The exposure of women to HIV/AIDS: Societal explanations

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The exposure of women to HIV/AIDS: Societal explanations

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DECLARATION

I, the undersigned, declare that, this thesis is my original work and has not been presented for a degree in any other university, and that all sources of material used for thesis have been duly acknowledged.

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This thesis has been submitted for examination with my approval as a University advisor.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CEDAW	Convention of the Elimination of Discrimination against Women
CSA	Central Statistical Authority
FMOH	The Federal Ministry of Health
GER	Gross Enrolment Ratio
HAPCO	The National HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
NGO	Non governmental organizations
NIH	National Institute of Health
OSSA	Organization for Social Services for AIDS
PLWHAs	People Living with HIV/AIDS
RH	Reproductive Health
STIs	Sexually Transmitted Infections
SIDA	Swedish International Development Agency
UNAIDS	Joint United Nations program on HIV/AIDS
WHO	World Health Organization

Abstract

The gender dimension of HIV/AIDS reveals that, owing to the social, cultural and economic reasons women comprise an increasing proportion of people living with HIV/AIDS worldwide. In reducing the exposure of women as well as decreasing the overall prevalence rate of HIV/AIDS, addressing gender factors are core issues to be critically considered. The general objective of this study rests on looking at how the societal construction of femininity influences the vulnerability of women to HIV/AIDS in Bahirdar town. This study used in-depth interview and focus group discussion methods as major primary data collection techniques. Purposive sampling technique is employed to select sample organizations and thereby 31 respondents. The finding of this study reveals that the societal values attached to femininity have great influence on the sexual behavior of women and their access to information and services on HIV/AIDS, increasing their exposure rate to HIV infection. Based on the finding of the study possible intervention areas, like design conducive environment towards the empowerment of women and gendered approach to HIV/AIDS, are also forwarded.

Introduction

With over 1,320,000 people living with HIV/AIDS at a 3.5% prevalence rate, Ethiopia has one of the highest HIV/AIDS rates in the world. (The Federal Ministry of Health (FMOH) and HIV/AIDS Prevention and Control Office (HAPCO), 2006). New infections are increasing at an alarming rate compounded by poverty, unemployment, stigma and discrimination, gender inequalities, harmful traditional practices and other interrelated factors. The statistics of FMOH and HAPCO (2006), estimated that, in 2005, there were 137,500 new AIDS cases, 128,900 new HIV infections, including 30,300 HIV positive births, and 134,500 AIDS deaths. More strikingly, the estimates revealed the existence of a total of 744,100 AIDS orphans aged between infancy and seventeen years old. This situation calls for integrated efforts as well as full attention and devotion of concerned bodies and the community at large towards mitigating the problem.

Due to the social, cultural and economic reasons women comprise an increasing proportion of people living with HIV/AIDS worldwide. Compounded by strong socio-cultural malpractices and low economic status of women, the prevalence of HIV/AIDS is higher in Ethiopia among women than men (FMOH and HAPCO, 2004). Especially in the rural areas, the predominance of strong social norms and practices denies women sexual health knowledge, which fundamentally hinders them from deciding on their sexuality. Besides, the limited access to economic opportunities and their disadvantaged position in decision-making, multiplies the vulnerability of women.

In reducing the vulnerability of women as well as decreasing the overall prevalence of HIV/AIDS, addressing gender factors are important. Thus, this research aims to contribute towards identifying more societal constructions of femininity governing the vulnerability of

women to HIV/AIDS. The researcher believes that the output of the study will contribute towards the constructive assessment of the issues in combating the problem of HIV/AIDS in the context of the Amhara region.

Problem Statement

The current figures show that, given their low societal status, AIDS is a disease increasingly affecting women. HAPCO and FMOH (2006) revealed that, in 2005, there were more women living with HIV/AIDS than men within the age groups of 15-29. It was pointed out that the prevalence of HIV among women was twice as much (1.9%) as compared to that of men (0.9%). This indicates that women are highly exposed to the virus compared to their male counterparts.

As stated by HAPCO and FMOH (2004), the major mode of HIV/AIDS transmission in Ethiopia is heterosexual intercourse, which accounts for 87% of the infections. In this regard, the vulnerability among women is found to be high due to their physiological characteristics. Furthermore, the responsibility of care and support of most AIDS patients heavily falls on the shoulders of women. This increases the probability of their infection rate due to the lack of protective factors. On the other hand, the relatively high rate of mother to child transmission of HIV/AIDS accounts for 10 % of infections. This further suggests that greater attention needs to be given to women in combating the overall HIV/AIDS related problems in Ethiopia. Women face higher risks of HIV infection than men because of their inferior status in the society that plays to restrain their ability to choose safer and healthier reproductive health behavior. Women’s decisions, even related to their own health, are hampered by a number of factors rooted in the social factors of a society. They are bearing a disproportionate burden of the disease and its impact because of significant gender

inequalities. As a result, these women face a higher level of stigma, discrimination, and poorer access to public health services. (AIDS Legal Network, 2006)

Gender roles and relations have a significant effect on the course and impact of the HIV/AIDS epidemic throughout the world. Understanding these gender roles and relations on individuals and communities abilities to protect themselves from HIV and effectively deal with with the impact of AIDS is imperative for expanding the responses to the epidemic. (Joint United Nations program on HIV/AIDS (UNAIDS), 1998)

According to UNAIDS (1998), Gender explanations on the two sexes often determine what women and men are supposed to know about sex and sexuality and hence limit their ability to accurately determine their level of risk and means to acquire accurate information and protect them from HIV.

Understanding these gender explanations and looking for alternative measures towards mitigation, are key issues in reducing the vulnerability of women as well as the general public to HIV/AIDS. Despite the recognition of the importance of understanding gender explanations, not much has yet been done to address differences in power relations between men and women in the area of HIV/AIDS. Only few program managers and policy makers in the area of HIV/AIDS recognize the importance of giving emphasis to gender explanations to the different sexes in addressing the problem of HIV/AIDS. (World Health Organization (WHO), 2003). Only few programs have sought to improve the sexual health of communities via interventions to improve women's social and economic status. The concern given to the issue by different responsible bodies are also minimal (UNAIDS, 1999). Likewise, the World Bank’s assessment of the Ethiopian HIV/AIDS policy found that gender has not been

included. Such failure to understand and address the special problems of women is among the reasons that perpetuated the rapid spread of the disease (Wuleta Betemariam, 2002)

More importantly, as indicated by Wuleta Betemariam (2002), in spite of being one of the core issues in addressing the problem of HIV/AIDS, research done on the area of gender explanations and HIIV/AIDS is very minimal. There are very few articles focusing on social construction of gender and its relation with HIV/AIDS (Harvard School of Public Health, 2006). This has been one of the factors that prompted the interest to undertake this research in the area.

General objective of the Study

The objective of this study is to understand how societal construction of femininity, influence the vulnerability of women to HIV/AIDS.

The research addresses the following research questions:

1. How the societal explanations of femininity influence the sexual behavior of women living with HIV/AIDS?
2. How does societal explanations of femininity influence women living with HIV/AIDS from accessing education, information and services about HIV/AIDS?

Operational Definitions

Femininity: refers to socially constructed ideas of what women should be like. (Stets and Burke, 2002)

Masculinity: refers to socially constructed ideas of what men should be like. (Stets and Burke, 2002)

Gender: It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. (Gupta, 2000)

Explanations of femininity: Meanings and perceptions attached to behavior, characteristics and role of women in the society.

