associations of PLWHA and care and support organizations. People who are both infected and affected by HIV /AIDS are always hidden due to stigma associated with the disease. As a result, the women were accessed through associations of PLWHA and care and support organizations that render service to HIV /AIDS infected and affected persons. Although initially about 35 HIV positive women were contacted from different care and support organizations and associations of PLWHA, based on their willingness to be interviewed and by considering other characteristics like marital status, education, age, occupation, stages of their illness, and degrees of status disclosure 15 HIV positive were selected for the case study.

Accordingly, five of the interviewees were accessed from Mekdem Ethiopia and three from Dawn of Hope Ethiopia (both are associations of PLWHA) four from Tesfa Development Association (a community based organization) and the three others from

Marry Joy an NGO. Representatives of these organizations were also interviewed on matters of their organization's activities and type of clients.

Data collection techniques included in-depth individual interviews, a focus group discussion with the women, direct observation and spontaneous and informal discussions.

With regard to how I selected the fifteen women, I first contacted associations of PLWHA and care and support organizations by presenting a formal letter from the department of Sociology and Social Anthropology and describing about the purpose of the research and offering a request to interview their members and/or clients. Representatives of care and support organizations and associations of PLWHA then introduced me to some of the interviewees and explained the purpose of my study and asked their consent. After this formal introduction with the women, subsequent informal meetings and discussions were held privately with the fifteen individual women. Some of the women also introduced me to their friends (other HIV-positive women).

I clearly explained to each individual woman about myself and the purpose of my study. I have promised them that their names shall remain in anonymity and that none of their family members, friends and that no one in their community would be contacted without their consent. In this way, initial contact and rapport started to be established between me and the women. And subsequent formal and informal meetings further created the bond and the trust. The trust between me and the women went to the extent of exchanging telephone calls on matters of mutual concern.

Most of the individual in-depth interview was held privately in the compound of the respective associations of PLWHA and care and support organizations since most of

them did not disclose their status to their family and/or the community at large. Two of the women were interviewed in their houses as they live alone. Two sets of interviews with another two women were also held in a public park as per their request. Moreover, frequent formal and, spontaneous conversations I had with them in their associations and care and support organizations provided me with huge amount of data. Upon a frequent visit to their associations and care and support organizations, I could observe the interactions among PLWHA and the activities of the organizations. In addition to this, the focus group discussion was held in the compound of Mekdim Ethiopia with eight women who were willing.

Although the actual data collection period ranges from mid October to mid January, contacts have been pursued with many of the women for a longer period. The frequent contacts I had with them and the subsequent trust, which is developed, on the course of the time helped me to obtain more information about the women's life experience. I also found it to be an important methodology in terms of studying the changing patterns of the women's health status and their relations with family members, and /or spouses over a period of time as Anannia (2000) noted. Much more, the fact that these women are in desperate situations necessitates the need to reach them out with a real emotional and financial support. It is thus with this understanding that I myself lend a hand to the best of my capacity.

### **1.5 Limitations of the Study**

The study is based on case studies of fifteen HIV-positive women. This is a small sample size which couldn't be representative. Besides, three months of field research is not long enough to cover all the consequences and the experiences of the women.

Most women had experienced a long history of sickness and would face new problems in the future. It is also important to realize that, in addition to the small sample size, there is also a source of socioeconomic bias. Many of the women who are included in the study had an extremely low income and the major reason in becoming members of associations of PLWHA and care and support organizations was to obtain mainly practical assistance. Though, I had intended to include some economically better-off women it wasn't possible since they do not visit associations of PLWHA and care and support organizations for fear of being identified having HIV. Besides, very few of those women who are members of associations of PLWHA were not willing to be interviewed.

Another most important concern is that the study dealt with the most intimate subject of sexuality, an area which is full of taboos, morals, emotions and fears. As HIV/AIDS is mainly a sexually transmitted disease that stems from a highly stigmatized condition, I found it extremely challenging to have open discussions with the women especially until they developed trust in me. Moreover, the fact that I am a male researcher was a challenge in its own since discussing with women about this intimate and personal issue proved to be really difficult. However, the frequent contact I had with them created sense of trust with which I managed to present myself with an air of familiarity so that I could gain insights into the issues raised by the research objectives.

The other constraint I faced is that although I had intended to interview family members and/or friends of the women, this was not possible, because most women had revealed their status only for very few others or not at all. They wanted to keep their HIV-status a secret, for fear of stigmatization, rejection and discrimination. This is highly understandable. I had to respect their privacy. Therefore, the relationships and reactions of relatives are described through the women's own eyes.

In addition to limitations in the representativeness of data, another source of concern lies in the translation of experiences or emotions into words and the difficulty I faced in summarizing and interpreting responses since every woman had her own story, life events and unique response to AIDS. However, although the findings fall short of being representative, the study comes up with informative insights to the general conditions in which HIV-positive women found themselves in Addis Ababa. It should be seen a rather rational thus simplified description of the complex reality of women living with HIV or AIDS.

## Chapter Two

### Women and HIV/AIDS: An Over View

As HIV/AIDS takes a greater hold on communities it became clear that the epidemic affects women and men differently due to physiological, socio-cultural and economic contexts of men's and women's different vulnerabilities to HIV infection and their different abilities to access resources in order to cope with the impact of the epidemic (UNAIDS, 1999).

These differences largely emanates from gender norms that ascribe to women and men a distinct set of productive and reproductive roles and responsibilities. Women's low socioeconomic status thus makes them highly susceptible to HIV infection. As a result trends in the incidence of HIV/AIDS infection among women are increasing especially in developing countries.

*Infection rates in young African women are far higher than young men. The average rates of infection in teenage girls were five times higher than in teenage boys. Among young people in their early twenties the rates were three times higher in women.*  
(Barnett and Whiteside, 2002, p.10)

Since the first evidence of HIV infection in Ethiopia was found in 1984, HIV / AIDS prevalence remained low in the 1980s. But sharply increased through most of the 1990s, rising from an estimated 2.7% in adults (15-49 years age group) in 1993 to 7.3% by 2000 (Ministry of Health, 2000). A marked increase in the number of cases was noted from year to year.

Kebede et al. (2000) and others reviewed the epidemiology of HIV infection in Ethiopia and major risk factors. They concluded that major factors contributing to the rapid

spread of HIV include persisting high prevalence of unprotected sex with multiple partners, seasonal migration of workers, dislocation of many people due to the civil war and resettlement programs, high STI rates in the general population, the disadvantage position of women in socio-economic and sexual decision making, increasing sexual activity among youth with multiple sexual partners due to delayed marriage, poverty, high unemployment rates, exacerbated by the mobilization of the armed forces, and lack of preventive and treatment programs. In Ethiopia during recent years females now have significantly higher AIDS rates than males in the 15-24 age groups (MOH 2002).

In Ethiopia like other African countries population patterns and changes in sexual behavior, especially in extramarital relations associated with poverty and gender inequities predominate HIV transmission dynamics in the absence of high-level homosexual and drug-induced transmission (UNAIDS, 2000). Children, adolescents and young adults have become increasingly exposed to HIV in recent years, with an estimated 250, 000 children infected in 2000 and 11.8 % of females and 7.5 % of males aged 15-24 (MOH, 2000).

The increasing incidence of HIV infection among women reflects their wider social, sexual and economic vulnerability. The central issue is inequality. Economic need, lack of job opportunities , poor access to education and training and cultural expectations of female submissiveness and male dominance combine to prevent women from actively making choices and decisions about their lives particularly with regard to limiting sexual risks and protecting their and their families health (UNAIDS, 1999) .

Besides, many women have low levels of education and have limited access to printed information on HIV/AIDS and STDs, many of them have poor understanding of HIV transmission mechanisms. Several studies in Ethiopia indicated that awareness or perceptions of risk were generally lowest among females, unmarried and less educated persons (Kebede et al. 2002). Women's low educational status also means that they are excluded from the formal employment as a result they often engage in activities that often expose them to sexual and physical abuse.

Most female sex workers in the towns came from rural areas in search of work and a better life (Baardson, 1991). However as there are fewer job opportunities besides bar maids, prostitutes and domestic helpers, they are exposed to sexual abuse (Pankhurst, 1992). Traditional harmful practices, including violence against women (rape, abduction and domestic violence), early marriage, ritual scarification, ear piercing and others are widespread in many parts of Ethiopia which expose women to HIV infection.

Several studies found that culturally sanctioned gender roles that circumscribe women's sexual rights in marriage render them vulnerable to HIV infection (Alemu, 2001; Annaia, 2000). Due to their lower social status and economic dependence married women may be unable to challenge their husbands' extra-marital affairs or insist on condom use for themselves even when they know they are at risk (WHO, 1994). High sexually transmitted disease (STD) prevalence in women still married to their first husband in Addis Ababa was associated with extramarital sexual activities of males (Duncan et al. 1994).

More over, women's traditional family roles are arduous. Women usually undertake most household tasks go through pregnancy, childbirth, lactation and rear children.

Large numbers of women are in fact household head but lack sufficient authority, money and material resources (WHO, 1994).

Inequities in the socioeconomic positions of men and women therefore make the psychological and social burdens greater for women than for men in similar situations. The dangers that women face from the AIDS pandemic have been described as a 'triple jeopardy' (Panos Institute, 1990). HIV and AIDS potentially threaten women as individuals, mothers and carriers. Women who have HIV or AIDS risk rejection and divorce, with loss of an income as a consequence. Women also experience greater demands related to coping with the effects of the epidemic. As elsewhere women in Africa are the main care givers. It is their responsibility to care for the sick, which may include husbands and children infected with HIV; but there may be no one to care for them at home when they are sick (de Bruyn, 1992).

The chapter is aimed at to give a background to the wider situation of women and AIDS. In the subsequent chapters the consequences of HIV/AIDS for fifteen HIV-positive women in Addis Ababa and their coping strategies will be presented. While presenting their individual stories, effort is made to situate the women's condition with the larger socioeconomic context.

## Chapter Three

### Socioeconomic background of the interviewees and their knowledge and attitudes towards HIV/AIDS

This chapter has two major parts. The first part, the socio-demographic profile of the interviewees, outlines the basic characteristics of the women in terms of their age, Place and family of origin, ethnic group, education, religion, martial status, number of children, past occupation and income, economic and living conditions. These characteristics are summed up in Annex 1.

The second part presents the women's illness perceptions, in particular their knowledge and attitudes of HIV and AIDS. Knowledge of and attitudes towards HIV/AIDS (as well as the perceived cause of the HIV infection) can influence coping ability as well as the way people seek treatment and social and other support. Various sections under this part of the chapter highlight the women's medical history including, testing of HIV in order to understand their medical background and the implication of HIV and AIDS for them.

#### 3.1 Socioeconomic background of the women

**Age-** The majority of the interviewees (8) were in their twenties and the age in this category ranged from 23-29. Six women were in their thirties (age range 30-38). The remaining woman was 18years of age. The fact that almost all of the women were in their twenties and thirties show that they were in their productive and reproductive ages.

**Place and family of origin-** Out of the fifteen women, nine were born outside Addis Ababa but had been in the city for more than ten years. Most of them were born and raised in a rural area. They came to Addis for work or education, either with partners or to live with relatives.

**Ethnicity-** About half of the women (7) belong to the Amhara ethnic group. Four women are Oromos and two Gurages and the remaining two are Tigreans. All of them speak Amharic fluently so that the interviews were conducted in Amharic.

**Education-** In terms of education, seven of them had educational background that ranges from grades six to ten. Three had completed grade twelve and among these two had training above 12<sup>th</sup> grade; one had training in food preparation and catering and the other one had computer and photography training. Two of the interviewees were in grade three and one of them was learning at the time of the interview, the only woman who was attending school. The remaining three interviewees were illiterate.

It is important to note here that according to the information obtained from representatives of care and support organizations and associations of People Living with HIV AIDS (PLWHAs) most of the affected populations are poorer, less educated people. HIV-positive persons who are more educated and economically well-to-do and those in power are much less willing to visit HIV/AIDS care and support organizations or in becoming members in the associations of PLWHA because they are economically better off and they fear that they could be identified as having HIV. Therefore, in most cases it is the less educated and economically poorer HIV positive persons who visit

care and support organizations and become members of associations of PLWHA for financial, material, and medical support.

**Religion-**The majority of the women (11) are followers of Orthodox Christianity which is one of the largest religions in the country. Three women are followers of Islam and the remaining woman is a protestant. Religion is an important element which many of them used as a major emotion-focused coping mechanism. It is treated in detail in chapter VI, Coping with HIV/AIDS.

**Marital Status-** Six women were widowed. Four of them stated that their husbands had died of AIDS while the remaining two were not definite about the causes of their husbands' death. However, from the symptoms, rumors and other indications these two women suspected that their husbands had died of AIDS. Since all of these women depended largely on their husbands' income for their and in some cases for their children's living, loosing their husbands' posed great problems for them.

Four of the interviewees were married at the time of the interview. The two women's husbands knew that they are HIV positive too. However, the other two women's husbands do not know their status although they were aware that their wives are HIV-positive. Two of the four married couples had good relationship whereas the other two couple's relationship was turned to be very bad directly due to HIV/AIDS. Of the fifteen interviewees, two women were divorced. One was due to HIV the other woman divorced before she learned her HIV- status. The remaining three were single one had a boy friend and the other one was a sex worker and the last one used to have multiple sexual partners.

**Children-** Most of the women (9) has no children. The remaining 6 had from 1 to 6 children. See annex 1. Three of these six women who have children are widowed. In some cases, older children are of assistance where as the younger children are a worry since most of the women worry much for their children's future.

**Past occupation and income** -Many of the interviewees (11) had no formal occupation before and at the time of the interview. And most of the women who were married said they had just been sitting at home taking care of their children and depended mainly on the income of their husbands. Six of the women had had some personal income (3) from petty trading. One of the six women used to have a small beauty salon and a small shop which her husband opened for her. Two of the six women worked as house maids and one of them worked as a daily laborer and the other one as a sex-worker. Only three women had a more formal occupation. They worked respectively as a cleaner and cashier at a restaurant, an employee of a private factory and a cashier in a private organization.

**Economic condition and income source-** Almost all the interviewed women were economically very weak, although some were relatively better off than the others. And according to most of them the major reason for coming to the care and support organizations and associations of PLWHA is for financial, material and medical support. Although some of the women obtained some kinds of financial, material and medical assistance from these organizations and associations of PLWHA they strongly noted that the support was not sufficient to live on and they were looking for additional income sources and economic support from relatives or elsewhere.