Culture: As per Taylor definition of culture, it is that complex whole which includes knowledge, belief, arts, morals, law, custom and any other capabilities and habits acquired by man as a member of society. (Conrad Phillip Kottak, 2000)

Tradition: the handing down of information, beliefs, and customs by word of mouth or by example from one generation to another without written instruction.(Merriam Webster online dictionary, 2007)

Position: Position refers to women's and men's political, social, economic and cultural standing in society(National Committee for the Advancement of Women in Viet Nam, 2004).

Literature Review

In the following part, different subject areas related to the study topic are considered. International and national instruments on women and HIV/AIDS are also incorporated. Moreover, different conceptual and theoretical perspectives and relevant policies on the issue are reviewed based on the existing literature.

Femininity and HIV/AIDS

Femininity and masculinity are socially constructed meanings of maleness and femaleness in a society (Vicci Tallis, 2002). Based on masculinity and femininity idea, usually society assigns different sexual roles for the two sexes. As it is indicated in Vicci Tallis (2002), thus, generally masculinity is associated with dominance and femininity with passiveness. This sexual division of role usually suppresses the sexual rights of women and constraint their freedom of choice with regard to sexual issues. Because of this, women are dependent on men to decide on their own sexuality.

Many countries still have patriarchal rules governing women's place in sexual relationships. In some societies, women are not allowed to choose their sexual partners or who they marry. These choices are made by men in their families. In situations where the man has all the power, a woman is most likely unable to insist on the use of condoms, or to take measures to protect herself from HIV. (Steve Berry, 2006)

In Ethiopia, there are societal roles assigned to each sex that greatly limit women's freedom to participate in social activities, decision-making and access to resources which make them dependent on men. Women are not allowed to make

decisions even concerning their own reproductive health. Less than 25% of women are able to decide on contraceptives by their own. These reasons among others are factors contributing to the escalating HIV/AIDS infection rates. (Swedish International development agency (SIDA), 2002).

According to Wuleta Betemariam (2002), In Ethiopia, where heterosexual transmission is the major mode of HIV/AIDS transmission, different social norms allow men to have more sexual partners. According to the literature, older men are encouraged to have sexual relations with younger women. This highly increases the infection rate among women. Added to this, women find themselves socially unaccepted if they verbally or behaviorally express their knowledge about reproductive health issues, let alone negotiating and deciding on their sexuality. They are expected to be sexually passive and shy which results in restricting their negotiation power to choose safe methods to protect themselves from the HIV infection. Men on the other hand are socially expected to be knowledgeable on sexual matters. As it is stated in Wuleta Betemariam (2002), they are encouraged to have sexual experiences and have multiple sexual partners. Moreover, the practice of having younger partners exacerbates the prevalence of HIV infection among women.

Education and Information on HIV/AIDS

As elucidated in Wuleta Betemariam (2002), due to various gender expectations, women are the most uneducated segment of the community. In most cultures, there is a gender value for men to be educated and have a higher income than women. Women in most cases are expected to confine themselves in household doing chores and taking care of the children

and older people. As a result, in most instances a priority is given for men to receive their education than women.

One in four adults in developing countries, about 872 million, are illiterate and out of these some 64 % or 557 million are women (Hunter, 2001). The situation is much worse in Ethiopia where 77 % of women have no education. (Aklilu Kidanu and Hailom Bantayerga,, 2002). The lack of education for women has contributed to the gender disparities in economics, power and social inequalities. Moreover, as specified by SIDA (2002), the population growth, reproductive health and the health status of the family, education of children in general and that of daughters in particular are highly determined by the educational status of women. In spite of this, school enrolment is very low for girls. As cited in SIDA (2002), the Ministry of Education indicated that the Gross enrolment ratio (GER) by gender shows that the ratio for girls was 47% and 67.3 % for boys.

Wuleta Betenmariam (2002) confirmed that due to their low education, many women do not have the knowledge and skill on how to protect themselves from HIV infection. Their level of knowledge is restricted to their skill of reading and writing and most of the time they are ignorant to HIV information and education. In many societies it is not encouraged for women to be knowledgeable about sexual matters. Lack of knowledge about sex further restricts them from accessing information on HIV/AIDS. Moreover, due to their low educational levels and positions in society, many women do not know and do not want to negotiate safe sexual practice with their partners.

According to SIDA (2002), unlike men, in most cases women do not use modern communication technologies like the telephone, radio, television and the internet to access to information pertaining to HIV/AIDS. Women are traditionally busy with household chores

and caring children, rather than spending time observing and viewing the media. Even if women find time to spend interacting and viewing the media, choosing channels or station, is usually decided by the man. This restricts the women from accessing the information of their choice. Due to the low utilization of media by women, their information and knowledge on HIV/AIDS is very limited which in turn increases their vulnerability to HIV. Thus, SIDA (2002) indicated that the HIV/AIDS awareness level for women in Ethiopia is 8%, whereas the level of awareness for men is 23%.

Access To and Use of Services

In 2007, the World Health Organization stated that the availability of women to access and use HIV/AIDS services was highly influenced by the social status that they hold in the society. The social and economic dependency of women, greatly affects their use of services and their ability to adhere to treatment. Due to their low economic status, women usually do not have the capacity to pay for different services. Thus, this prevents them from accessing what is best for their well being. If they can afford to pay occasionally, their responsibilities at home seldom let them get proper treatment on time.

The social norms that describe sex roles and responsibilities influence women's access to and use of health services, including services for HIV/AIDS. Gender norm of being non assertive about sexual issues, restricts women from seeking basic services about reproductive health. As pointed out by WHO (2007), gender related factors increase the woman's economic vulnerability and dependency; which in turn increases their vulnerability of being infected. Women are therefore exposed to sever consequences, the lack of services, and ignorant of information to survive when infected or affected by AIDS.

Impact of HIV/AIDS on Women

As indicated by UNAIDS, (1999), due to different factors related to gender and femininity, women are highly affected by the impact of HIV/AIDS, more than the other segment of the society. If their spouses fall ill, the woman also become responsible for looking after the economic means for the survival of the family, as well as caring for the patient. In many cultures, as indicated by UNAIDS (1999), women are not allowed to inherit the property of their spouses. This creates more complications of survival after the death of the spouse. Coupled with this, many women do not have the proper education and training to obtain employment opportunities. As an alternative some women are forced to be involved in commercial sex to earn a living.

In addition, as stated by UNAIDS (1999), the gender norm of caring for children becomes another burden for women as many children are orphaned as a result of the pandemic of HIV/AIDS. It is not uncommon for a woman with HIV infection, to also be the caretaker for children and other family members who may also be HIV-infected. They often lack social support and face other challenges that may interfere with their ability to obtain or adhere to their own treatment for their diagnosis of HIV/AIDS. (The National Institutes of Health (NIH), 2006)

In accordance with UNAIDS (1999), the girl child also suffers the impact of the pandemic next to her mother. When the household burdens increase, it is the girl in the family who primarily shares the responsibility with her mother. Whenever there is shortage of resources, it is the girl who will be the first to leave school. In times when both the father and

mother die, much of the burden for taking care of the family transfers to the girl child. She might also involve herself in commercial sex or engage in a relation with an older partner seeking economic security. As mentioned by UNAIDS (1999), this phenomenon has far reaching consequences in terms of the health of young women. Reported consequences include, early child bearing, poor educational attainment, economic dependency on a male partner and diminished access to productive resources. These identified factors contribute to the vulnerability of HIV/AIDS.