**Living Conditions**-Of the interviewees, five lived in *kebele* house, four in private rented house, four with their family (with parents), and one lived in a store owned by an *iddir* and the last one in a very small house that her husband got from a friend. Of the four women who lived in private rented house, two lived alone; one lived with her two children and the third one with her husband and six children. The monthly rent they pay for the houses that they rented privately ranged from 40 to 180 Birr, which according to all of them a major worry and a big drain on their little income. One woman resorted to selling her furniture and jewelries to pay for the house rent. These women did not want to disclose their status to the owners of the house because they fear that, if they did they would be forced to leave from the house by the owners. As a result most lived with a threat of losing the houses in which they were living in.

Those women who were living in the *kebele* rented accommodation were relatively stable and paid monthly fee which ranged 3 to 9 Birr. Four of the women who were living with their parents had little privacy. Two of them had a normal interaction with their family since they did not disclose their status. However, the other two young women's status was known by their family. Although one of them has experienced a positive reaction from her family, the other one has faced an extremely negative response and ill-treatment from her siblings as a result she felt very much disappointed. She was looking forward to live independently by renting a house either from the *kebele* or to rent from private house owners but couldn't able since she had no income of her own.

### **3.2 Illness concepts**

The concept of 'illness' refers to interpretations, explanations and predictions with regard to one's health status (Schussler, 1992). The course of chronic disease is not only determined by biomedical or genetic factors, but also by the way the patient deals with his or her illness. Everyone has a subjective understanding of their self and also of their disease. This personal attitude towards sickness, the corresponding strategies and the interactions of the sick person with medical staff, with relatives, with partners and with the community at large naturally influence the course of the disease. The patient's subjective attitudes often exist in opposition to scientific, medical viewpoints (Schussler, 1992). Thus the individual woman's knowledge and attitudes towards HIV/AIDS influence the manner of coping and the course of the disease.

### **3.3 Knowledge of and attitudes towards HIV/AIDS**

Knowledge and attitudes towards HIV/AIDS can influence coping ability as well as the ways people seek treatment and social or other forms of support. This section presents the interviewees' knowledge and attitudes towards HIV/AIDS.

Most of the women indicated that when they were tested they had very little knowledge about HIV/AIDS. It was after the test results that they came to know more about the disease. However, although most had very little knowledge and misconceptions about HIV/AIDS before they learned their status, they knew that the major mode of transmission is being sexual intercourse. The following statements of the women illustrate the women's knowledge and attitude towards HIV/AIDS:

*I knew that HIV is a sexually transmitted disease and I knew also that the most risky groups are sex-workers and drivers who travel to different parts of the country. My husband was a driver who frequently goes to field trips and I used to tell him to have condoms always in case if he might be tempted to sleep with other women since he was usually away from home. But he was angry and was not willing to accept my advice. Instead he was telling me that he was loyal to me but at last he brought the virus to me.*

*(S, 24, divorced)*

*Before I learned about my HIV positive status, I knew very little about HIV/AIDS and most of it was misconceptions about the disease. If someone is infected with HIV, I thought that, he/she would die immediately. However, since I had learned my status two years ago my knowledge about HIV/AIDS increased through the counseling I obtained, and through discussions I had with other persons who are also HIV positives.*

*(W, 29, Widowed)*

*I used to think that if a person is found to be HIV positive, all is over and he/she would die very soon. This was the idea that I had six years ago when I learned about my HIV positive status. However, although at first I got very much depressed and was waiting for my early death, through time my knowledge about the disease improved and I learned that there is a possibility of a long life if one takes care of his/her own health.*

*(F, 29, Single)*

*My husband was a truck driver. We used to have a very good relationship and we discussed many things openly and I used to tell him to protect himself from HIV by using condom.*

*(K 38, widowed. Husband died of AIDS)*

In the focus group discussion women indicated that before they learned their HIV positive status they used to equate AIDS with death. They thought that once a person has AIDS, all is over; no chance of living after that and it shows the lethality and certainty of death in AIDS was powerfully conveyed through media presentation of images of skulls and bones. All of the interviewees reported that they heard about HIV/AIDS from media, mainly from radio and/or TV.

At the time of the interview, however, the majority of the women's knowledge of HIV/AIDS was found to be high. It is of course after they learned their status that their knowledge increased considerably through participation in associations of PLWHA and

care and support organizations by counseling, by self-learning about the disease and by having discussion with other persons who were HIV-positives. And they indicated that knowledge helps an HIV positive person to cope better with the illness.

The majority of the women also indicated the possibility of living longer with HIV/AIDS. In particular, they noted that nutritious food help an HIV positive person to stay healthy. What the women strongly commented in relation to nutritious food was that although they knew much about its importance for their well being, since they were economically very weak they couldn't get nutritious diets.

The women had very high knowledge regarding the transmission mechanism of HIV/AIDS other than sexual intercourse and they indicated how they took action to protect family members and others as the following statements of the women illustrate:

*I use a blade to cut my nails and I lock it in my drawer in order to keep it away and no one else is going to use it. Although I eat and sleep with my sister and with my friends, I care much not to infect them.*

(L, 24, divorced)

*Although it is me who prepares food for the family, I do not use anything which is sharpened and which might cut and bleed me. I do not cut onions or meat with a knife. It is my daughter who does this job. I do this to protect my children.*

(G, 32, Widowed with three children)

*I am a member of woman's iddir. No member knows that I am HIV positive and I participate in the iddir as every member but I do not want to use knife to cut onion or something else. I deliberately avoid this to protect other people.*

(K, 38, widowed)

All in all the knowledge of the women about HIV/AIDS is found to be high.

### 3.4 Testing

Many medical conditions require laboratory tests on samples of blood, urine, saliva or tissue to identify infections or other health problems. Tests may be carried out on healthy individuals to detect hidden problems or on people who are already ill. Although HIV is found in various body fluids, HIV tests are generally done on blood because the virus is most concentrated in blood. An individual may be diagnosed as being HIV-positive once HIV enters the blood stream and stimulates the immune system to develop antibodies. Antibodies to HIV usually develop within three months of infection, and by six months approx. 95% of infected persons can be expected to seroconvert (test positive for HIV antibodies) (Jackson 2002, Alonzo & Reynolds, 1995).

Although there are no much research which explore in depth the reasons why individuals seek HIV antibody testing Alonzo & Reynolds (1995), it is well understood that the decision by individuals to take an HIV test often involves fear, stress, dilemma and anxiety which stems from the potential negative consequences of an HIV positive result. Individuals may thus spend considerable time grappling with the decision of whether or not to be tested, sometimes preferring an ambiguous HIV status and opportunity to merely flirt with the possibility of a stigmatized HIV identity. It has been argued that in the decision making process of taking the test, the individual will confront fears, beliefs, guilt and risk at a personal level. Although having a test for HIV is a positive step towards taking the possibility of infection seriously; it should not be taken lightly (Alonzo & Reynolds, 1995; Annania 2000; Kloos et al. 2000).

An individual may be diagnosed as HIV positive early or late in the HIV disease trajectory. Whether late or early there are specific issues and stresses surrounding a

positive diagnosis. It is a profoundly disturbing realization, especially for young adults and for their family, to have to address the possibility of a significantly shortened life span as a consequence of HIV. For a younger mother, a positive diagnosis may be even more disturbing with the possibility of having infected her infant and/or the knowledge that she may eventually need to place young children in the hands of others for care (Alonzo & Reynolds, 1995).

The widespread perception that being HIV-positive is the equivalent of a death sentence in the absence of affordable drugs keeps many persons from being tested and has caused some orphans to be denied access to orphanages on the ground that limited space was prioritized for individuals expected to live longer. Stigma, denial and fear of disclosure due to discrimination among HIV/AIDS-affected persons continue to fuel the epidemic and remain a serious obstacle to any control efforts in Ethiopia and other African countries (Kloos et al. 2000; Annania, 2000; FHI, 2000).

The interviewees underwent HIV testing for various reasons; four of the women tested because their husbands got sick and developed symptoms of HIV/AIDS and died of it. All of the women in this category knew that their husbands had died of AIDS and they wanted to know their status too. Very few women learned their HIV status because they got sick for some period with symptoms of HIV/AIDS and the doctors or health staffs advised them or themselves wanted to get tested. Two of the interviewees got tested because their children became so sick a few months after they were born. And when their babies were tested they were found to be HIV positive and the women took the test and learned their positive status. Three women took the HIV test as a prerequisite in order to apply for visas to go abroad. One of the interviewees learned her status when her husband continuously urged her to bear him a child but she decided they had

to be first tested for HIV before they bear children. And she took the test alone because he refused.

Almost all of the interviewees noted that the decision making process in order to get tested is emotionally exhausting since they suspected that the result most likely would be positive especially due to their vulnerability and exposure to HIV through their partners. In the focus group discussions the women indicated that it took them several months even to a year, or more to decide to be tested. As mentioned above, the interviewees reasoning to take the blood test varies but none of them decided to get tested voluntarily just to know her status. Therefore, other factors pushed them to take the test. Anticipating potential negative reactions and to avoid the personal trauma of an HIV positive status they remained undecided for sometime until something pushed them for the test (details of the motivation that led the women to be tested is described in chapter IV).

The women took the test in government hospitals, private clinics and in different governmental and non-governmental organizations that offer VCT service on HIV/AIDS. Most of the women were tested two or three times at different centers for the sake of confirmation. Initial reactions to the news of being HIV positive were anxiety, anger, fear, confusion or numbness, sorrow and disbelief. All of the women noted that learning one's positive status was very painful and most expressed that, "*I thought it was the end of my life*".

The period since first knowledge of HIV status ranged from five months to six years. Six of the women had known their status a year ago; four two years back; three women

learned their status three years ago. One of the women learned her status five months back and another woman learned her HIV positive status six years ago, the longest period of all the interviewees.

### 3.5 Perceived cause of HIV infection

I tried to obtain information indirectly from the women regarding how they believe they contracted HIV. With the exception of one woman who believed that she had contracted the virus through unsterilized medical equipments when she undertook surgical operation, the majority of the interviewees said they acquired the infection through sexual intercourse. Most of them indicated that their husbands' or boyfriends are the source of their infection. The following statements illustrate the women's perceived causes of HIV infection:

*I was virgin before I married this man. I never had sexual intercourse with other men except him. I know I got it from him.*

*(S, 24, divorced)*

*I know for sure that I got the virus from my husband. He used to go out with different women. I heard from a friend that he had a relationship with a sex worker who has died a little before his death. Since I was dependent on him and had three children to look after, I didn't want our relationship to break.*

*(G, 34, Widowed)*

*My husband used to be a truck driver and he was to be away from home most of the time and I usually fear that he might get sleep with workers and when he got sick, I knew that it was AIDS. We both tested positive and therefore I knew for sure that I got it from him.*

*(K, 38, Widowed)*

*Few years ago my husband got sick but he couldn't get recovered. His behavior was also started to change. One day he called me and told me that he wanted to tell me a very secret and bad news. He kneeled down and told me that he is found to be HIV-positive. He cried saying that he is guilty of infecting me with the virus.*

*(D, 35, Married)*

Two of the interviewees felt responsible for being infected with the virus. One of them used to be a sex worker and the other one had multiple sexual partners. One young woman said she believed that she has got the virus from a person who raped her a few years ago.

The socioeconomic conditions of the interviewees reconfirm the wider social, sexual and economic vulnerability of women (see Annex 1). Economic need, lack of job opportunities, poor access to education and training and cultural expectations of female submissiveness and male dominance combine to prevent women from actively making choices and decisions about their lives particularly with regard to limiting sexual risks and protecting their and their families' health. As Barnett and Whiteside noted, "It is estimated that 60-80% of African women with HIV have had only one partner but were infected because they were not in a position to negotiate safe sex or prevent their partners from having additional sexual contacts" ( Barnett and Whiteside, 2002 p. 185).

### **3.6 Health Status**

Although many of the interviewees learned their status one and/or two years ago, for most the disease began earlier and most indicated symptoms related to it beginning such as diarrhea, coughing, loss of appetite, weight loss, skin problems, Herpes Zoster and TB. But at the time of the interview, most women looked fairly healthy though there were some with signs and symptoms of the disease. One of the interviewees was at the stage of full blown AIDS. The stage in which an HIV positive woman finds herself may influence coping ability.

However, the traumatic event of being diagnosed with HIV/AIDS, does not only bring health complications and an imminent death to the infected person. Yet beyond the pains and cost of the disease itself are the social meanings of AIDS. To know you have AIDS is to be constantly aware that you have more than just a disease; it is to embark upon a profound symbolic reordering of your life. It is important to recognize that a person with AIDS confronts not only bodily diseases but also potential guilt, potential stigma, potential secrecy and potential self blame (Plummer, 1988; Alonzo & Reynolds, 1995; Annania, 2000).

Due to fear of stigma and discrimination, individuals therefore, must struggle with issues concerning the meaning and consequences of their HIV status in terms of managing its potential discovery and orchestrating its disclosure to partners, family, and friends and to the community (Alonzo and Reynolds, 1995; Annania, 2000). As Goffman (1963) noted as with any secret, and especially a stigmatizing and discrediting one, the individual must engage in "information management" the primary question become: "To display or not to display: to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when and where" (Goffman, 1963, P. 42). The following chapter presents degrees of the interviewees' status disclosure and discusses the reactions they have experienced.

## Chapter Four

### Disclosing HIV Status to Others: The Social Dimension of HIV/AIDS

Research on disease explanatory models such as (Kleinman, 1980) revealed that people everywhere make attempts to perceive and attribute meanings to various diseases, infer signs and symptoms, grade diseases according to intensity, and label and categorize them as curable/incurable and contagious/non contagious.

Throughout human history, illnesses that are contagious, incurable and those related to sexual organs have given rise to feelings of fear, dread and shame in society. They have served to stigmatize the infected and created labels and categorize for them (Gilmore and Somerville, 1994). Like leprosy, TB and Syphilis, AIDS has also joined the ranks of such dreaded diseases. AIDS which is understood socially as being both sexual and life threatening is likely to be socially disruptive in the extreme (Sontag, 1991, Barnett and Blaikie, 1992).

Stigma is a social construction which dramatically affects the life experiences of the individuals infected and affected by HIV/AIDS. At its most basic level stigma, from Goffman's (1963) perspective, is a powerful discrediting and tainting social label that radically changes the way individuals view themselves 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. Thus, the discrepancy between what is desired and what is actual, 'spoils' the social identity, isolating the individual from self, as well as , societal acceptance (Goffman, 1963).

Since its recognition in 1981, the Human Immunodeficiency virus (HIV) has aroused deep human responses. In the United States, where the HIV epidemic emerged among gay men and intravenous drug users, a persistently negative societal response has played and continues to play a critical role in the experiences of individuals infected with the virus (Alonzo & Reynolds, 1995). In some developing countries, where the primary transmission mechanism of HIV is heterosexual intercourse, HIV/AIDS is seen as a "woman's disease" because of its perception as a sexually transmitted disease and its association with sex workers who are regarded as the reservoir of STD and HIV infection (Songwathana and Manderson, 1998). The metaphoric use of language in AIDS is a powerful indication of the stigma attached to it (Sontag, 1989). At least seven metaphors have been used in interpreting the meaning of AIDS (Gilmore and Somerville, 1994);

- 1) *AIDS as death - not only biological but social and sexual as well, and depicted often by images of skulls and bones.*
- 2) *AIDS as punishment- for immoral and sinful behavior like homosexuality and commercial sex.*
- 3) *AIDS as crime- the HIV infected are perceived as criminals and "guilty" of harming their "innocent" victims.*
- 4) *AIDS as war-it is interpreted as an enemy or an invader to be fought with war like zeal and preparedness.*
- 5) *AIDS as otherness - it is seen as a problem of "them" and not "us" and a distinction is made between the infected" and the "uninfected "the "sick" and the "well".*
- 6) *AIDS as horror - HIV infection is interpreted as an abject, terrorizing invader or demon and those infected are demonized.*
- 7) *AIDS as villain - the infected are perceived as villains for creating the epidemic and those not infected are seen as heroes.*

In Ethiopia, several researches provide evidence of the usage of such metaphors and the presence of high level of stigma against people infected and affected by HIV/AIDS (UNAIDS 1997; Annania, 2000; Lindtjorn 2001; Shinn 2001; Alemu 2001). Kloos and Damen (2000) noted that, stigma, denial and fear of disclosure due to discrimination among HIV/AIDS affected persons continue to fuel the epidemic and remain a serious obstacle to any control efforts in Ethiopia and other African countries. In the following sections, degrees of the interviewees HIV status disclosure is presented with the aim of examining their relationships with their partners, families, and friends and with the community.

#### **4.1 Degrees of HIV Status Disclosure**

Disclosing the news of positive HIV status to someone is a very hard and difficult decision since it could affect the relationship and social activities of the infected and affected persons. By considering the essential processes through which the women personalize the illness; the dilemmas encountered in interpersonal relations; the upcoming sections explore the extent to which the interviewed women revealed their HIV status to partners, family members, friends and the community.

The degree of openness to partner, family, relatives, friends and community varied individually but can be roughly classified as absolute secrecy, selective openness or full openness. From the interviewees, nine of them selectively disclosed their status to partners, some family members, close relatives and/or close friends. The remaining six interviewees kept their status absolutely secret. None of the interviewees wanted to reveal their HIV status in their community for fear of discrimination and stigmatization. It is, of course, the possible reactions women anticipated and the perceived social

support that largely influenced the women's status disclosure as will become clear in the following sections. By anticipating potential reactions from those people whom she would reveal her status an HIV-positive woman must choose whether and when and whom to tell.

## 4.2 Anticipated Reactions

Due to fear of stigmatization and discrimination none of the interviewees wanted to reveal their HIV status to the wider community, and with an attempt to determine potential reactions and degrees of acceptance, the majority of the women tried to evaluate the possible reactions they would face if they reveal their status. The followings statements of some of the interviewees are in witness thereof:

*After I knew my status, I sometimes discuss some general things about HIV/AIDS with my friends and neighbors when we drink coffee or when we are together. I try to evaluate their attitudes. Of course, none of them knew that I am HIV positive. I am very much cautious regarding what they say. Once, during coffee hours in my house, one of my friends said "Don't change my cup. These days it is hard to use anything together due to this bad disease". Although she didn't know about my status it hurt me very much and I thought that she and other members of the community would stigmatize and discriminate me and my family if they know my status. Thus I have decided to remain unnoticed.*

*(M, Married, 30)*

*One night, few days after I learned my HIV positive status, my family was together in the house and a TV program about PLWHA was running and we were all watching it. And my older sister said, "...in order to stop the further spread of HIV, it would have been good to kill those HIV positive people. These people are responsible for infecting others" I was seriously shocked by her cruel decision and I have promised to my self not to reveal my status to any one even to my close relatives, to say the least.*

*(W, widowed, 28).*

*After I knew my status, I always attentively follow any discussion, gossip or anything about HIV/AIDS when my friends and neighbors discuss or talk about it. Mostly, I hear that if some one dies or is seriously sick in our locality people gossip that he/she is HIV positive or died of AIDS, and they try to blame and condemn the person and I fear that I would also be stigmatized and rejected. Therefore, I decided not to reveal to any one in the community.*

*(Y, 33, widowed)*

Different studies of knowledge, attitudes and behavior concerning HIV/AIDS have been conducted and most often these studies indicate that knowledge about HIV/AIDS has

increased though unevenly. However, behavioral change to avoid contracting AIDS appeared relatively low. A finding knowledge does not necessary relate to behavior (Kebele et al. 2000; Taffa 1998).

In the focus group discussion held with the women, they indicated that it is difficult to tell others because most people know little about HIV/AIDS. They commented that although the knowledge and attitude of the society towards HIV/AIDS and PLWHA changed through the years there is still continuing stigmatization and discrimination against people living with HIV/AIDS. Therefore they stressed that it is unwise to reveal one's positive status to the community. This made the strength of fear of discrimination and stigmatization clear. One of the women put the following remark:

*My neighbors do not clearly understand about the disease. I don't blame them for this because I myself know much about it after I have learned my HIV status a year ago. I used to gossip and chat with my friends as someone became seriously sick or got thinner that he/she has AIDS. Therefore, if I reveal my status they would not react positively and they wouldn't come around me. Of course, I knew that my husband died of AIDS but the people in my locality knew he died of TB. And you know that there is a close relationship between TB and AIDS, and if some one died of TB people suspect that he/she died of AIDS. In order to avoid this suspicion I told my neighbors and my relatives that my husband didn't die of TB but with poison that some people gave him.*

*(K, widowed 38, husband died of AIDS).*

Most of them expected negative responses because they had seen it happening to other HIV-positive persons or heard about it from others. Most of the women were also advised by the counselors not to reveal their status to the wider community except to those people whom the women had strong trust and would get practical and emotional support. Many of them also made it clear that they did not want to reveal their status since '*it would not help*' because others could not provide them with material and financial assistance: as the following statements of the women illustrate:

*I do not want to reveal my status to anybody except to those whom I trust they could assist me practically. It is of no use to tell even to close relatives or friends for they could not help you practically except feeling sorry for you.*

*(B, widowed, 26)*

*I and my husband told our HIV positive status only to a few of his relatives whom we trust they would assist us in practical terms. My parents and my relatives are all poor and they could do nothing for me and I decided not to tell them.*

*(D, Married 35. Husband HIV positive)*

*I have no body that I can rely on and ask for help. My brother is very poor, daily laborer whose income is not even sufficient for him and his own family. We do not visit each other frequently. My parents are living in the countryside and they are extremely poor who even look for assistance from us. I am really alone and have no strong relationship with any body. Therefore, since there is no one whom I could reveal my status and expect help, I have kept my status absolutely confidential although I am very much sick and the symptoms clearly indicates my illness. If I openly reveal my status to any body in the community, they would despise me and chase me away like other HIV-positive persons who exposed their status.*

*(A, married, 23, with full blown AIDS)*

Anticipated negative reactions and disbelief in other people's ability except those people whom the women believe they would get assistance indicated that there is still strong fear of negative reactions although most of the women have pointed out the presence of some change in attitudes of the people towards HIV/AIDS and PLWHA. In the focus group discussion, it was indicated that instead of stimulating and encouraging each other to reveal one's positive status, the women seemed to influence each other with negative stories and probable negative responses from others. All these factors suggest that a woman must have a great belief and trust in others to have confidence and reveal her status.

Some of the women who have children did not want to disclose their status in their community because they fear that their children would be stigmatized and discriminated. They fear and think more for their children than for themselves as the following statements of the women made it clear:

*I am already infected, I do not care much about myself whether people know or not about my status. However, I care much for my children whom I really love and who are my hopes and my relief. I do not want them to be stigmatized and discriminated just because their mother has HIV. They have done nothing wrong and I always take great care not to show any sign of or reveal my status to the community for their sake.*

*(G, widowed 34, mother of three children)*

*We have six children whom we are looking after. Five of them are under our care. It is only our first son who has his own income. I and my husband worry more about our children than ourselves. We don't want to reveal our status to the community because we have children not yet grown up and we do not want them to suffer from discrimination and stigmatization by the community member. We do not want anyone to point its finger and to gossip around our children that they are children of HIV positive parents. We don't want them to live in shame for us and we want them to live freely.*

*(D, married, 35, mother of six children)*

Some women also thought that others should not be suffered for the news of their HIV positive status (for knowing their status). They preferred to keep it for themselves or for some selected persons, and not to reveal for others i.e. for mothers not because of fear of stigmatization and discrimination but because not to hurt and inflict pain on them.

The following statements of the women can be illustrative on this point:

*I don't want to tell my HIV status to my mother whom I love very much and I know she adores me. I live with her and with my younger sister after my husband died two years ago. She cares for me very much. I don't want to tell my HIV positive status to her and make her suffer and worry for me.*

*(W, 28, widowed)*

*I told my status to my older sister, her husband, and to their daughter who is also my friend. However, although I sometimes live with my mother who is old, I didn't tell her about my status and I will never tell her because she is old enough and has to die peacefully without worrying for me and I don't want to hurt her.*

*(F, Single, 29)*

In summary, a number of factors made the women conceal their status. Fear of being rejected by family, friends and the community. Some also expected discrimination because they had seen it happening to others or heard about it. However, the fear may have been greater than the actuality and most never tried to talk with important others about their status. Discrimination was the main reason but most women did not want to reveal their status because they thought it would not help since others would not be

able to assist them mainly with financial, material and practical support. Against this background, it must be emphasized that a woman must have a great belief and trust in others to have confidence to reveal her status and expect help.

### 4.3 Reactions Experienced

Individuals exist in networks of relationships, the social network is central to the process of human growth, development and crisis intervention. A social network may consist of a person's family, friends, neighbors, relatives, employer, teacher welfare worker, physician, lawyer anyone with whom a person has regular social intercourse (Hoff, 1995).

*We are conceived and born into a social context. We grow and develop among other people. We experience crises around events in our social milieu. People around us friends, family, the community help or hinder us through crises (Hoff, 1995, P.133).*

Different individuals have different networks. As mentioned in the previous sections while six women kept their status absolutely confidential, nine of the interviewees were open about to some degree. They revealed their status to one or more relatives or very rarely close friends whom they had strong trust and confidence. This section gives a detailed account of the personal stories of these women regarding their status disclosure; that is for whom, why in what circumstances as well as the reactions of those persons who had learned the positive status of the women as described in the women's own words. By doing so, the section also highlights each of the woman's background and why and how she took the HIV test.

## Case 1

W is a young woman whose age is 28. She was born in Addis and attended education up to grade 9. Before she got married, she worked as a cleaner and a cashier in different hotels. She then married an EPRDF soldier in 1990 E.C. They used to live in a privately rented house. After they lived for two years, her husband got sick and his illness was found to be TB but he couldn't get recovered although he took all the medications that the doctors prescribed. She then started to suspect him as being HIV positive because of some symptoms she noticed. He died after giving her some clue regarding his HIV positive status.

*After he spent several days in the hospital, he told me what the doctors have told him. He said, "The doctors have requested my consent to take my blood for HIV test but they warned me not tell my wife" and he told me his agreement and he was tested. However, he and the doctors didn't tell me about the result. He died in August 6 1992 shortly after the blood test and I strongly suspect that he had died of AIDS.*

After her husband's death, she returned to her mother's house since she had no job and income of her own to live by. For two years, she led a very difficult life since she suspected that her husband had died of AIDS and she was worried about her status. However, she didn't dare to be tested until situation dictated her when she started to recognize some symptoms of the disease.

*Two years after the death of my husband, I started to have some symptoms like persistent cough and diarrhea. I also lost a significant amount of weight and my mother used to tell me that the reason that I was in a bad physical and mental condition was because of the sorrow of my husband's death and she advised me to forget it, and to take care of my health. But as I strongly suspect it wasn't the case as my mother thought and after a long and difficult process to convince myself to be tested, I decided and took the test in April 1994 and I found that I was HIV- positive. I then took another test just to confirm and there too the result was found to be the same.*

After she learned her positive status, she kept her result absolutely secret for sometime. But later decided to tell to her older sister's husband anticipating that since

he is educated he could understand the problem, and that she thought he would provide her with some kind of moral and practical assistance. She told him but didn't get the anticipated positive response and she deeply regrets and always curses the day that she told him her result. She expressed her feelings in the following words:

*After I knew my status I kept it to myself for some months but later I decided to tell to my older sister's husband who was educated believing that he would assist me morally and financially. However, after I told him, let alone assisting me, he never saw me almost for the last two years. I also stopped going to their house. I always regret for revealing my result for him and I decided not to tell any one since I got no assistance and sympathy from the person whom I believed I would get. I thanked him only for one thing that he didn't tell my status to my sister and to others.*

The positive or negative reactions a woman had experienced from the people whom she trusted most and revealed her status play a significant role in disclosing her status for others or confiding it to her own. As it is evident in the upcoming cases it also influences the women's coping ability and in coming to terms with an HIV-positive status.