Most societies associate the HIV infection with promiscuity. This stigma and discrimination against HIV positive women contributes to the underlying message of sexual objectification and oppression. In most societies, for male to be promiscuous seems to be minor moral question, when it comes to the women it is a curse, deadly sin. For these reasons, the stigma and discrimination against HIV positive women is much worse than HIV positive men. (Royal Tropical Institute, 2000)

International Instruments on Women

Although women are half of the total population globally and major contributors to the economic development, they have been seen as a passive segment of the community and historically considered as dependents. Most women were viewed as incapable of actively participating in different development activities as well as decision making processes. They did not have equal right on different issues as their male counterpart and also restricted from fully benefiting from different resources and benefits. It was in the 1970s that the issue of women and development got the attention of the national development agenda. (Royal

Tropical institute, 2000). Especially, after the 1980's women's issue have got special consideration in different national and international conferences. The Convention of the Elimination of Discrimination against Women (CEDAW) was one of the leading conventions on the right of women adopted in 1981.

The convention emphasizes human rights of women. In addition, it commends states to take into consideration the issue of men and women equality in their legal system as well as in the economic, political, social and cultural sectors. The convention demands the replacement of all discriminatory laws with laws that forbid discrimination against women. This convention is also the only human rights treaty that asserts the reproductive rights of women. (Ministry of Women's Affairs, 2006).

Stated by women's affairs office/office of the prime minister (2005), especially after the fourth world conference on women in Beijing, China ,in 1995, the issue of women has got due attention by different government and development agencies. As mentioned by the same report, the Beijing Platform for Action embarked trials that demanded for a renewed commitment towards the full realization of human rights instruments and effective strategies for achieving gender equality that have been developed through efforts to implement CEDAW and key provisions of other international instruments and conference documents.

It identified the most pertinent issues of gender discrimination and called for governments' commitment. After this, the issue of women has come to an attention to different government and development agencies through out the world. Different measures like policy formulation on women; incorporating women issues in

different development agenda establish different units on women and the like to integrate gender perspective in the policies and programs were taken.

Even though different governments and development agencies have taken policy measures and designed different implementation strategies, as indicated by Royal Tropical institute (2000), due to different deep rooted gender barriers, it could not be possible to fully realize the policy objectives. Because of these, women's participation on different activities is obviously limited in most of the developing world; thereby economic life of women compared to men is simply miserable.

Ethiopian National Policy on Women

According to Women's affairs office/Office of the Prime Minister (2005), the national policy of Ethiopian women was formulated in 1993 to secure women's equal rights to socio economic development. As stated by SIDA (2002), the main objectives of the National Policy of Ethiopian Women include, creating and facilitating conditions for equality between men and women, creating conditions to make rural women beneficiaries of social services like education and health, and eliminating stereotypes, and discriminatory perception and practices that constrain the equality of women. In implementing the policy, a number of strategies like participation of women in the formulation of policies, laws, rules and regulations and ensuring the democratic and human rights of women are designed.

In reviewing the overall content of the National policy of Ethiopian women, Women's affairs office/Office of the Prime Minister (2005) affirms that there are some pertinent women

issues which are not covered by the policy that might create gap in fully realizing gender equality in the country.

Women and Ethiopian HIV/AIDS Policy

The National HIV/AIDS policy of the federal Democratic republic of Ethiopia was formulated in 1998. The policy aims to promote overall health care, including psychological care for people living with HIV/AIDS, STI treatment service, HIV/AIDS testing and screening and protecting the rights of those affected by the disease (The Center for Reproductive Law and Policy, 2001).

The major objective of the HIV/AIDS policy of Ethiopia is to provide an enabling environment for the prevention and control of HIV/AIDS in the country. The HIV/AIDS policy provides due consideration for women and HIV/AIDS. Among other specific objectives, conscious of the contribution of gender inequality in the further spread of HIV/AIDS in the country and aware of the need for including women living with HIV/AIDS to have access to information and services regarding HIV/AIDS and family planning that help them to make reproductive choices and decisions are the major once which give special consideration for women (The Federal Democratic Republic of Ethiopia, 1998).

Theoretical and Conceptual Framework

In the following section different theoretical perspectives on the development of femininity are reviewed based on the existing literature. Even though, these theoretical perspectives can help to understand how feminine behaviors are developed, as the

study is a qualitative research, the research objectives and questions can be best explained from the emerging themes of the finding.

Development of Femininity and Masculinity

Femininity and masculinity definitions are socially constructed meanings assigned for maleness and femaleness. Stets and Good noted, femininity and masculinity or one's gender identity refers to the degree to which persons identify themselves as masculine or feminine. (As cited in Stets and Burke, 2002). It is society that decides the appropriate behavior attached to being feminine or masculine. People learn the self meaning either being feminine or masculine and shape their behavior accordingly.

Along with the biological factors, as indicated in Stets and Burke (2002) sex typing can be determined by social processes. Through socialization, individuals learn the behavior, personality characteristics, emotional responses, attitudes and beliefs considered proper for their sex. The two sexes can learn and determine their appropriate personality through the process of socialization. According to Stets and Burke (2002), Socialization is a process of shaping asocial infant to a social being through developing social skills and a sense of self, and internalizes social norms. This socialization can be done at family, school, peer, community level and the like. Through this process, the two sexes can identify themselves and behave ‘proper’ to their assigned sex role according to their cultural expectations. There are four major theoretical orientations in explaining the process of sex typing: Freudian and neo Freudian psychoanalytic theories, Social Learning Theories, Cognitive Developmental Theories, Sandra Bem’s Gender Schema Theory.

Freudian and Neo Freudian Psychoanalytic Theories

This theory is based on the assumption that the two sexes develop different personality based on their childhood experience to anatomical differences. The theory explained in terms of the Oedipus and Electra complexes where children are attracted to the opposite sex parent and hostile toward the same sex parent. Thus, identity develops through identification with the same-sex parent. Thus, boys come to learn masculinity from their fathers and girls learn femininity from their mothers.

According to Chodorow as cited in Stets and Burke (2002), the relation between mother and son is more of different and separate as they are from different sexes. Unlike this, mothers relate more in a continuous and uniform manner with their daughters as they are the same sex. The strong bond between mothers and daughters, facilitate the learning of femininity. Concurrently, mothers distance themselves from their sons who respond by shifting their attention away from their mother and toward their father. Through identification with their father, boys learn masculinity.

According to Freud, the psychological differences for the two sexes are based on the Oedipus and Electra complexes. Concerning sex status, as stated by Stets and Burke (2002), this theory considers women to have lower status than men and they are also taken as incomplete men. On the other hand, men are considered as complete and deserve higher social status than women. It perceives women as inferior than men because of their sex organ and all behavioral and personality differences of the two sexes can be attached to the presence or absence of a genital organ.

Social Learning Theories

Based on this theory, the two sexes learn gender roles in the course of direct process of socialization through reward and punishment, indirectly through observation and imitation. By this process, the two sexes develop ‘’appropriate’’ personality and behavior to their respective sex identity and eliminate undesired behavior according to their culture. According to this theory, individuals, especially children imitate or copy modeled behavior from personally observing others, the environment, and the like (Lindsey, 2005).

Social learning theories emphasize that individuals' personality and behavior can be shaped and molded by social forces and can be internalized. Society, through socialization process, can shape the personality of individuals according to the desired expectation. This theory is best exemplified by orthodox role theory which stated the sexual division of labor constructs distinguished roles with scripts for how to act, behave and think. (Mc and Nielsen, 1990)

Through using positive and negative sanctions, different socializing agents like family, peer groups and the like can teach individuals to develop the appropriate behavior to their sexes. According to Mc and Nielsen (1990), in this regard, there are two basic learning processes in developing sex typed behavior:

Operant Conditioning

In this learning process, boys and girls are rewarded for behaviors appropriate to their respective sexes. To the contrary they are punished for undesired or inappropriate behaviors. Through this socialization process, the two sexes can develop the appropriate sex role and personality.

Imitation or Modeling

In this learning process, the two sexes choose similar sex to theirs and try to model and imitate the behavior and personality attached to that specific sex. Through this process, boys and girls can develop appropriate behavior and personality to their sex.

Cognitive Developmental Theories

As stated in Mc and Nielsen (1990), this theory emphasizes the importance of sex labeling i.e. calling the child a boy or a girl. According to the sex type, there are different personalities and behaviors attached to each sex. There are also different activities associated to the different sexes. After being labeled as a boy or a girl, the child chooses appropriate personality and behavior to that specific sex. Once a child's gender identity becomes established, then the child can select appropriate personality and attitude which is appropriate to his/her sex.

According to this theory, children recognize the gendered nature of the world in terms of sex and Sex typing is part of their intellectual development.

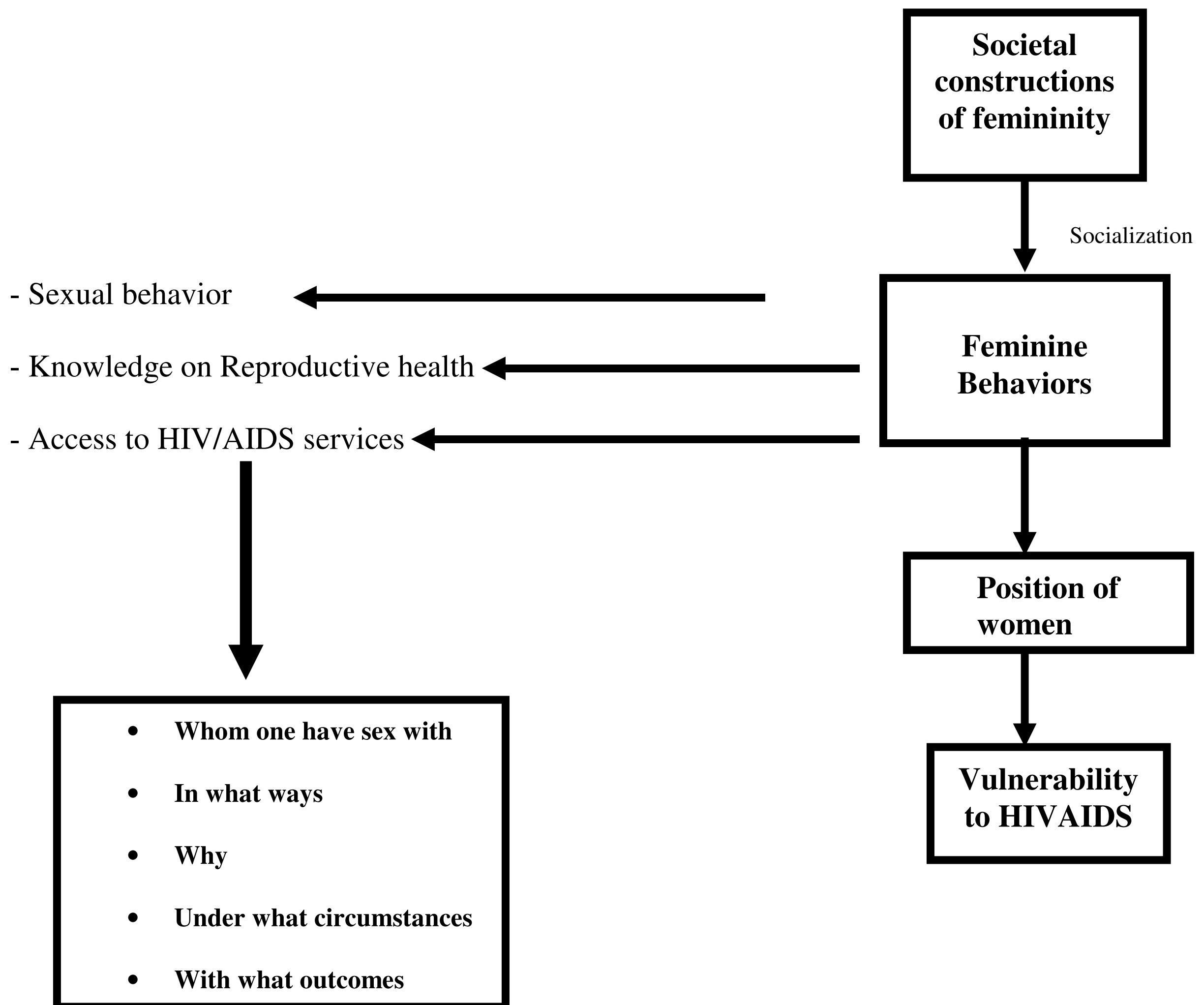
Bem's Gender Schema Theory

This theory tries to incorporate both aspects of cognitive developmental and social learning theories. Gender schematic processing as explained by Mc and Nielsen (1990), is a process by which the child develops sex typing thorough the process of encoding and organizing information based on the cultural expectations of masculinity and femininity.

As Lindsey, (2005) elaborated, according to this theory, children learn the appropriate behaviors attached to being feminine and masculine in their culture. Besides, they learn to apply behaviors appropriate to their sexes. Then, the child can continuously categorize and code different new information according to the sex typing. This means that there is

continuous interaction between the child's pre existing schema and new information which enables the child to distinguish different attributes of maleness and femaleness.

The following conceptual framework is developed from the existing literature. It shows the link between the societal construction of femininity and its influence on the behavior of women as well as their exposure to HIV/AIDS.



Research Methodology

Description of the Study Area

Bahirdar is the capital of the Amhara regional state located at 560 kms to the north west of Addis Ababa. It is center for business and tourism being one of the major centers of attraction of tourists in the country where interesting sites like Lake Tana, the Blue Nile fall, old churches, monasteries and monuments are located. The town has ten major sub cities and a total population size of 96,140 of which the male population accounts for 45,436 and females constitute 50,704 of the total population. (Central Statistical Authority (CSA), 1995).

As it is indicated in the MOH (2004), With regard to health, the town is characterized by high birth and death rates, low knowledge of reproductive health including HIV/AIDS, high prevalence rate of unwanted pregnancy, unsafe abortion, early marriage, and overall low level of reproductive health (RH) services.

The prevalence of HIV/AIDS is extremely high and apparently the highest in the country. Based on surveillance data, the Ministry of Health estimated the adult HIV infection rate to have been 20.8% in 2003, which shows the highest prevalence of HIV/AIDS in the country. Illiteracy, unemployment, migration, silence, harmful societal practices like female genital mutilation and early marriage are contributing factors for the high HIV/AIDS prevalence in the town. Due to all these factors Bahirdar arouses academic curiosity to study the social factors related to women and HIV/AIDS.

Research Design

The research is of qualitative nature as it mainly deals with societal constructions of femininity that tend to require in-depth information which is mostly qualitative by nature. It is also explanatory; as it mainly tries to describe explanations of femininity that intensify the

exposure of women to HIV infection. Using qualitative method helps to gain full insight and rich information on the issue. As qualitative research is concerned with developing explanations of social phenomena, using this method is the best method in understanding the research issue that is also related to social issues. In addition to these, this research method facilitates better understanding of the experience of the research subjects.

Sampling Method

The study used Non probability sampling technique as a major sampling method. Purposive sampling technique is employed to select participants of the study. Bahirdar town is selected on purpose for the research because of the high prevalence of HIV/AIDS and the existence of a wide range of gender factors related to women and HIV/AIDS.