## **Case 2,**

**K** was a widow whose husband has died of AIDS. She was born in *Gondar* and she was 38 years of age. She came to Addis when she was 12 to live with her aunt. She attended education up to grade 7. She then left her aunt's house because she was not happy with the way her aunt treated her. She served in different houses as a housemaid and then married a man. According to her marital history, she married three husbands one after the other. She lived with her last husband for six years. He was a truck driver. And in 1994 he got sick and the illness was diagnosed as tuberculosis (TB) from which he couldn't recover. She said the following regarding the relationship they had and the testing:

*I and my husband had no children but we had very good relationship. We care for each other. One day, I told him that he was sick and the Doctor said his illness was TB but he could not recover from his illness soon. Finally, I asked him that both of us should be tested for HIV. I told him I would also be tested with him because I wanted him to have courage for the test. He agreed and in September 30, 1995 E.C we took the test at Zewditu hospital and our result was found to be positive. We kept our HIV-positive status completely a secret and he died two months after the news.*

*I am living in a community where most people are poor and less educated. I don't want to reveal my status there. I know that they will stigmatize and discriminate me. Most of my relatives are living in the countryside and it would be of no use to tell them except hurting them and making them worry for me.*

*The only person with whom I have trust, strong bond and relationship is my aunt who is economically better off. She used to advice and help me practically many years before I learned my HIV-positive status. I was really convinced of the positive reaction she would show me if I reveal my status to her, and I told her about the cause of my husband's death and my HIV-positive status. She felt very sorry for me when I told her but promised to help me in any way possible.*

*She really reacted positively and with empathy. She collected money from her children and from other relatives for me with the reason that "Her husband has died and she has no income to live by and there is also no one who could help her". And she collected 800 birr for me. In many countless occasions, she helped me in everything possible but above all the moral support and the relief I got for sharing the news of my positive status helped me emotionally. I always go to her house and spend the day there.*

Although most of the women revealed their status to someone with the aim of getting practical support; financial and material some of them like the woman in case 2, indicated that sharing the news of one's status with others also help psychologically and emotionally.

### **Case 3**

T was born in Gojjam. She was 29. She came to Addis while she was a child to live with her older sister and to attend education. She lived with her sister and has completed grade 12 in 1987 E.C. After completing high school, she was working in a private organization and she was introduced with a man who later married her in 1990 E.C. He was a merchant and they were living in a house rented from a private owner. After they got married, he opened for her a small shop and a beauty salon. They had two children. After almost four years in marriage, her husband got seriously sick and died.

*I was confused regarding the cause of my husband's illness and death. I had recognized some symptoms of his illness like coughing, diarrhea, weight loss. And I started to suspect his illness being AIDS. But I couldn't believe it would be the case. This was because we got married by taking blood test for HIV and we were found to be HIV-negatives. Besides we were very much religious and we trust each other. My husband has died when I was two months and fifteen days pregnant of our second child. Six months after my husband has died, I gave birth to my second child. [They had two children, a girl and a boy who are three and half, and two years age respectively].*

Regarding how she learned about her status;

*My second child gets repeatedly sick just few months after he was born. I suspected that there is something wrong and the nurses advised me to have the baby tested and its result became positive. I then took the test in November 1995 and the result was found to be the same. I told the whole story to my husband's mother in order to take care of my three years baby girl after I died. I told her that the cause of her son (my husband's) death was AIDS. My husband's mother is really a good woman. She felt very much sad about me and my HIV positive child. She really reacted positively. She assists me in anything possible especially in coming to my house and caring for the children. She brings soap, food (and other things) to the children and for me and helps me in washing the children's clothes, in preparing food etc and in accompanying me when I regularly visit different clinics for my baby's treatment. I know that my child who is HIV positive will die soon. By now he is seriously sick. [She was crying while saying this]. I hope that, my first child is negative, she looks healthy and I don't see any symptom but I feared to get her tested.*

*I also told my status to my religious friends in order to pray for me and my child. They come to my house every Sunday and pray for us. They are giving me hope and moral support that God will soon cure me and my child. Although my older sister is here in Addis, I don't want to tell her because we have no good relationship. We are different in religion. She is an Orthodox Christian and I am a Protestant. And I used to be an Orthodox but converted into Protestant. But she was against my decision. Besides she wasn't happy when I got married with my husband because he was a Protestant. Therefore, now I do not want to tell her since we have no good relationship. My parents and my other siblings are living in the countryside and we do not have much communication and it is of no use to tell them.*

#### **Case 4**

S is a very shy young woman of 24 years of age. She was born and raised in Addis Ababa and completed grade 12, and took catering and food preparation training. She was living with her mother and with her three siblings before getting married 1993 E.C. She and her husband were living in a Kebele house which her husband used to live before he married her. Her husband was a driver in one insurance company. She learned her HIV positive status in November, 1995 E.C. She describes the whole story as follows:

*Before I married him, I never had any sexual intercourse. He is the only man whom I know sexually and I was virgin when we got married. We were married with a church ceremony [With 'Kurban'] because I am very much religious. After we got married, he always asks me to bear him a child but I disagreed and told him that, if we need to have children, we must get tested for HIV but he refused. So I went alone and took the test and I was found to be HIV positive. I couldn't believe the result and I was extremely nervous and told him the result very angrily and thrown the certificate at his face. Surprisingly, the news did not bother him. Rather he tried to cool me down. I was expecting that he would also be very sad for the news, and he would also run for a blood test to know his status. He just told me that "... being HIV positive doesn't mean the end of the world; it is possible to live with it for so long. Many people are living with it. What is important is to love and care for each other" And I asked him whether he knew his status before but he said he doesn't want to know. From all his reactions, I convinced myself that he knew his result before we got married. I just gave everything to God and started to live with him. But as days passed by his behavior started to change. He stopped giving me the monthly house expense and started to shout and yell at me and he began to nag me always and finally chased me out from the house. Although it is him, who brought the virus to me, he treated me very harshly. I got really annoyed with his reactions and told to my older brother about my HIV status and the relationship I had with my husband.*

*I told him because he is a counselor in a high school and he was always good for me. I also needed practical and moral assistance from him since I was chased away by my husband and stated to live with my mother. My brother was really very sad and gave me brotherly advice and promised me that he would assist me and urged me not to worry but to care for my health. He is really very much helpful for me. He cares for me more than I deserve. He always and advises me not to worry and he visits me regularly although he lives separately in his own house having his own family. With the support of him, I told to the kebele administrator secretly about how and why my husband chased me from the house. And since I am a lawful wife, I claimed to have the house divided in to two for me and for my husband. After a month of negotiation between the kebele administrator, me and my ex husband the house was divided into two and I started to live a very peaceful life.*

*With the financial support I got from my brother, I bought basic equipment and utensils and started to live a very peaceful life. My younger sister whom I told my result lately for the sake of her own protection usually comes home and we spend the night together. We chat, eat, and sleep together but I care much to protect them. I do not use a bleed or a needle with them. My close friends also visit me but they do not know my HIV positive status. I did not also reveal my status to my mother since it will hurt her very much.*

## **Case 5**

F is 29 years of age. She was born in Akaki. She came to Addis in 1973 with her family. She sometimes lives with her mother and sometimes lives with her older sister. She completed grade 12 and took computer and photography training. She has never been employed and couldn't get job. As a result, with the advice and financial assistance of her older sister in 1990, she decided to go to Jeddah and work there with her sister's daughter. As a pre-requisite for obtaining a visa, both of them (she and her sister's daughter) took HIV tests. It used to take a week to receive the result at that time and when she went there with her sister's daughter to collect the result her code

number wasn't there and she was told to come in the afternoon and to talk to the doctor. While her sister's daughter was HIV- negative, she tested positive and was devastated. She never dreamt that this would be the case. She felt that her life had fallen apart and any hopes she had of working, getting married and having children were gone as the following statements of her illustrate:

*When I went to collect the result, I was confident enough that it would be negative. I just had only a boy friend that I trust very much. I never had sexual partners except him and that was the reason which made me have more confidence of being HIV negative. When I took the result, my cousin was there and I was crying, when she asked me what is wrong with me, I told her about my status and she too cried. It was my sister, who gave us the money for the blood test, so she was expecting our result. I was confused, embarrassed and feared to tell my result to my sister. I decided not to tell her and wanted to give her a false reason that the result was not yet finalized and postponed for the coming week.*

*I went home and slept but I was crying the whole day. When my sister came back after working hours the first thing she asked was about our result, and her daughter told her that it has been postponed for the coming week but my sister was not convinced and asked her daughter the whereabouts of me. And she told her that I slept because I had a headache. She came to the bed room and called me. I was covered with the blanket but she removed it from my face. My eyes were red, the color of my face faded. She then immediately noticed that there was something wrong with me and asked me what has happened. I couldn't control myself and burst into tears without uttering a word. My sister got confused and asked her daughter to tell her what was happening. She too started to cry and I murmured the words that I got AIDS.*

*Immediately the color of my sister's face was turned to Pell and shouted "What are you talking about, I couldn't believe this, how come?" And she started to cry, and yelled at me that, "How could you get infected unless you were going out with many men? It means that I didn't know you although you live with me," she was yelling and shouting at me and throwing very bad words and she blamed me that I have disgraced the name of our family. I got very much annoyed that she almost labeled me as promiscuous and angrily shouted at her that I am not a woman that she is talking about. And I told her that I had a boy friend and didn't sleep with many men as she said. It was in the middle of this situation that her husband arrived and saw that all of us were crying and he wanted to know the cause immediately. He asked my sister (his wife) what has happened. She told him about my result. He was very much sad and started to cool down all of us. He is a very educated well behaved man and he told us that, "Any body can be caught with HIV and it doesn't always imply that being HIV positive means the person is promiscuous or has bad behavior. It is not only the problem of one person or one family", he said, "It is knocking every one's door." So he told my sister and me that one should not argue on a matter which has passed, but to look for a solution. That night he told us many things about HIV/AIDS and tried to cool down us. He privately advised me not to worry, but to care for me and for my health. He told me many stories regarding the possibility of living longer with HIV if one cares for her/him self. He promised to assist me in any thing he can. But he warned us not to tell others, even to my mother.*

*Although, at first, my sister tried to accuse and blame me for disgracing our family name, with the advice of her husband she soon became helpful and caring. Every body in the house, my sister, and my sister's husband and their daughter are very much positive for me. We eat together, talk and laugh as usual. Although, sometimes I live with them and sometimes with my mother, they always ask me to live with them where I get most of the caring. Mostly I forget that I am HIV positive because of their good approach, sympathy and treatment. After some five years, I have started to have diarrhea, skin problems, and lost weight during which time I*

*acknowledged that the time of my death has approached. I also thought that anybody could easily identify me as HIV-positive. I then told myself that I don't have to suffer since I will not be cured and decided to commit suicide. I then went to my mother's house for a week since I couldn't make it in my sister's house. One midnight I woke up and closed the door inside and attempted suicide but I was rescued by my mother's house servant. My mother and her servant do not know about my status. My sister and her husband heard about my attempt and came to my mother's house and since I was seriously sick, they took me to Menelik II hospital and I spent two months there. And they were around me day and night.*

*With the money that my sister's husband gives me every month, I began to take the antiretroviral (ARV) treatment. I have started to recover physically and emotionally. Besides my sister's husband brought me to Mekdim Ethiopia where I found many HIV-positive persons who are in similar, better and worse condition than me. I am convinced that one could live long with HIV especially if the reactions of others are positive. Thanks to the support and the positive reactions that my families provided me. They did everything they could. Without their support, sympathy and positive response I would have killed myself so early.*

## Case 6

J Was born in Dessie. She was 18 years of age, who is the youngest of all the women that I interviewed. She came to Addis in 1983 after her parents divorced. Her father brought her to live with his sister. She lived with her aunt for some years but then left and worked in two houses as a housemaid.

*After my father left me with my aunt, I started to live there happily. But when I grew up I recognized that my aunt wasn't treating me equally with her children who were of almost the same age with me. I didn't go to school but her children were going. I used to work the whole day all the works of the house while her children were playing. Then, I started to complain and our relationship turned to be bad. Although I didn't know much about Addis, I decided to be employed in someone's house and earn money. I did that with a help of our neighbor housemaid without the knowledge of my aunt.*

She worked in two houses for some months but was not satisfied with their treatment. And then with the help of a broker, she got job in a hotel as a waitress but ended up there being a sex worker.

*The broker told me that he got job for me as a waitress in a hotel where only food is served. However, after I went there and worked for two days as a waitress, the owner ordered me to serve in the bar during the night. All of the girls who were working in the bar were sex workers. I then started to do "business" [the term used by sex-workers to refer to sleeping with clients with some amount of money]. It was in this way that I ended up as being a sex-worker and then finally to be infected with HIV.*

While working there she got pregnant and undertook abortion. After the abortion, she got seriously sick and became physically weak. And with the advice of a nurse she took HIV-test in 1993 and learned her positive status. In her own words:

*After looking my physical condition, the nurse asked me about my living condition and my work. I told her that I work as a waitress in a hotel. Then she requested my consent to get tested and I agreed. The result was positive. I didn't know what to do. I have no where to go. Although I have a brother he is economically very weak. I know that he couldn't help me thus I did not want to go there. I also couldn't go back to the hotel since I was sick and couldn't work. Having heard my entire story the nurse felt very sad and offered me to live with her. At that time she [the nurse] was single and was living alone. She advised me not to be worried and told me that Marry Joy [the organization where the nurse was working] would assist me in medication and other financial support. Although I was very sad with the news of being HIV positive, I was happy upon the nurse's very positive reactions.*

*I lived with her for six months and when she got married, I told her that I should go out and rent a house with a friend of mine (a sex worker) whom I told my result. With the 90 birr that Marry Joy provides me on monthly basis I rented a house and started to live with my friend. Although at the beginning I had a good relationship with my friend she started to complain that I could transmit HIV to her since we share household utensils. And without my consent, she told the owner of the house about my HIV positive status and the owner started to stigmatize and discriminate me. Usually after I used of the toilet she washes it. And I once heard her warning her children saying that, "Do not go to her house and do not eat whatever she gives you and do not go to the toilet after she used it" I then decided to live alone by going to somewhere else where no body knows about me, and rented a house in the outskirts of Addis around "Asko" with 40 birr and started to live there. It was at this time that I decided to tell to my older brother. One night, I went to his house and told him privately about my HIV Positive status. He cried a lot saying that "You are my only sister I am going to loose you by this bad disease." He blamed the disintegration of our family and himself for not carrying for me and bringing me up properly. He told his wife about me in my presence. They were really sad about the news and as usual we ate, drunk and talked together and they told me to visit them regularly. And they promised me to do anything they could for me. I am very much satisfied with their moral support though economically I knew that they could do nothing for me.*

*I have also revealed my status to some friends of mine whom I know recently but I tell them that I got the virus from a boy friend who deserted me after he discovered my HIV positive status. They are all very friendly, and very positive towards me. They spent most of the time with me. Two of my friends are living with their parents and they told their parents about me and they help me practically. I enjoy going to their houses. I play, eat, talk, and laugh with them. Our friendship and their positive reaction extended to the point that I sometimes wear their clothes and they also wear it again. Because of these positive reactions, I do not think mostly as having HIV.*

## Case 7

**M** is 30 years of age. She was born in Wollo. Due to the drought, her uncle took her to Jimma in 1977 E.C, and there, she attended school up to grade 6. Then she married to a man who was a merchant. She then came to Addis Ababa in 1985 with him and

they became a parent to one child. A year after they came to Addis, her husband died of a car accident and she started to live on her own with her only child and engaged in petty trading. She used to live in a private rented house. In 1994 E.C she married a man who was at that time a taxi assistant and now a taxi driver.