Organization for social services for AIDS Bahirdar branch and Tesfa Gohe Ethiopia were purposively selected to make the research process smooth by facilitating contacts with people living with HIV/AIDS who are included in the study. Furthermore, purposive sampling technique is employed to select participants of the study. A total of fifteen women living with HIV/AIDS between the age of 18 to 49 who have the knowledge of the subject matter and who are of Bahirdar origin, participated in the in depth interview. Besides, another sixteen women living with HIV/AIDS between the age ranges of 18 to 49 who have the knowledge of the study topic, purposively selected from the two organizations are included in the two focus group discussions.

Organization for Social services for AIDS

Organization for Social services for AIDS (OSSSA) is one of the pioneer organizations in Ethiopia to establish community based care and support for orphans and PLWHA. It was

established in 1989 by the government of Ethiopia and different major religious institutions in the country. The organization among others has major objectives of providing quality care and support services for PLWHAs and AIDS orphans and reducing the prevalence rate of the virus. Care and support, counseling, education, prevention, rehabilitation, training and drug treatment are among the major intervention areas of the organization. It has different branch offices in Dire dawa, Addis Ababa, Amhara, Oromiya, Tigrai, Hararti, Southern people nations nationalities regions. (Catholic relief Service, 2007)

Tesfa Goh Ethiopia

It is one of the leading associations established by people living with HIV/AIDS. Besides PLWHAs, it is also consists of orphans due to HIV/AIDS. It was established in 1998 by a group of eleven people living with HIV/AIDS. The major objectives of the association are providing education on HIV/AIDS and protect the rights of HIV-positive persons. Among others; education, care and support, medical support and treatment for AIDS-related illnesses and advocacy are the major intervention areas of the association. Currently, it has more than 10,000 members and twelve branch offices in Addis Ababa, Nazreth, Debre Zeyt, Debre Birhan, Awasa, Shashemene, Dilla, Harar, Bahir Dar and Humera. (AIDS resource center, 2007)

Data Collection Tools/Instruments

In undertaking the research, both primary as well as secondary source of data are used. The Primary data was collected from April 21 to May 20 2007. In-depth interview and focus group discussion methods are employed for the primary data collection process. To enrich the

primary data, secondary data from the internet, books, different organizations' reports, strategic plans, training manuals and other relevant documents are also incorporated.

Given that the study mainly deals with explanations of femininity; using in-depth interview allowed the researcher to gain extensive information on different factors related to the study topic. As has been mentioned earlier, in addition to the in-depth interview method, focus group discussion method is employed as a data collection technique with the aim of adding information and accessing a broad range of views on the study topic. This method helped in facilitating interaction among group members and gave opportunity for participants to raise pertinent issues.

Data Collection Procedure

To secure the consent of Organization for social services for AIDS and Tesfa Goh Ethiopia, letter of cooperation from Addis Ababa University was provided before conducting the interview and the focus group discussion.

Part of the in depth interviews with women living with HIV/AIDS were carried out at the office of the two organizations. Half of the other in-depth interviews were conducted at the respective home of the interviewees. The two focus group discussions were prepared at a rented small hall in the town. Each discussion group consisted of eight members. On average, each discussion took a total of one and half hours. The researcher of this study moderated the discussion and tape recorders were used.

Questionnaire

The researcher of this study conducted all the in-depth interviews using Open, Semi structured interviews. The questionnaire has three parts asking the respondents to provide information on gender explanations of femininity increasing the HIV infection rate among

women. Part one of the questionnaire deals with background information on the informants. Part two is prepared for obtaining information on sexual behavior of the respondents. Part three of the questionnaire focuses on access to education and information on HIV/AIDS where as part four deals with access to different services related to HIV/AIDS.

The focus group discussion is structured through a checklist of open-ended questions and a moderator facilitated each discussion. Part one of the checklist directs towards obtaining information on the demographic factors of the respondents. The other part of the checklist mainly focuses on gender explanations of femininity increasing the vulnerability of women to HIV infection.

All the questionnaires for the in depth interview and the checklist for the focus group discussion were first prepared in English then translated into Amharic to conduct the interview and the focus group discussions. A Professional language expert evaluated the accuracy of the translation.

Data Analysis

The collected data is analyzed in line with the objective of the research and the emerging themes from the data. In this process, all the key issues, concepts, and themes by which the data can be examined are identified. This is done by drawing on previous issues and research questions derived from the aims and objectives of the study as well as issues raised by the respondents and views or experiences that recur in the data.

When necessary, elementary quantitative techniques are also used to summarize and present the research data. Moreover, direct quotes of respondents are also incorporated to give better explanation. The data is presented according to the appropriate part of the thematic

framework to which they relate. Associations between themes, with a view to provide explanations for the findings are also identified.

Ethical Concerns

PLWHAs and others who have contributed to this research were asked for their permission to do so. Oral informed consents were asked from PLWHAs to participate in the study and gave their consent with informed understanding of the intended purpose.

Finding and Analysis

This section deals with the major findings of the study. The major findings are presented according to the thematic areas, which were identified through literature review and major objectives of the research. The findings are analyzed based on the existing literature and the research questions. Elementary quantitative techniques and direct sayings of the interviewees are also used to present and analyze the data.

Demographic Characteristics of Respondents

Age

The respondents were between the ages of 20 to 40. Thus, out of the total respondents four were between the ages of 20 to 25 years, three between the ages of 25 to 30 years, seven were between the age of 30 to 35 years and one respondent was 38 years.

Two of the focus group participants were between the ages of 18 to 20. Six were between 20 to 25 years, four between the age of 25 to 30, and the rest four were between the ages of 30 to 35 years.

Religious Background

Concerning their religion, most of the informants were from Christian religion. Ten women were from orthodox religion and four were protestant religion. Only one respondent was from the Muslim background. Eight of the focus group participants were from Orthodox religion, four from protestant and three from Muslim religion.

Educational Status

Looking at the educational status of the research subjects, the findings showed that most have attended secondary level education. Only, two respondents were diploma graduates where as eleven of the respondents completed 12th grade and hold other certificates. On the

other hand six have secondary education, four have attained primary education and the rest eight were illiterate.

From the finding we can observe that out of the 31 respondents, 23 were educated some how enough to grasp and analyze HIV related information. Though, high HIV infection is mostly related to low educational status or illiteracy, the relatively high number of literate respondents might direct to other themes other than educational background to explain the exposure of the women to HIV infection. The major observation we can cite here is merely having certain education does not guarantee compatible information on HIV/AIDS or a more likely chance to achieve behavioral change usually society expect to see from those who enjoyed modern education. So other than being educated, there are many more factors which might determine the level of awareness or knowledge that people have on HIV/AIDS.

Marital Status

When we look into their marital status, the majority of the informants were widows. Out of the 31 research participants twenty one were widows and the rest were single. As stated in Barnett and Whiteside (2002), without antiretroviral treatment it is estimated that a person infected with HIV/AIDS can live about 10 years before falling ill. The death of the husbands before their wives; therefore to some extent, indicates husbands earlier infection. This might further show that the husbands' earlier risk sexual experience before their marriage. As explained by one of the research participants, there is a traditional norm in the community that influences women to marry elders who have much more life and sexual experience. She said that:

> ''When the husband is older it is generally regarded as he has accumulated life experience that can be good for marriage. He can have

> good life experience and know everything which can help him to have good knowledge for marriage. '' (Woman age, 33)

This societal influence forced the women to involve in unbalanced sexual relationships, which could explain the reason for their HIV infection.

Occupational Status

With regard to their occupational status, twelve were unemployed, six were janitors, few of them were small vendors and daily laborers, and the rest were working in different HIV/AIDS organizations as chasers, computer operators, store keepers and care givers.

Sexual Behavior of Women

Behaviors Attached to Femininity

In the prevention of HIV/AIDS, it is important to determine behavior that might increase infection rate. Changing risky behaviors are significant in reducing exposure to the infection. With the aim of understanding behaviors attached to femininity, which might increase the risk of women to HIV infection, a question was forwarded to the research participants for reflection. As they shared their perspective with the researcher, the cultural background instigates to exhibit the following cardinal characteristics to be acceptable in the face of others. Shy, reserve, ignorant of their feelings, fearful, tolerant , passive, obey their partners, focus on their daily chores and taking care of children, no public appearance without the consent of their partners, use ornaments if it only pleased their partners.

As stated in Mc and Nielsen (1990), social learning theory depicts men and women as shaping their personality according to the expectation of the society. From the findings, it can be discerned that there are certain behaviors assigned for men and women in the community. Most of the behaviors attached to femininity, apart from influencing the women's behavior to

be passive and ignorant; also pressurize them to be dependent on men which also contributed a lot in their exposure to HIV.

As avowed in Stets and Burke (2002), alike the social learning theory which indicates individuals' personality and behavior can be shaped and molded by social forces and can be internalized, the majority of the women participated in the research shaped their behavior according to the societal expectation which also directly influenced their sexual behavior. The characteristics which they are expected to show, in general, does not encourage them to be assertive, rather they are rewarded when they hold back all that might directed them to develop risky sexual behavior. They obey and submit to their partners' interest without question, thus exacerbating the hazard of being infected. Besides, the women are also expected to be calm, tolerant, traditional and consequently reserved from questioning their rights and limit them from using different modern technologies.

Sexual Practice and Discussion among Partners

Having free discussions on sexual issues between partners is advantageous in exchanging knowledge on HIV/AIDS and developing open sexual relationship. This further leads, the partners to adopt healthy sexual life and increase their commitment to their relationship. Apart from discussions, practicing once knowledge freely and expressing sexual feelings and gratifying feelings in an appropriate way; leads towards healthy sexual life that proves to be important in the effort to reduce HIV infection rate.

With the exception of two interviewees, who stated that, they openly discussed sexual issues with their partners, most of the informants in the research said that they did not feel good about discussing sexual issues with their partners. Similarly, with regard to practicing knowledge, apart from one respondent, all the respondents indicated that they were not

comfortable in expressing or practicing the knowledge they had on sexual issues. While conducting the research, soliciting the informants' idea on the issue of expressing sexual feelings was challenging. The women were felt shy to hear the question let alone share their true experiences. Most of the women participated in the study, testified that they did not communicate their sexual feelings to their partners freely. Only one informant witnessed she has the habit of openly expressing her feelings to her husband.

As mentioned by the respondents and focus group participants, lack of intimacy between partners, limitation of their knowledge, other cultural influence along with the lack of open discussion in the culture were the major constraints the informants had in expressing their feelings, practicing their knowledge and discussing sexual issues with their partners. Society usually tends to keep sex related issue in the dark. Though sometimes, women find themselves anxious to share what they know and to gain what they lack, their environment would not allow them to feel safe and relaxed. If they manage to put aside the prejudices, it could be hard to escape the fear of rejection, suspicion and the like. A woman who experienced this all, quoted as follows:

> ''It was very difficult for me to discuss such issues with my husband. If I raised such issues, he would not have felt good about me. I was shy to talk with him. I did not know him much and was afraid him. I was living with him because I depend on him for survival. I considered him as my father. Most of the time, I did not talk and did not feel comfortable with him.''(Woman, age 26)

As indicated in the finding, the societal consideration of sexual issue as taboo highly restricted the women from discussing, practicing and expressing their sexual feelings. Beyond the societal influence, as confirmed by the women, factors like age difference, arranged

marriage, economic and educational difference, lack of closeness and the like between partners indirectly influenced the level of discussion and practice they had with their partners.

> ''I knew much on different issues about reproductive health. Even though I knew much, I did not express my knowledge. Since it is not common to express your knowledge on sexual issues, I did not have the courage to communicate my knowledge. If I practiced my knowledge, my partner could have suspected me of having an affair. Because of this, I hide my knowledge on different issues on reproductive health from my husband which might be valuable for our health. Since there was the pressure of the culture, I did not want to express my knowledge anywhere.''(Woman, age 23)

Though the respondents had some knowledge on sexual issues, they were not free to practice their knowledge which reserved them from having healthy reproductive health. Unlike men, practicing new knowledge on sexual issues is not encouraged by women in the community. Practicing new knowledge and using new technologies like condom were left to men, totally ignoring the reproductive right of women. Women's responsibility of protecting themselves and their family from different reproductive health problems like HIV/AIDS is; therefore, left in the hands of men. As a result, due to the passive behavior attached to femininity in practicing sexual knowledge, the women were not in a position to protect themselves from risky behavior of their partners. One of the respondents elaborated the harsh consequences she would have encountered if she had raised sexual issues to her partner.

> ''If I had raised such issues, my husband would have considered me rude and deviant. He would have expelled me from home and considered me prostitute. It is not common for decent women to raise such issue. I knew that he had some other partners other than me. However, since I was weak physically and economically, I could not raise the issue or take any measure. Because of my weak economic stand, I didn't get the courage and capacity to take all the consequences of departing from my husband. Due to this, I had forced to live with him by scarifying my life. ''
> (Woman, age 30)

This case points out the fact that the imbalance in economic and educational status between partners also determines the existence of open discussion on sexual issues. Cultural barriers in openly discussing sexual issues among partners might also develop fear and feeling of shyness in expressing sexual feelings which might lead to unsatisfactory sexual relation. Moreover, fear to openly discuss risky behaviors among partners might be one explanation for the women's HIV infection. One informant explained the difficulty she had and the freedom her husband had in communicating sexual feelings.

> ''since I am a woman it was difficult for me to say such things. Such kinds of issues are left for men. I did not tell my husband about my feelings. If he wanted to have sex he could have whenever he wanted to. They are the one who communicate such issues. There was the influence of the culture to express feelings. In our culture, women are not expected to show their feelings. They have to hide their feelings. They are not even allowed to discuss about their feelings with their partners. Seldom, if they want to communicate their feelings to their partners, they use different gestures.''(Woman, age 22)

As per the finding, expressing sexual feelings in most cases was left for men. Women were expected to conceal their sexual feelings or at least passive receiver when it comes to sex. Because of this, they felt shy and frightened to convey their feelings. This might lead to the lack of sexual gratification by partners resulting in an extra marital relationship in search of sexual fulfillment. This perhaps describe the fact which WHO (2003) stated as gender norms affect sexual behavior of individuals through defining societal ideals of feminine and masculine behavior and sexuality. Being ignorant and hiding sexual feelings, directed the women to inappropriate sexual relations increasing their vulnerability to HIV infection.

In similar area, in an effort to explore the level of desire respondents had to information on sexual issues; the majority of the respondents specified that they did not have

any interest to know about sexual issues. Few respondents; however, expressed a high level of curiosity towards such issues. Those who lacked interest attributed the absence of desire to; religious discipline, cultural influence, tight upbringing and lack of information on such issues.

> ''Since sexual issues are hidden issues in the community, I even feel shy to think and raise such issues. I did not have any interest of knowing such issues. If I expressed my interest to know such issues, my family and the community would have thought that I had started sexual relation. Because of this, I did not have the courage to raise such issue for discussion'' (woman, age 32)

As we can realize from the finding, the virginity value of women in the community hold back the women from seeking information on sexuality and HIV/AIDS. Besides, as Sexual issues are considered as junk and hidden in the community, the women did not have the interest to know about it. Even those women who were interested in knowing about it were reluctant to talk about it as they were shy and afraid. Because of these, the women were forced to know next to nothing about sexual issues and HIV/AIDS.