*After my first husband died, I was living with my only child and was struggling to earn an income that would cover the house rent, food and other expenses of me and my child. In 1994 E.C, I got married to a young man who was my neighbor. We started to live together. A year and three months after I married him, I got sick and went to Marry Joy, and the doctor told me that it was TB. I started to take the medication. However; I couldn't take rest and take care of my health since I had to earn money to live by. My second husband usually got drunk and smokes he didn't give me enough money on a monthly basis. The hard work in addition to the sickness made me physically very weak and I lost significant amount of weight and finally it threw me on bed. It was at this time that the home care providers of Mary Joy came to my house and saw the situation and asked me to have a blood test for HIV if I agreed. I agreed and went to Marry Joy and I tested positive. I couldn't believe it and took other blood test in Teklehaymanot Clinic. There too, the result was the same.*

*I then told my husband about my HIV positive status. I know that there is nothing I could do after it happened so it is better to live peacefully with my husband and with my daughter who is now 10 years old. My husband agreed to take a blood test and he was also found to be HIV positive. He used to drink and smoke but since then he has stopped taking them and began to care much for himself and for me. We have now a very good relationship. He also got his third grade driving license and is working now as a taxi driver.*

*I also revealed my and my husband's HIV status to an old woman whom I consider as my mother. I know this woman in 1985, the first time I came to Addis. She was my neighbor. She has a good heart for me and for my child especially after the death of my previous husband. When I am usually away from my house, she and her family take care of my child and due to this my child and the old woman have built strong bond and they call each other "mama" and "my child". Whenever I need something, the first person I run to is this old woman. It is she who made my social relationship in the community very active. I became a member of women's 'iddir'. We have really a very good relationship and she is the only person of whom I tell my secret. Although I know that it will hurt her very much I have decided to reveal my HIV positive status to her for the sake of my daughter who has already lost her father and who will also lose her mother and will become an orphan. When I told her, she was very much sad and cried holding me tight and said, "you are not a women to deserve this "[HIV]" She encouraged and advised me to take care of me and my and said, "God will cure you, go to churches and always take holy water." Her encouragement and advice besides her real promise to be on my side as usual really helped me in accepting the situation I faced. I also told her that she is the only woman with whom I shared my result. She warned me not to reveal my status to anyone in our locality.*

*Her practical support and sympathy became even greater after I revealed my status to her. She regularly visits us and brings sugar, soap, and other things. We drink coffee together as usual. She helps me in the house work when I get sick. She prepares food, and washes our clothes. I do not have words to express her practical support and sympathy. She is really the gift of God for me and for my child.*

*Regarding my relatives, my parents have died; two of my brothers live in the countryside and we have no contact. One of my older sisters is living here in Addis having her own family and a job. She is not so much supportive for me and we don't have a strong relationship. I visit her occasionally before I knew my status. At first I decided not to tell my sister about the news of*

*my HIV positive status as she did nothing for me in the wake of the crisis. However, some months after I learned my status, I decided to tell her in the belief that as she is my sister in blood she would feel the problem that I faced and could help me in any way possible, especially in taking care of my child. It is true that when you are desperate and do not know what to do, you turn to any body for a help let alone to your close relatives.*

*I went to her house and told her, but she didn't feel very sad as I expected. She just told me to visit her regularly, although it was me who needs to be visited. I just went back to my house hoping that she would come soon, and decided not to go to her house unless she came to me. Until now, for about eight months since I told her, she has never come and asked me and I did not also go to see her. I feel really guilty of revealing to her.*

## Case 8

**N** was born in Kebridahar. She was 23. She came to Addis when she was five, and started to live with her grandmother who was living alone. She has one brother and two sisters but she didn't grow up with them. She had no formal education. In 1991 E.C just after the death of her grandmother she married a man and they started to live in a privately rented house. In 1993, two years before she knew her HIV status, they got divorced, and started to live on her own in a house which she rented from private owner. In order to earn a living, she was working as a daily laborer earning 6 Birr a day. One of her younger sisters was working in Beirut and she wanted to take her to Beirut and send her some money for the process.

*When my sister sent me money for the process, I took the blood test and found out that I am HIV- positive. I don't know how it could be. Of course, I had a very severe stomach ache and frequently visit clinics and hospitals and once undertook a minor surgery. Immediately after the news of my result, I got seriously sick of TB. Until this time, I was living alone on my own. When I got seriously sick and unable to work, I went back to my family to live there. My family knew that I was a TB patient but they may suspect about my status since they know that I had to take a blood test for HIV to go to Beirut. But I told them that I didn't yet take the test because I have to recover from my illness before I start the process.*

*The moment I went back to my family, I noticed that my siblings have no good attitude to me. It was only my mother who was sympathetic with me. Although my siblings didn't know for sure my HIV positive status, they have started to stigmatize and discriminate me with the reason that I am a TB patient. Therefore, since I could transmit it to them, they openly told me not to eat with them, use any of their utensils and not to touch let alone wear my sister's cloth. I was also made to sleep on the floor just on the corner of the house. Although my brother is educated (having a degree) he is the first one who reacted negatively to me. It is he who provides money for the family expense. My father had died long ago and my mother has no job. Though my mother was very sympathetic to me she had to obey and respect his order since the family is dependent on him. Therefore, she didn't say anything against their negative reactions towards me. Of course, she didn't know that I am HIV-positive.*

*Due to their reactions, I decided not to reveal my status to my siblings. If they know my status, I was sure that they would chase me away but I believed that my mother would do something and react positively if she knows and I decided to tell her. And when I told her, she cried and felt sad and advised me to rely on God. It is really very good to talk to someone who can at least sympathize with you.*

*The situation got very bad when once my sister discovered my HIV positive status. Since I had no education and I couldn't read and write all my medical prescriptions, I wanted a prescription to buy medication and I asked my sister to read the prescriptions for me so that I could recognize and identify it. Along with the prescriptions, my sister found my HIV positive certificate and I saw her face turning into pale and dropped the paper on the floor. I knew that she discovered my status and I told her by crying. However, instead of feeling sad for me, she shouted at me that, "you have almost killed all of us, you should have told us your HIV-positive status so that we could protect ourselves." And I told her that the reason for not revealing my status was because I lacked the courage. However my sister replied, "It would have been good to fear it [HIV] first rather than bring it here by wondering around" I really felt very sad for her negative reaction and even wanted to die immediately. I have decided to commit suicide and cried the whole day. When my mother came she found me crying and asked me the reason. I told her every thing and said that I wanted to die immediately rather than being treated negatively by one's own immediate family member.*

*Although my mother angrily told my sister not to treat me like this and not to tell my brother about my HIV positive status, I was very much touched with my sister's severe reaction and promised to myself not to reveal to any one. I thought that if my immediate family members, my siblings treated me like this, I can easily guess how the reaction would be much worse from others. Now, I go away from our village and spend most of the time in different churches and come at night only to sleep. I do not want to meet anybody; my siblings and others from our locality. I badly need to have my own house of whatever bad quality it could be. But I have nothing to eat let alone to pay for a rent. That is why I am suffering all this much in the family.*

*Although I have decided and even once attempted to commit suicide, with the help of God, I am alive. But as you can see me I am sick, physically weak, and lonely. I have no hope and future. I have no one who could assist me financially and materially. The only person I ask for help is an HIV positive woman whom I know at Marry Joy. It is only with her that I talk and ask for a little amount of money. She is very much helpful.*

When judgment and avoidance replace understanding and assistance, the resulting fear, prejudice, and ignorance can add insult to injury for individuals who are in crisis.

## **Case 9**

D was born in Chaha. She is from the Gurage ethnic group. She was 35 years of age and a mother of six children. She came to Addis in 1983 with her husband. She has no formal education. Her husband used to be a tailor and they had relatively a good income and living condition. They live in a house which they have rented from private

owner with a monthly payment of 180 Birr. She has no income of her own; her major occupation was and still is caring for the children and the house work.

It has been a little over a year since she learned her HIV status. She took the test because her husband got sick for increasingly long periods and couldn't recover. Due to this, the doctors advised him to have HIV test, which he did without telling her. It was after he knew his status that the doctors advised him to share his result with his wife and also to convince her to have a blood test. The whole story presented in her own words as follows:

*Few years ago, my husband became sick. He had a problem with his skin. He frequently visits hospitals and clinics and he also goes to traditional healers but he couldn't get recovered. His behavior also started to change. He started to complain for every thing, and he couldn't have a good sleep. One day, when our children were out of the house, he told me that he wanted to tell me a secret and bad news and told me he is HIV positive. He was crying, kneeling down on the ground and holding my legs and was asking my forgiveness saying that, "I killed you and our children. I am guilty. I know that you know no man except me, you are loyal to me but I betrayed you". And he told me that the Doctors advised him tell to me and also to get me tested. Upon his request I took the test immediately and found out that I am also positive. I was really shocked with the news. It disturbed me not just for my life but for my children's future. And since they are very young and couldn't accommodate this kind of heart breaking news at first we didn't want to tell our status and make them suffer. However, with the advice of the counselors we told the first three of them in order to protect themselves and provide care for us when we get sick. Besides, since my husband is unable to work, one of our sons took over my husband's work and earns an income for the family. When we told them, they were shocked and felt very sad and cried a lot, especially our daughter couldn't stop crying and she is still very much worried. We told them that they should keep this news for themselves and strongly advised them not to worry much for us. Since then they care much for us and we live happily with our children. One of our sons took my husband's job and works hard and it is he who earns a living for us.*

*My husband's brothers also know about our HIV positive status. They are living in Shashemene. He went there and told two of his brothers about us. They are economically in a good position and they are helping us since then. At first they gave him 500 birr and promised him that they would visit us frequently. They visit us in turns at least once in a month and give us some amount of money or buy for us 'teff' or anything that is essential for us. When my husband was healthy, it was him who visited and helped them since they became independent and self-reliant. Since we are living in a house that we rented from private owner paying the rent became difficult apart from the other expenses for eight family members. We badly need to get support from anywhere, especially from his close relatives whom we believe would extend helping hands. And thanks to God they have reacted positively. They [her husband's brother] are our security for our children especially for the younger ones. They have now started to buy clothes and educational materials for the children. They are really helping us a lot.*

*The other person to whom I told about our status is his uncle's wife. We had a very good relationship in the good times. Especially I and she respect each other. One day I had a dream that she had discovered my HIV positive status and felt sorry on me because I didn't tell her.*

*In the morning I told my husband that I am going to tell her since I couldn't hold this as a secret from her any longer. Thus, I went there and told her. She was extremely sad for me and for my children and blamed men as a whole that they bring the virus to their innocent wives who know nothing except their house and their children. She promised to help me in anyway she could and immediately sent for us 50 killo of 'teff'. She comes to our house regularly and assists us practically.*

*It is only for his close relatives that we revealed our status because economically they are in a better position than my relatives. Hence, they could assist us financially and materially. All my relatives are in the countryside and they are poor. It is of no use to tell them. They may feel sorry for us but they couldn't help practically. For the sake of our children, and our social activity and as we are living in a house rented from private, we are extremely careful not to reveal and not to show any indication of our HIV positive status to the community.*

## **Interpretation and Analysis of Cases**

The reactions and behaviors of relatives, close friends, neighbors and/or other people whom the women told their status are described through the women's own eyes. And as can be observed from their description, in most cases people to whom the women did reveal their status had apparently not discriminated in the way or to the extent that women have anticipated. Few described experiences of some degrees of stigma from house sharers or owners. One of the women experienced severe stigma from close relatives. These women are in a desperate physical and psychological condition as the result of the negative reactions they experienced. When judgment and avoidance replace understanding and assistance, the resulting fear, prejudice, and ignorance can add insult to injury for individuals in crisis (Hoff, 1995). Case 8's experience can be illustrative of this point.

Most women however noted with gratitude, the support they received from family members, friends and neighbors. They described getting support, sympathy and care from most people to whom they have revealed their status. The positive reaction the women experienced is life enhancing and helped most of them considerably in coming to terms with HIV/AIDS. However, the fact that none of the women wanted to reveal

their status to the community shows that there is strong fear of stigmatization and discrimination.

Willingness to reveal one's HIV status and obtaining emotional and practical support seems to depend on strong relationship with others (strong social network). Further, telling one's status can be seen as a process; at first to confined it to one self and as time goes to think over it with questions of whether to reveal or not, for whom, when and how. A woman often told someone for the first time when there was no choice when she could no longer cope economically or psychologically or someone suspected. Also some did as a precaution, to have a caretaker for their children.

When HIV positive, people fear rejection and those in their environment fear infection, people may avoid talking to each other. This has usually been explained as an effect of former negative AIDS prevention campaigns in the media. The lack of education and the fear inducing approach used in the first campaigns in Ethiopia stressing the incurability of HIV/AIDS and its transmission by promiscuous behavior seem to have been influential. The widespread perception that being HIV positive is the equivalent of a death sentence in the absence of affordable drugs keeps many persons from being tested and those tested positive kept their status absolutely confidential as a result.

The most remarkable observation was that although there were differences in status disclosure, fear of stigma and discrimination meant that none of the women was fully open ( largely kept silent )about their HIV status. Yet self – disclosure is a prerequisite for community awareness of the threat of AIDS and to prevent further transmission. Stigma, denial and fear of disclosure due to discrimination among HIV/AIDS-affected

persons continue to fuel the epidemic and remain a serious impediment to any control efforts in Ethiopia and other African countries (Kloos et al. 2000; Annania, 2000).

Fear of stigma caused women to hide the cause of their suffering, and this secrecy seemed to confirm the existence of severe discrimination. Though discrimination should not be underestimated, this anxiety appeared exaggerated. Rejection or abandonment by relatives or others whom the women told about their status however, not often occurred. Fear of stigmatization seemed greater than the reality.

Though most women preferred to conceal their status for fear of stigma and discrimination, concealing deprived from getting emotional, social and economic support. Secrecy towards relatives and others can result in great loneliness, thus making coping even more difficult. As it is evident in the previous chapters, most of those women who have revealed their status were obtaining practical and emotional support which helped them to cope better with the consequences of HIV/AIDS.