Practicing Safe Sex

Apart from having knowledge on HIV/AIDS, negotiating and practicing safe sex is very important in preventing HIV infection. Though few respondents bargained on having safe sex with their partners, because of different reasons like; fear and shyness, carelessness, lack of awareness, trusting partner, fear of the outcomes and the like inhabited most of the respondents bargaining interest on having safe sex with their partners. One respondent while explaining the outcome if she raised the issue of safe sex with her partner said that:

> ''If I raised such an issue my partner would have suspected me of cheating on him or would say that I do not trust him enough. Because of this, I did not raise the issue of safe sex with my partner. If he wants to practice safe sex he can use whatever protection methods he likes. I do not also question him on that. But

> when it comes to me, it raise other issue other than practicing safe sex.’’ (Woman, age 23)

Along with this, the interviewees were also asked to discuss over the issue of having safe sex with their partners. Consequently, almost all respondents indicated that they did not. One respondent stated:

> ‘’Men usually do not restrict themselves with one. They usually have more than one partner. They consider it as normal act. They do not also bother about HIV/AIDS. They just do whatever they think right. They do not see the negative side of their promiscuity. Since I did not have the awareness on HIV/AIDS, even though I knew that my partner had multiple relations, I did not speak a word.’’(Woman, age 36)

As discussed earlier, most of the women did not negotiate and practice safe sex with their partners. Apart from lack of awareness, fear of their partners, was also mentioned as major reasons for not negotiating and practicing safe sex. The societal expectation of women to be inferior to men in sexual relationship, women’s reservation to raise sexual issues and the existing power imbalance between partners highly influence women’s negotiating power on safe sexual relationship and practicing safe sex. A woman expressed the difficulty of practicing safe sex by saying:

> ‘’Women who are using contraceptive and condom are considered as prostitute by the community. Because of this, most women afraid to buy and use condom or other contraceptives. This further limits us not to negotiate and practice safe sex with our partners’’. (Woman, age 32)

Unlike men, women who are trying to negotiate and practice safe sex were not accepted in the community. Women trying to negotiate or practice safe sex were labeled as promiscuous, and there by discouraged from practicing safe sex. From the experience of the research participants, it is clear that due to these reasons, the women were not in a position either to negotiate or practice safe sex. As indicated by one woman:

> ''I did not know about his behavior properly. Since we were married through arranged marriage, he is totally stranger for me. He spent nights out whenever he wanted to. I did not know where he went. I was afraid even to question him the reason. Though I desperately wanted to know my husband and my HIV status, I did not raise the issue of having a spouse HIV test.''(Woman, age 26)

Due to those feminine behaviors attached to women and the power imbalance, even knowing the promiscuity of their partners, the women were not able to decide to have safe sexual practice with their partners.

Decision Making

Decision-making power of women in reproductive health is very crucial to cultivate healthy sexual life. The decision making power in selecting partner, has a direct impact in accelerating the HIV infection rate. Even under massive cultural differences, it is widely believed that relations established with the consensuses of the two partners are more successful and can lead to a healthier sexual relationship. In this respect, the study tried to identify decision making process of the women in selecting their partners. Questions were forwarded for the interviewees and focus group participants to assess their experiences in choosing their partners. Some of the study participants reported that it was their family and relatives who chose partners for them. Other few respondents stated that they had selected their partners by themselves. One respondent indicated that it was her partner who picked her up. In general, most of the women stated that there was high pressure of their parents on their decision to choose a partner.

It is clear from the responses that there was direct and indirect family influence in making decisions for women in every thing considered to be 'tough' and 'critical' for their future. The reasons given for the interference of parents and relatives in choosing partners

include lack of opportunity for women to approach partners and their shyness to communicate with them and make decision once they get the opportunity. Besides, Selecting partners who are relatively well to do, have similar religious affiliation and good family and ethnic background were also the other major reasons given for the interference of family in choosing partners for the women. Social expectation in general pushed women to leave their lives in the hands of others and jeopardize their decision making power. Such conditions force them to accept the social perception without questioning and that makes them vulnerable to HIV infection. In elucidating this, a woman said:

> ‘’My family thought that they could choose me a partner who is educated, has a good job, the same religion as mine. They generally felt like they could find me someone who could give me a better life. By so doing, they were keeping the good name of the family. If I had tried to choose my partner, they would have thought that I had been involved in a sexual relation with my partner without their knowledge and it would have been unacceptable. That made us refrain even from thinking of choosing our own partners.’’(Woman, age 32)

Family involvement in choosing a ‘good’ partner for a woman ultimately indicates the consideration of Women as a source of income and social status to the family. Consequently, women are denied their right to freely choose their own sexual partners.

Since the women are supposed to be dependent on men, usually they are encouraged by the society to marry someone who is economically well off. They are also influenced by the culture to marry someone who has good family background without checking out his HIV status. Usually, parents, while choosing a partner for their daughter do not take into consideration the issue of HIV/AIDS.

In the case of arranged marriage, love between the two partners does not also get that much consideration in selecting a partner. Unlike men, who can choose their own partner, the

women are forced to be involved in a strange relation. A relation based on the will of one partner and without mutual love, most of the time, is not workable and subject to adultery. The interviewees also mentioned that if a woman refused the decision of her parents, she would be cursed and discriminated from the community.

Along with this, the study also tried to assess the decision making power of the women in their reproductive health. Only few respondents said that they had some power in decision making with regard to sexual issues and other major issues in their families. Even though she had a part in decision making, one respondent explained, that most of the time the final decision was her partner's.

> ''I had part in decision making. We discussed equally and decide. I also participated in most important issues in the family. However, the last decision was my husband's since there was a saying like **'ሴት ምን ብታውቅ በወንድ ያልቅ** '' (however, knowledgeable a women is all final decisions are made by a man) which degrade women position in decision making. Because of this, though I had participated in decision making, most of the decisions were of my partner's.''(Woman, age 23)

The majority of the respondents stated women's inferior position in the society to men and lack of economic power led to most decisions in the family be made by their partners. The interviewees' lack of educational opportunity also led to their lack of decision making power. One woman while justifying why she was not active in decision making said:

> ''since he was better than me in every aspect, it was his ideas that got acceptance. He was more educated than me. He was also making good money. He knew everything and he was the one who led the family. Therefore, he could do anything he wanted in the family. No one question him and I did not have any right to decide. '' (Woman, age 30)

Even though some women had some level of power to participate in decision making process, they were not in a position to reach final decisions which are acceptable both for the women and their partners, mainly due to societal influence. Most of the women found

themselves helpless in the face of the society. But this could not stop them from expressing their pain; as one respondent puts the common thing in a most common way by saying:

> ‘’It is my husband who makes decisions. I am very reserved from openly discussing issues and it was him who took the upper hand in deciding on different issues. It is not good to refuse men’s ideas. Women are expected to be concerned in cooking and not in decision making.’’(Woman, age 32)

There is a dictum in the community that reflects the perceived inferiority of women in decision making and in effect holds back women from making decisions. Based on the community role division, decision making as a task has left to be carried out by men and women are not supposed to make decisions even on issues that matter to their lives. From the experience of the women, we can learn that women’s little or no participation in decision making holds them back from deciding on having healthy sexual relationships and adopt healthy sexual practices with their partners.

Differences of Partners

Among other reasons differences in age, educational level and economic status between partners affect HIV infection rate. Vis-à-vis age difference, all respondents reported that their partners were older than them. Only few respondents said that they had less than five years of age difference with their partners. Most of them said they had differences of 10 years and above. The following account of a respondent can help illustrate more the case in point.