Berer and Ray (1993) noted that fear, stress and depression, isolation and feeling unable to manage a situation affect every one, especially people who are ill, feel they have no control or may become ill at any time. Women may be particularly susceptible to stress and depression, or at least seek help for these more often than men. Fear of rejection often leaves women afraid to tell anyone or seek help. As a result, many feel isolated and alone.

## Chapter Five

### Consequences of Being HIV Positive

HIV/AIDS is having an enormous impact on individuals, households, communities and societies at large. It has changed the lives of individuals, ruined their health, and caused their deaths, left survivors to mourn. It is changing not only individual lives but also the trajectories of whole societies (Barnett and Whiteside, 2002).

Individuals who are infected always confront an impact on their health. In most cases they face an impact on the resources they have. And the impact of individual ill health and death depends on who the individuals are, their place in society and the resources they, their households, communities and societies have. "The reality for individuals is that, as with their chance of being infected, the impact of the disease will depend on their circumstances and the resources they can command "(Barnett and Whiteside, 2002, P.183).

Variation in individual impact was starkly illustrated by Judge Edwin Cameron in a speech to the 3rd International conference on HIV / AIDS. Cameron described how, although he fell severely ill, his access to good health care and drugs enabled him to pursue a vigorous, healthy and productive life;

*I can take these tablets, because on the salary I earn as a judge, I am able to afford their cost --- In this I exist as a living embodiment of the iniquity of drug availability and access in Africa... My presence here embodies the injustices of AIDS in Africa because, on a continent which 290 million Africans survive on less than one us dollar a day I can afford monthly medication costs of about us \$ 400 per month. Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigor. I am here because I can afford to pay for life itself. (Cameron, 2000) as quoted from Barnett and Whiteside, 2002 p. 183)*

Initial states of individual health, nourishment nutritional states, degrees of physical exhaustion, mental state, work conditions, residential location all influence susceptibility

to HIV infection ( Farmer, 1996; Cohen; et al. , 1999). With specific relation to HIV/AIDS, how the disease progresses and its outcome is also an expression of social and economic inequality (Chaisson et al., 1995). Life expectancy after HIV infection is associated with diet, environment, and state of mind, housing and a host of other factors that are usually related with income.

The generally low socioeconomic position of women accords HIV/AIDS a profound impact. Women, especially in developing countries suffer most from the epidemic. In addition to increased risk of infection and vulnerability and greater difficulty in taking preventive measures, inequities in the positions of men and women make the psychological economic and social burdens of the disease greater for women than for men in similar situations. Also the social and economic conditions in which they must cope with the epidemic are potentially severe (de Bruyn, 1992; UNAIDS, 1999).

### **5.1 Socioeconomic Consequences**

Some research works done on the socioeconomic consequences HIV/AIDS for individuals and households stress that AIDS affects the age group which is not only sexually but also economically most active. In general, the producer/consumer ratio in afflicted and affected households changes unfavorably (Barnett and Blaikie, 1992; Barnett and Whiteside, 2002).

There are direct consequences for households due to medical expenses and loss of income as patients and those caring for them become less productive or lose jobs. This drains family resources, resulting in a lower standard of living, less nutritious food, and decrease in life expectancy. Children may have to leave school because fees cannot

be paid and their labor is needed. AIDS robs children of their parents, elderly are deprived their children's care and of a decent burial, families face extinction as young people die childless, and fear of infection strains relationships ( Barnett and Blaikie, 1992; Barnett and Whiteside, 2002). How individuals and households survive depends on their resources; labor, cash reserves, income generating activities and skills. Social resources, mainly networks of material and emotional support, may become more important (Schussler 1992; Hoff, 1995).

Having no educational background beyond primary and in some cases secondary education, most women are virtually excluded from formal sector employment. As Barnett and Blaikie (1992) have noted, women are therefore often self-employed vending food or beer or engaged in physically hard work despite their ill health.

As described in the socioeconomic background of the interviewees, the majorities have lower educational background, have no formal occupation and most are economically dependent on their husbands (see Annex 1). As a result, most women faced direct socioeconomic consequences when their husbands became ill and died, and when they got sick and unable to work. Direct impacts were generally a loss of income and basic shelter. Moreover, some had children to care for.

*Women are likely to be disproportionately affected by HIV/AIDS when a male head of household falls ill. The burden of caring for children orphaned as a result of the pandemic is bore chiefly by women. Loss of income from a male income-earner may compel women and children to seek other sources of income, putting them at risk of sexual exploitation.*

*(UNAIDS, 1999, p.3)*

An illness or death reduces household income, not only because the affected individuals can't work but also because illness increases expenditure on medical care

food and so on. This economic consequence gets worse when a husband (who is mostly the only breadwinner of the family) becomes sick and dies.

Most of the interviewees whose husband's had died of AIDS strongly noted that, just after their husbands' death, their monthly income fell almost by 100% and some desperately tried to get some kinds of assistance and help from relatives, associations of PLWHA, and from care and support organizations. In the focus group discussion, the women indicated that, their major reason in becoming members in the associations of PLWHA and care and support organization was for financial material and medical assistance.

Of the interviewees, six women had been widowed. Of these, three have children to care for. Among them two have very sick children due to HIV. Since almost all of these widowed women were dependent largely on their husband's income for their and their children's living, losing them coupled with their illness caused considerable consequences. They were confronted with problems of how to get support for them and for their children. Most of them remained impoverished, struggling for the day to day survival of themselves and their children. The following narratives of the women illustrate the consequences of HIV/AIDS for them:

*My husband was a merchant. He had a small shop in Mercato. He also opened for me a small beauty salon. We were living in a house that we rented from private owner with monthly payment of 180 birr. We have two children who are three and half and 2 years of age. My husband got sick for about two years and visited different hospitals and expensive private clinics but he couldn't get recovered and then died. My husband died when I was pregnant of our second child. While he was ill, we spend a huge sum of money. Our business activity also failed. After he died, I was left with very small amount of money. I have to pay the monthly house rent; I have to care for my children. On top of all these, my second child gets always sick and caring for him and getting him medical treatment often made the situation worse. Things became complicated when my child and I found to be HIV positive. I have completely finished the savings that I had and is selling some of the house furniture and my jewelries to pay for the house rent and for our daily living as well as for medical expense for me and my child. I get*

no practical assistance from any body except from my husband's mother who helps me in the house work, in caring for the children and in bringing some items like soap and sugar. My parents are in the countryside and I didn't disclose my status to them since it couldn't help. (For a detail, see case 3 in Chapter IV). Now my living condition is really very bad. Before my husband died, we had a very good income and a very good living condition but now the life I have with my kids is very much different. I am now very much desperate and needs some kinds of financial, material and medical assistance. It is becoming even difficult for me to get some thing for the daily expense for me and for my two kids let alone to pay for the house rent. I am looking for a small house with little amount of payment. I will also continue selling the assets that are left.

(T, 29, Widowed. Has two children and one of them is HIV positive)

My husband used to work as a teacher in an elementary school and he was earning about 500 birr per month. We have three children whose age is 16, 11 and 5. I had no job and we were depended only on his income. We are living in a house that we have rented from the kebele and we pay 9 birr monthly. When my husband was alive we had relatively a good living condition. However, when my husband got sick and couldn't get well we spend much money for his medication. And Just after he died two years ago, our income ceased completely and as a result our life changed. I faced a very difficult problem of getting income to live by and to care for my three children. I have no relatives who are economically better off that could assist me. My mother is a poor woman who is vending very small amount of food items in a local market. I really faced a very difficult situation and I had nothing to live by? What shall I feed my children, what about their school fees? They are not yet grown ups that needs to be cared for. Learning my HIV positive status did not disturb me as such than worrying for how to get an income just to live by. I then started to work as a daily laborer in our kebele with payment of six birr a day despite my illness. Our living condition is completely changed.

(G, Widowed, 34, Mother of three children)

It has been three years since my husband got seriously sick and unable to work. He used to be a tailor and was earning a very good amount of money for the family. We have six children and five of them are under our care. It is only one of our eldest sons who get some amount of money for the family especially after my husband got sick and unable to work. I have no education and no job I am a house wife. (For a detail, see case 10 in Chapter IV). We live in a house that we have rented from private and the monthly payment is 140 birr. Our living condition drastically changed because of my husband's sickness. It became difficult to get some money for the eight family members living expense let alone to pay the house rent. It was last year that my husband's cause of illness found to be HIV and I too learned my HIV positive status. We revealed our status to very few relatives of my husband in order to get financial and practical assistance. They cover the house rent and are paying the monthly 'iddir' membership fee, school fee and clothing for our younger children. However, we found it extremely hard to depend on some body for longer period. For the daily house expense, our son is struggling to get money by vending used clothes. I didn't reveal my status to my relatives, since they are in the countryside and are economically poor.

(D, 35, Married, have six children)

We [she and her husband] were leading our life with the income that my husband was getting by working as a truck driver. I was a house wife and was just sitting at home since I had no job. We were living in a house that we have rented from kebele with a monthly payment of 11Bbirr. We had no children and my husband's income was enough for us. However, after he died a year ago, I started to lead a very difficult life with almost no income source to live by. We also

*spend much money for medication since he got sick and there was no money left. I thank God because we were living in a kebele house and the payment is not expensive. If we were living in a privately rented house by now I would have been on the street since I would not be able to cover the house rent. By now I am living mainly by selling out my jewelries and house furniture's. Of course, I get some kind of financial and medical assistance from Mekdim Ethiopia but it is not enough to live on. My aunt whom I revealed my status also helps me practically. (For a detail, see case 2 in Chapter IV)*

*(K, 38, Widowed, husband died of AIDS)*

Of the interviewees, two young women went back to their parents.

*Before I got married, I used to work as cleaner and a cashier in different restaurants. But after I married, I stopped working and became a housewife. My husband was a soldier and we were living in a house that we had rented from private. We have no children. We were leading our life with my husband's income but just two months after he died, I went back to my family to live there since I had no income to cover my daily expenses let alone to cover the house rent. It is really shameful to go back to your family after you have married and started to live your own life. Now like a small child, I am dependent on my mother who is vending onion, tomato, potato and other items in a small local market. Physically I am weak and cannot engage in hard work because of the illness. I always feel sorry for being dependent on my mother while I should be expected to help her.*

*(W, 28, Widowed)*

*After I was divorced with my husband three years ago, I was living on my own by working as a daily laborer and was earning 7 birr a day. I was living in a house that I have rented from private on monthly payment of 40 Birr. However, a year ago, I got seriously sick and learned my HIV positive status. I was unable to continue to work as a daily laborer and could not be able to earn money for my living. Therefore, I went to live with my family but my siblings treated me very negatively. Although I faced such negative reactions, I am living there since I have nowhere else to go. And although my mother is sympathetic with me she couldn't do anything practical for me. She herself is dependent on my brother who stigmatized me most. The disease has changed my life extremely. It made me very weak and unable to work. As a result, I went back to my family to be dependent and experienced harsh treatments. (For a detail, see case 8 in Chapter IV).*

*(N, 23, Divorced, stigmatized by siblings)*

Although many people face similar socioeconomic problems in Ethiopia, they are more substantial for a woman who is HIV positive. Socioeconomic consequences of the disease were great for all women but some are highly affected since they get no support from relatives, partner, and associations of PLWHA and from care and support organizations. The following statement of a young woman elaborates the point:

*I am very much sick. I spent the whole day on my bed. Most of the time I get nothing to eat. My husband has no formal job, he works as a daily laborer but he smokes, always gets drunk, and*

*chews 'chat'. He buys something to eat or gives me very small amount of money only when he wants. I have no words to express my living condition. My life is more than miserable. I have nobody for whom I could reveal my status and expect support. My relatives are in the countryside, I only have a brother in Addis Ababa but he too is very poor, even unable to get enough money for his own family. I didn't tell him my HIV-positive since I expect no practical support. I have no one who could assist me. My partner knows that I am HIV positive but he said he doesn't want to know his status. He always insults and blames me for being always sick and unable to give birth for him. Since I had gonorrhoea for almost six years, it made me unable to bear a child. I am leading a very painful life. I don't know what I did to deserve all these pains and sufferings at this young age. I know that I am dying. I am counting the few days that I am left with. I don't want to disclose my status to anyone in the community and aggravate my sufferings by being stigmatized and ostracized.*

*(H, 23, Married, with full blown AIDS) 1*

In many cases, there was no family member to help. Some women receive one or more types of support from one or more relatives and some others get some kind of financial, material and medical assistance from associations of PLWHA and from care and support organizations. Besides, some couldn't be able to work and earn money for their living due to their illness

As mentioned above, some of the interviewees' husbands died and others relationship broke up as a result income from the partner disappeared. Some of the women also have children to care for. Women who have HIV-positive children suffer most. Two of the women have children who are sick due to HIV. And caring for their sick children, in addition to their own illness, and the extra money needed by the women for medical treatment worsen their circumstances. With bad economic condition, caring for their sick children besides their own illness became unbearable for them. The followings are statements of the women regarding their experience:

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<sup>1</sup> A very desperate young woman who said that she has been raped by a man she didn't know. She believes that she has contracted HIV from him who gave her gonorrhoea.

*I have two children. The youngest one, whose age is two and half years, is HIV positive. He is always sick. I have to take him to hospitals and clinics time and again. It is really painful to see your own child suffer from HIV. My husband has died. I have no job and income. I have finished the money that I saved in the good times. Now I am selling some of the household assets for our living and for the medical and nutritious care of my child.*

*(T, 29, Widowed)*

*I have four children. Three of them are from my first husband. Their age is 17, 13 and 9. My only child from my second husband is aged a little over two years. He usually gets sick and when his blood was tested it was found to be HIV positive. I always take the child to clinics and hospitals. It is really very difficult. I have no time to rest. Although, I told my husband about the child's and my HI- positive status he doesn't help me and doesn't care for his own child. Rather he blames and insults me. I am alone and know nothing to do. By now I have nothing let alone for medication but also to feed myself and my children.*

*(A, 35, Married, mother of four children)*

HIV/AIDS potentially threatens women as individuals, mothers and carriers. As elsewhere, women in Africa are the main caregivers. It is their responsibility to care for the sick, which may include husbands and children infected with HIV. But there may be no one to care for them at home when they are sick (de Bruyn, 1992). The dangers that women face from the AIDS pandemic have been described as a 'triple jeopardy' (Panos Institute, 1990).

## **5.2 Consequence on reproduction**

HIV/AIDS being predominantly a sexually transmitted disease, the groups at greatest risk are those between 15 and 50 years of age, often described as the sexually active (Barnett and Whiteside, 2002). As can be referred from the socio-demographic background of the interviewees, almost all of them are in their early years of child bearing age at the time of the interview; eight in their twenties, six in their thirties and one 18 years of age. However, although they were in their childbearing age, only six of them who had children. Among them, with the exception of two women who had other reason for not having children, the remaining seven noted that they had no and/or will

not have children due mainly to HIV/AIDS. In the focus group discussion, women indicated that they were strongly advised in hospitals and clinics not to get pregnant and have a child and those women who already had children were told not to have more.

Women carry greater psychological burdens with the issues of pregnancy and parenthood. Seropositive women have been shown to have higher risks of pregnancy-related complications, such as spontaneous abortions, premature births and prenatal mortality; their children, both seropositive and seronegative, may show increased morbidity. Where fertility is an important value, women who unwillingly give up motherhood must deal with their own unhappiness, the displeasure of their husbands and relatives and diminished status within the family and society-at-large (de Bruyn, 1992).

In Ethiopia, as in many African countries, having children is important to a woman. Women are socially positioned and culturally defined to be fertile and to achieve this speedily. Although the childless interviewees wished to have children, due mainly to their HIV-positive status, they could not have. Thus they felt very sad and desperate as the following statements illustrate:

*Because of the support and sympathy I get from my family I mostly forget having HIV but I get depressed when I think that I couldn't bear at least a child.*

*(F. 29, had a boy friend)*

*The worst thing of having HIV is that you can not give birth. If you bear a child while you are HIV positive it will also be HIV positive and soon die. You too will be physically weak due to pregnancy and care for caring the sick child. I was told this in the hospital. I am really very much desperate for not having a child.*

(B, 26, Widowed, husband died AIDS)

*I do not mind to die because human beings die and there is no one who can escape from death but the worst thing of dying with AIDS is that you die with out giving birth even if you need.*

(S, 23, divorced)

*I desperately need to have a child. Especially after the doctors have told me that I shouldn't get pregnant and bear a child due to my HIV-positive status. My friends have children; they spend most of their time with their children. They are their hopes. I need to have at least a child who will remember me after I died.*

(L, 25, Single)

Most of the women who were childless knew that it was possible for them to get pregnant but due to complications it would bring on their health as well as the high probability of bearing an HIV-positive child as they were told by medical professionals made them not to take risk.

The impact of HIV/AIDS on individual woman's reproduction has also greater implication on household composition, reproduction, size and sustainability. Households with adult female infections experience lower birth rate and higher infant and child mortality rate. In households where a parent or both parents have AIDS, the likelihood is that fewer children will be born and that a significant proportion of those who are born will die in infancy or early childhood. Inevitably, this means that the personnel of the household are not replaced and that the life way and traditions of that household are not carried forward (Barnett and Whiteside, 2002).

### 5.3 Pressure on Marital Relationship

HIV/AIDS in addition to having a devastating impact on the health, economic and psychological well being of infected and affected individuals, its pressure on the social relationships of infected individuals with partners, relatives, friends and the community at large is great (UNAIDS 1999; de Bruyn; 1992; Annania; 2000; Melese; 2001; Sebsib, 2002).

Details of the interviewees' social relationships with their families, with friends, and with the community at large is described in the previous chapter. My intention in this section is to show how HIV/AIDS affected the women's relationship with their husbands. The influence of HIV/AIDS on marital and sexual relationships is particularly great. Women who have HIV or AIDS risk rejection, abandonment and divorce with loss of an income as a consequence.

Of the four married women at the time of the interview two women's relationship with their husband's turned to be very bad due to HIV/AIDS. They reported that their husband's usually blamed them for having HIV. One of them noted that the source of her HIV infection was her husband. Although these women have found staying with their husbands extremely painful, they were living with them because of their dependence on their husbands for their living, having no one to turn to and because of the problem of housing. The following narratives of two women illustrate how the relationship the women had with their husbands were affected because of HIV/AIDS:

*I learned my HIV positive status when our child was found to be HIV positive. For sometimes, I kept quiet. But with the advice of the counselor, I told my husband about me and our child HIV-positive status and asked him to have a blood test. At this time he shouted at me to keep quiet and said he will never be tested. Before this news, I can say we had relatively good relationship. However, since the day I told him, his behavior and the relationship we had changed dramatically. He started to come home late at night being drunk. He shouts and*

*insults me. He never cared for our sick child. He stopped giving me the house monthly expense on a regular basis. Only occasionally he threw very little amount of cash. I have three children from my previous husband. Since their father has died, they are living with me. They have found very difficult to live in this kind of situation. One of my eldest daughters whose age is 17 has left the house recently due to this problem. I don't know for sure where she is, but I suspect that she works in a hotel. Although I and my husband are living in the same house we are no more a husband and a wife. We do not sleep together, we do not eat together and we do not have any good relationship. I am living in that house with my children since I have no where else to go and I told the kebele administration secretly to give me another house or to divide the house that we are living in to two.*

*(A, 35, married, relationship very much bad due to HIV/AIDS)*

*The relationship I have now with my husband is totally different from our past relationship due to my illness. My husband is an illiterate man. He has no formal job. He earns money by carrying goods in the local market. Although his income is extremely small, we had a relatively good relationship before I told him my HIV positive status. Of course, even before I knew my HIV positive status, I always get sick because I have gonorrhoea and it couldn't get cured. When I learned my HIV positive status, I felt very much guilty and sorry for him because I know that I got the virus not from my husband but from the person who raped me six years ago. And I felt guilty that I infected my husband. But when I told him about my status and asked him to have the blood test, he said he doesn't want and insulted me for having HIV and for not bearing him a child. And he always says to me, "I do not need to feed a dying person. You even didn't bear me a child. I just let you live here only for the sake of God." This reaction always disturbs me more than the disease. And since I am very much sick and have no where to go, I am forced to live with him. I always spent each day on bed and he throws me something to eat by saying, "Just not to be sinful or cursed in the eyes of God"*

*(H, 23, Married, with full blown AIDS)*

In addition to these women whose relationship with their husbands turned to be bad, one of the interviewees got divorced due to HIV/AIDS. When she told her husband that she has HIV, he reacted very negatively and chased her away although he was the source of her infection (for details see case 4 in chapter IV).

## Chapter Six

### Coping with HIV / AIDS

The term 'coping' has been used in various ways by different authors but according to Murphy and Moriarty (1976); it is a general term including defense mechanisms, active ways of solving problems and methods of handling stress. Barnett and Blaikie (1992) explain the process;

*Coping is about the ways in which we all recognize that our normal expectations of how life is and ought to be are adjusted when we realize that 'normality' has, for whatever reasons, switched to 'abnormality'. In recognizing that such a transition has occurred, we search for explanations of the new circumstances in which we find ourselves; we adjust our expectations and we search for courses of action that will enable us to achieve whatever goals are culturally significant for us. These processes require us to develop not only practical strategies for coping, but also language and concepts to deal with the new situation.*

*(Barnett and Blaikie, 1992, P. 39)*

Many coping mechanisms have been developed by PLWHA to deal with life with HIV/AIDS and the stigma that surrounds it. Some of the mechanisms used by the women include decisions around disclosure- disclosing where care and support is envisaged and not disclosing where stigma is anticipated, joining PLWHA networks, religion, counseling, acceptance and some others. These coping responses of women can be classified into emotion-focused and problem-focused coping (Carver et al. 1989).

The general model developed by Carver et al. (1989) regarding individual's ways of coping with stress, although not specific to HIV/AIDS appears to be relevant to the situation of women who are HIV-positive because of its emphasis on individual coping patterns. Carver et al. (1989) distinguished between two general types of coping; problem focused-coping and emotion-focused coping. Problem focused-coping aimed at problem solving or otherwise doing something to alter the source of stress. Emotion-

focused coping aims at reducing or managing the emotional distress associated with (or cued by) the situation. Although most stressors invoke both types of coping, problem-focused coping tends to predominate when people feel they can do something about their situation. And emotion-focused coping tends to prevail when the stressor is experienced as something that must be endured.

Though Carver et al. present the strategies separately; the interviewees' responses show that these mechanisms overlap. Most women used more than one type of coping at the same time. Of the problem-focused activities Carver et al. list, active coping and seeking instrumental and social support were mostly used by the interviewees. Of the five aspects of emotion-focused coping listed four; (seeking emotional social support, positive reinterpretation, acceptance, and turning to religion) were used by the interviewees. Additional forms of emotion-focused coping, which are not described by Carver et al. and which were used by the women include, hope for a cure, having children, mental disengagement that women used to prevent themselves from thinking about HIV/AIDS and social withdrawal (avoiding social interaction).

The following sections give examples of separate coping responses used by the interviewees. Also HIV/ AIDS involve various stages of illness. Coping with AIDS is different from coping with HIV. The stage (ranging from HIV infection to full blown AIDS) in which a woman finds herself influences her search for a particular coping strategy.

## **Problem-focused coping**

Among problem-focused coping strategies, seeking instrumental social support is mostly used by the women. As described in chapter IV, women revealed their status only to very few others where they anticipated practical and emotional social support. Instrumental social support is conceptually different from emotional social support, but in practice, they often occurred together.

The case presentations indicated the income sources of the women and shows whether and where the women get practical and emotional support in order to help them cope with the socioeconomic as well as their physical and psychological problems.

People with HIV/AIDS cannot hope for rapid change in their suffering, especially if they live in a developing country. The lack of affordable treatment options influences individual's perception of their disease situation and the way they deal with their illness (Schussler, 1992). Thus individuals who are infected always confront an impact on their health. In most cases they also face an impact on the resources they have, as illustrated in the previous chapter (Consequences of Being HIV-Positive).

An individual's ability to cope with as well as to adapt different coping strategies to challenge these multidimensional consequences depend on who the individual is, its economic, education and social status as well as its access to good healthcare and available social support.

*In the absence of treatment infected individuals can expect to experience periods of illness that increase frequency, severity and duration. A few individuals may, through a combination of appropriate lifestyle, good nutrition and good luck, not fall ill. However for most as CD 4 cell counts decline, so does their state of health (Barnett and Whiteside, 2002 p.183).*

Although most women realized there was no cure for AIDS and the cost of retroviral drugs is high, they considered the possibilities of a long life with HIV. Some knew some things to do in order to stay healthy, especially in relation to food and drink, abstaining from and/or minimizing sexual intercourse and changing life styles. This knowledge helped some women to cope actively by caring for their general health in order to slow the development of full blown-AIDS.

*You can live many years without getting sick if you properly take care of your health by taking nutritious diets. As much as possible, with the little money I get, I try to have good foods and fruits in order to keep my self healthy.*

*(K. 38. Widowed)*

*I used to be a sex worker and I got the virus from there. Although I had no where to go when I first hear my status, I did not attempt to go back to the hotel since the general condition in the hotel; drinking, smoking and many other things would exacerbate my illness. I therefore, started another kind of life which is extremely different and better than the life I had.*

*(S. 18. single)*

*I know that in order to stay healthy and live longer, one should get nutritious diet. The counselors and others also tell us this, but it is really hard to get something to eat for me and for my children in the usual meal hours let alone get nutritious diet.*

*(G. 34. Widowed. With three children)*

Women in the focus group discussion indicated that although they knew the importance of nutritious diets and good living conditions for staying healthy, their economic conditions did not allow them to apply such strategies. As a result most women turned to emotion-focused coping strategies.

## **Emotion – focused coping**

The women turned to diverse emotion-focused coping strategies. These include:

**Religion:** - Nearly all women used religion as a primary coping strategy. A resort to religion, having faith and devotion to God may be a very adaptive and powerful form of coping. Most emphasized that their future was up to God and almost all take holy water in order to get cure or improve their health. The use of religion as a primary coping strategy by many involves a variety of reasons but may in part have been reinforced due to the fact that some people were said to have been cured by turning to religion and by taking holy water (**see Annex 2 and 3**). In some Orthodox churches i.e. in 'Entoto' St. Mary Church and in 'Entoto Kidanemehret' Church there are hundreds of HIV-positive persons and AIDS patients praying and taking holy water. Some even witnessed that they got cured after they prayed and took the holly water for some time.

Annex 2 and 3 presents witnesses of some people who confessed that they got cured by turning to religion and by taking holy water. Their story was found in a journal which Entoto St. Mery church published. These people presented HIV status certificates which show that they were once HIV-Positive and after some time they found to be HIV-negative. As presented in the journal they took the test in accredited testing center. It is of course difficult to believe and accept the stories of these individuals in scientific terms. Many reasons could be give for false positivity ranging from misplacement or sample blood to the problem with the laboratory equipments. But the presence of some people who wittiness getting cured and the use of religion served the women as a source of emotional support, a way for positive interpretation or acceptance.

*I am a very devoted Orthodox Christian. I always pray, fast and take the holly water. Even, long before I learned my status, I always go to churches. I married my husband with a church ceremony. After I learned my HIV positive status, I fully gave my life to God and even became more religious.*

(S. 24, Divorced)

*Few days after I learned my status, I went to 'Shenkora Yohannes' [a very famous church for its holy water healing power] to take holly water and of course to get cured. There I got a monk and I confessed. He gave me a very spiritual advice that helped me in accepting the situation I faced. My life is on God. It is He who makes plan for me. And I really have great trust in God that he will cure me.*

(B. 26, Widowed)

*I am a protestant. I have colleagues with whom I pray before I knew my and my child's status. I told them about myself and my child and asked them to pray for us. Every Sunday they come and pray for us. The pastor says AIDS is a disease which can only be cured through strong trust in God and praying. And I believe that.*

(T. 29, Widowed)

*I usually go to church; I pray and take holy water. At home I have holy water which I brought from different churches. I drink it or wash my body with it whenever I get depressed or feel sick and immediately after I get relief.*

(K. 38, Widowed)

*I used to be a Muslim. Now after seeing many people getting cured by strong belief in God and by taking holy water, I became a Christian and I really have a very strong belief in God that he will cure me. I pray very much in the mornings, in the evenings, to God and I feel better now.*

(A. 18, Single, used to be a sex worker)

In almost all cases, religion helped women in coming to terms with the situation and most emphasized that their future was up to God.

The other type of emotional-focused coping women use is **seeking emotional social support**: - Most women sought emotional support from others and revealed their

status. The sympathy or understanding they obtained helped them to come to terms with an HIV status as the following statements of women illustrate:

*When I was found to be HIV Positive and when my husband chased me away, I wanted to share my problem to my brother. And when I told him, he felt very much sad and gave me a brotherly advice. His positive reaction and sympathy for me helped me a great deal in feeling that I have some one whom I can talk to.*

(S. 24. Divorced)

*I was very much shocked when I first learn my HIV-positive status and I badly needed someone whom I could tell. I told an old woman who is my neighbor. She really was very sad for me, but told me that she would help me and my child in any way possible. I really felt very happy with her good reactions.*

(M. 30. Married)

Those women who experienced negative reactions from their relatives or from someone to whom they revealed their status anticipating practical and emotional support seemed less able to come to terms with HIV/AIDS. And they used negative emotional coping that is social withdrawal or avoiding social interaction.

*It is not the illness that disturbs me much; it is rather the very negative reactions of my siblings which made life very hard. I am very much desperate and hopeless. I hated myself. Mostly I think of killing my self if I am no more useful, thrown by my own family. But I say it is not good in the eyes of God. In order to avoid meeting my siblings and other people, I spent most of my time far from our locality and come home let at night after they slept.*

(N. 23, Divorced)

The reason for this detachment, depression, hopelessness and loss of affection was created not only due to their illness and the impending death, but also the negative attitude and reactions of others especially close relatives.

Another important emotion-focused coping strategy which helped most women is the knowledge that they are not the only ones infected with HIV. At the time of the

interview, many women know someone with HIV/ AIDS personally. By seeing others in the same condition, they felt less lonesome. Before learning their status most women knew no one living with the virus. Although some knew their husbands had died of AIDS, their knowledge of and attitudes towards HIV/AIDS were very much limited and often surrounded by misconceptions (See Chapter III). The first time the women learned of their HIV positive status, most thought they were the only ones or among a very few positive persons and felt it was the end of their life. It is of course one of the reasons that most PLWHA kept their status absolutely confidential and most spend their time at home or somewhere else having no one to share to their problems. But knowing others with the same conditions helped most in coming to terms with HIV/AIDS.

Most women know someone with HIV or AIDS personally; most immediately felt they had some thing in common, and were sympathetic. Since most of the women have joined association of PLWHA and care and support organizations with the referral of the counselors or doctors or with the advice of someone, they noted the opportunities this created in knowing others with HIV/AIDS. Seeing others in the same condition, they felt less alone. Both in the focus group discussion and in the individual interviews the women indicated that the people whom they have strong links, relationships and sympathies are other HIV-positive persons. They help each other emotionally and practically. Since most of the women revealed their status to few other persons or not at all, seeking emotional social support was for the most part directed at other HIV-positive persons.

There was a great deal of interaction between the women and other PLWHA that I observed in their associations (Mekdim Ethiopia and Dawn of Hope Ethiopia) and other care and support organizations where I accessed the women. Their interaction ranges from talking daily to each other and sharing common worries and problems to practical support individual PLWHA at the time of severe illness or when one faces critical economic problems. In this way, they have created their own networks of practical, but for the most part emotional assistance, in which they help each other.

*It's better to tell someone who is HIV-positive than to tell anyone else, because we have one thing in common.*

*(focus group).*

*When I learned my HIV positive status, I almost fainted. I was crying loud not for me but for my children who have lost their father and who would lose me too. A young woman who was in the clinic came to me and said openly that she too is HIV positive and told me that there are more people living with the virus for many years and promised to take me to the association in which she was a member where I could get some kind of assistance. There, I got many people with HIV. I learned that I 'm not the only one. I also get practical, emotional and medical assistance from the association. If I haven't been there with the help of that good girl, my life could become more miserable.*

*(G. 34, Widowed)*

*I have friends who are also HIV positive. We talk about the virus on and on and the more we talk the more we learn about the virus and the more we get used to it.*

*(K. 38, Widowed)*

*At first, when I learned about my HIV-positive status, I kept it to myself and was reluctant to go to associations of PLWHA although the counselor advised me assuming that what I would get there except being identified by others as being HIV positive. However, as time went on and when I got life very hard due to my husband's negative reactions to me, I told my brother and he brought me to Mekdim Ethiopia and there I got friends whom I could talk to and share my worry. Although, all of us have good relationship and sympathy to each other, I have three close friends (younger women). We have strong bond and relationship. We usually visit each other. Whenever anyone of us get sick or face difficult problem we assist each other to the best of our capacity. Most of the times we talk, laugh and chat together and in this way we are accepting our situation.*

*(S. 24, Divorced)*

*One of my major problems in living with HIV was finding someone whom to talk to. At home there's no one to tell my problem, because it is a secret. Here we are the same so, I am free to talk. It helps me by talking with others, sharing ideas and helping each other.*

*(W. 29, Widowed)*

*I have a friend who is also HIV positive with whom I share about my problems.*

*(N. 23, Divorced)*

Initially, most women joined PLWHA associations seeking instrumental social support. As mentioned in chapter 3, poorer PLWHA are more willing in joining PLWHA associations and in going to care and support organizations apparently due to their greater need for material support. According to Ato Zewdu Tadesse president of Dawn of Ethiopia:

*It is a fact that there are many HIV positive persons who are in power, educated and economically in better positions but they do not come to associations of PLWHA or do not visit HIV/AIDS care and support organizations since they do not want to be identified as having HIV. It is those infected and affected persons, who are economically very weak, jobless, and homeless who come to us in need of support.*

However, in addition to instrumental social support the emotional support they get through counseling, training, and through the various interactions between themselves and the sympathy they have for each other may even be more important to the women. One of the women who had joined Mekdim Ethiopia five years after she lived alone with HIV described the situation as follows:

*Since I learned my HIV-Positive status in 1990 E.C I have been at home. I never went to association of PLWHA and care and support organization because with the practical and emotional support I got from my family, I lived for about six years. All these years I knew no one who is living with the virus and I thought I am one of the very few individuals who are living with the virus. And although my relatives are very much helpful to me, we don't discuss about it. At the end of last year, I got very much sick and I thought that the time of my death has arrived and I attempted suicide by deciding that I shouldn't have to suffer much from the illness*

*but my attempt failed. After seeing my physical and psychological conditions, a doctor advised my relatives to take me to associations of PLWHA where I shall get emotional support by seeing others who are living with the virus for so long. After I went there just at the beginning of this year, my hope and health has improved because I got many people who are living with the virus for longer years.*

*(F. 29, Single)*

**Counseling-** The major aspects of the service rendered by the respective associations constitute professional HIV/AIDS counseling and psychological support. Women who were counseled intensively and especially those women who had been trained in counseling and home based care appeared to have come to terms with their HIV-positive status and coped better than those women with little or no counseling and training.

*When I first learned my HIV status, I was devastated. I thought that my life was over. I couldn't sleep well. I had no hope. But with the counseling I received from Mekdim I came to know the possibility of a prolonging life. I took a counseling training. I now accepted my status.*

*(L, 24, Single)*

**Having Children-** Although, children were a major source of stress for the women since they worry for the future of their children who are likely to become AIDS orphans within a few years, having children was also perceived as an emotional burden. On the other hand, mothers considered children also as a source of emotional support and they appeared more concerned about their children than about themselves. Mothers longed to see their children grow up and care for themselves. This kept them wanting to continue living.

*My children are my relief. Whenever I fell desperate or angry I get calm when I see or think of them. I have left nothing to continue living except my children. I forget my HIV-positive status when I talk, laugh and play with them. I always pray to God to let me live until my children could live on their own.*

*(G, 34, Divorced. With three children)*

*We have six children and we are very much concerned about our children than for ourselves. I spend most of my time with them. Three of the oldest children knew about our status. They are everything for us. I get worried whenever I think of the future of our children.*

*(D. 35, Married. With six children)*

**Positive reinterpretation-**Positive reinterpretation is aimed at managing the emotions resulting from distress rather than dealing with the stressor. Seeing one's own relatively informed state as an advantage; and seeing positive aspects (Carver et al. 1989). This concept was illustrated in the focus group discussion as follows:

*We are better off because we know our status and we know many things about the virus. And when you know it you care for yourself and for others too. You stop taking or doing things that aggravate your illness.*

*(Focus group)*

*There are many more people who are HIV positive but who do not know their status and they may not care for themselves and for others since they don't know their status.*

*(Focus group)*

Acceptance, most women had accepted their HIV status to a large extent. "What do you do once it happened other than accept it?" was a statement used by most women.

Hope is an emotion focused coping response that is particularly important to those with HIV. Many women coped in part through hoping. For most women hope often comes from religion by having confidence or devotion to God; finding a purpose for living. Of course, it may overlap to some degrees with other strategies.

*I am now attending class because I believe that with the help of God, the doctors will find a cure for the disease.*

*(S, 18, single)*

*It is not the end of the world. Every one dies. It is not good to think about it, it is only God who knows when your time is over.*

*(L, 24, single)*

This discussion shows that coping with HIV/AIDS appeared to be complex for women. They used a combination of emotion-focused and problem-focused coping strategies, sometimes using several strategies at once and sometimes shifting among strategies over time.

## Conclusion

The individual stories of 15 women living with HIV/AIDS clearly show the gravity of the socioeconomic consequences of the epidemic on women. As can be referred from the socio-demographic background of the interviewees, almost all had low educational background, most have migrated to the town in search of a better life, had no formal occupation and many of them depended mainly on their husband's income. The socioeconomic conditions of the interviewees reconfirm the wider social, sexual and economic vulnerability of women (see Annex 1). With few exceptions, most of the women reported a husband or a boyfriend as the source of their infection.

HIV/AIDS had brought many complexities on their life and expectations. The women's socioeconomic conditions had also changed considerably since their diagnosis. Separation from or negative relationships with a husband due to HIV status created even more financial consequences; those who were widowed also lost income and their living conditions worsened. Besides, some had children to care for. Most women indicated that their major worry is how to get a living for them and for their children. They seem to be less worried about their HIV-positive status. As discussed HIV/AIDS affects women as individuals, mothers and careers. HIV/AIDS drained the women's resources and some potential sources of income or support remained underutilized due to fear of stigmatization and discrimination if they revealed their status and asked help. Some tried to obtain support from close relatives but most family members were not around since they came from the countryside and their families are living there. Besides, most of the women's families were themselves economically weak so that they couldn't able to provide economic support. Those women who were absolutely

confidential noted that it is of no use to tell family members or others if they couldn't help practically.

When HIV positive, women must cope not only with anxieties and physical symptoms but also with the response or expected response of partners, family, friends and the community. Mainly due to fear of stigma and discrimination most did not talk about their HIV status with close relatives or friends as a result they would have had to bear these psychological and the economic consequences completely on their own. This secrecy seemed to confirm the existence of severe discrimination. Though discrimination should not be underrated, this anxiety appeared exaggerated. Rejection or abandonment by relatives or close friends, however, did not often occur. Most women who have disclosed their status appreciated the positive reaction and the economic support they obtained from relatives. Nevertheless, few of the women had experienced discrimination from relatives, house sharers and from others.

With regard to coping with the socioeconomic and psychological consequences of HIV/AIDS, women used various types of coping. These include decisions around disclosure-disclosing where care and support is envisaged and not disclosing where stigma is anticipated, those women who have strong social network are in a better condition because they obtain practical and emotional support from others.

Becoming members in the self help groups (associations of PLWHA) and care and support organizations was another important emotional, material and financial source for most women. The respective associations of PLWHA and care and support organizations provide information, care and counseling, and material support. The value of this approach was that it helped HIV positive women talking and sharing

common worries with others and helping each other. They were encouraged to live positively which meant caring for yourself and your children, eating healthy food, not thinking too much and having a positive attitude towards the disease. This was often the first place women had come out with respect to their HIV status, and seeing others in the same conditions they felt less alone

One could see that the most important function of associations of PLWHA and care and support organizations is that in giving HIV positive persons hope through counseling, and a place to talk. Communication with others helped some women to learn and accept their disease.

Although the practical support they obtained was far from enough, women emphasized that the material support was very important to achieve acceptance. In fact most women seemed to worry much about daily survival of herself and that of her children than concern about her infection.

The description in this study about the dire consequences of HIV/AIDS on women shows the gravity of the problem and calls for efforts to be made by the government, NGOs, civil society organizations and by the general population to assist PLWHA in general and HIV-positive women in particular.

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### ANNEX 1 Important characteristics of the women

Case Reference*	Age	Place of Birth	Education	Marital status	No Children	Status disclosure
K	38	Gondar	Grade 7	widowed	-	Selective
G	34	Addis Ababa	Grade 8	widowed	3	Absolute
W	28	Addis Ababa	Grade 9	widowed	-	Selective
S	24	Addis Ababa	12+ training in food preparation	divorced	-	Selective
F	29	Akaki	12+ computer and photographing training	single	-	Selective
B	26	Ambo	Grade 8	widowed		Absolute
T	29	Gojjam	Grade 12	widowed	2	Selective
H	23	Wolkite	No formal education	married	-	Absolute
D	35	Chaha	No formal education	married	6	Selective
A	35	Addis Ababa	Grade 10	married	4	Absolute
N	23	Kebridhar	No formal education	divorced		Selective
M	30	Wollo	Grade 6	married	1	Selective
J	18	Dessie	Grade 3	single	-	Selective
L	23	Addis Ababa	Grade 9	single	-	Absolute
Y	33	Addis Ababa	Grade 4	widowd	2	Absolute

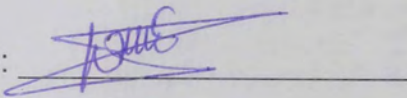
\* The alphabets are substituted the women's name and are used as a reference to identify a particular women through out the discussion.



## DECLARATION

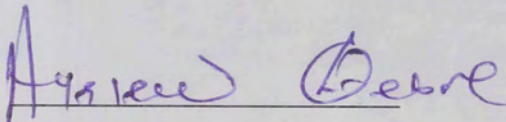
I, the undersigned, declare that this thesis is my work and that all sources of materials used for the thesis have been duly acknowledged.

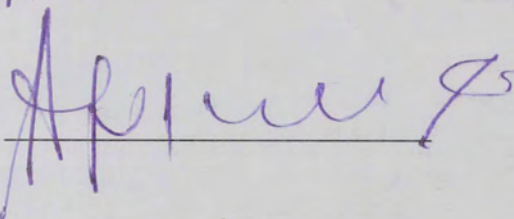
Name: Habtamu Demele

Signature: 

Date June 2004

Confirmed by:

Advisor: 

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