> ‘’We had 25 years of age difference. It was my family who choose him for me. But he was very rich. That’s why my father chose him for me. Because of our age difference, he did not consider me as his wife. So he treated me as if I was his daughter and he was even married and had four children before me. ‘’ (Woman, age 26)

Pointed out earlier, most of the respondents have wide age differences with their partners. Usually older men have high probability of having sexual experience before their marriage. This causes them to be high HIV/AIDS risk group compared to their wives who are young and without much sexual experience. The respondents explained that the reason for the large age differences is the belief in the community that men need to be physically stronger and age wise older than women. One key informant said:

> ‘’According to our culture a woman has to be younger than her partner. The men need to be senior and the women junior. If the husband is older than the wife, he can control her and she can be under him. His age can teach him a lot and can have much more wealth than her. ‘’ (Woman, age 20)

It was also explained by the interviewees that an older husband is believed to be more responsible and understand things properly. The argument is that a man, who has more experience in life, will not be eager to see women other than his wife and therefore respect his marriage. Here we can analyze that men’s sexual experience before their marriage is accepted by the community. Besides, the community’s expectation of women to be under the control of their husbands totally incapacitates them from protecting themselves from what ever risk their sexual relation with their partner may cause.

In terms of educational level, except for one respondent, the rest of the informants indicated that their partners were better educated than them. One respondent while explaining the rationale for the educational level difference between men and women said:

> ‘’since women are considered as dependent on men, men need to be more educated than women. If a man is educated he can make money and lead his family properly.’’ (Woman, age 23)

As observed in the finding, instead of educating women and helping them to be self sufficient, women are encouraged in the community to be dependent on men. Their

dependency on men further leads them to an unbalanced relationship which puts them in a situation where they cannot avoid sexual risk. Besides, when a husband is much educated than his wife, the power relation between the two cannot be equal. In this kind of relationship, the women's idea usually gets suppressed and they lose their saying in the house. Though the husband has risky behaviors, the unbalanced relation between the two forces the wife not to react.

With respect to economic status, all of the research participants are economically weaker than their partners. As mentioned by WHO (2007), because of lack of bargaining power and fear of abandonment and destitution, women who are economically vulnerable are more likely unable to negotiate the use of protection with their partner and leave relationships that they perceive to be risky. One informant, in explaining the existing economic difference, said that:

> ''Men have the responsibility to fulfill all the needs of the family. He usually involve in outside home activities. He is the one who is making money for the family. Women usually do household activities and have the responsibility of fulfilling the will of their husbands. They usually do household chores and take care of children. Since it is common for women to involve in household activities, most husbands also do not allow their wives to work outside home.''(Woman, age 38)

According to the gender role difference, the community has assigned different responsibilities for the two sexes. This may coincide with orthodox role theory as indicated in Mc and Nielsen (1990), the sexual division of labor constructs distinguished roles with scripts how behave and think. As indicated in the finding, for many reasons, societal influence being the major one, women are not encouraged to be involved in different work outside home. Their restriction to household activities has thus kept them back from becoming economically strong as their men counterparts.

The reasons given by the respondents and focus group participants for the economic disparity between men and women were, freedom for men to go wherever they want and do whatever they can, and in contrast women's exposure to different abuses, restriction to household activities and lack of opportunity to attend their education. The hope for a better life and Women's dependency on men were also cited as reasons for women to incline to choose partners who are well off economically.

The societal attachment of traits like softness, dependency and comfort to femininity enforces women to look for partners based on their economic benefits without properly considering risky sexual behaviors. Economic dependency on their partner forces the women to have little power to negotiate and decide on their sexual life.

As we have seen from the interviews and focus group discussion findings, the women were much younger and had low educational level and economic status compared to their partners. The societal norm of male supremacy in education and economy, led the women to have partners far older than themselves. Moreover, the value towards wealthy and educated partners influenced women's decision in choosing partners without due consideration to HIV status. Women do not also have equal opportunities for education as men in the family. The role assigned for women in most cases kept them in the kitchen where educational competencies are not required. Consequently, women are the most uneducated segment of the community restricted them from involving in different activities outside home.

In general terms, the meaning of femininity is attached to dependency and inferiority. This deprived of their self confidence and rendered them dependent on men. As indicated by UNAIDS (1999), women living in socially and economically dependent relationships find it

difficult to avoid risky sexual relationships. Besides, the existing power imbalance between partners hampers the women from negotiating and protecting their sexual rights.

Access to Education and Information on HIV/AIDS

Knowledge on HIV/AIDS

Having knowledge on HIV/AIDS is the first step in preventing the infection. The level of knowledge we have on the transmission and prevention methods can influence our orientation to a healthy behavior and practice. In this section the respondents were requested to explain the level of awareness they had on HIV/AIDS before knowing their HIV/AIDS status. Nine of the informants stated that they did not have any awareness on HIV/AIDS, three had some knowledge and the rest indicated that they knew enough.

From the finding, we can see that only 21% of the research respondents knew enough about HIV/AIDS, and about 60% of the participants did not have any knowledge on the subject, which shows the low level of awareness among the respondents on the issue. Though, having awareness and knowledge are among the major prevention strategies, most of the women lacked proper awareness on HIV/AIDS. This fact explains their exposure to HIV infection.

Concerning the knowledge the informants had on HIV/AIDS transmission modes, most of the respondents knew that HIV/AIDS can be transmitted through unprotected sexual contact and blood transmission. Only one respondent mentioned mother to child transmission on top of the above mentioned causes. As indicated in Barnett and Whiteside (2002), the main modes of HIV transmission are unsafe sex, from mother to child and infected blood. However, from the finding we can understand that even those women who claimed to know enough about HIV/AIDS had partial knowledge.

The respondents were also asked to identify the barriers they encounter to access different information on HIV/AIDS. Thus, most of the women identified lack of knowledge, unavailability of HIV/AIDS education, lack of network to get information, preoccupation with different household activities and care for children, inaccessibility of mass media like radio and television, being young, occupation with different activities in search of livelihood, inability to get opportunity to participate in different educational programs as the major barriers to information on HIV/AIDS.

For most respondents, the barriers for accessing different information on HIV/AIDS were much related to lack of time and network. Unlike men, usually women do not participate in different activities outside home. On the other hand, men have different opportunities to discus with different people and get different information. As one respondent explained, the fact that women do not have the freedom to participate in different discussions, especially reproductive health issues, prohibits them from having information on HIV/AIDS. One respondent stated:

> 'I did not have much freedom with my partner and previously with my family to express my feelings and discuss reproductive health issues. When I raised such issues, I used to be told to keep my mouth shout. This made me afraid of asking any information on HIV/AIDS restricting me from having much knowledge on the issue. (Woman, age 26)

Besides, unlike their men counterparts, women have a lot of responsibilities in the house that keep them too busy to get different information. Mostly, according to the role division of the community, household activities are left to women. Unlike men, even those women who are involved in different activities outside home are expected to take on household chores. This create burden on them that restrict them from attending different information means. As one participant of the research elaborated:

> ‘’The issue of HIV/AIDS was not that much open at that time and I was too young to know such issue. Though, I heard about HIV/AIDS, I did not give much concern. I was doing and living in my aunt’s house. For living I had to work hard. All the household activities were left for me. I was also involved in preparing local drink for the small business that my aunt had. I was too busy with different household activities and I did not have much time to listen to such issues.’’(Woman, age 22).

As has been mentioned by the respondents, lack of knowledge was also cited as barrier to have access to information. In most societies, because of women’s lack of priority for education, a considerable number of women are illiterate. This lack of knowledge hinders women from having information on risk reduction of HIV infection.

The women also had societal barriers for accessing information on HIV/AIDS. As stated by the interviewees, the poor social attitude on reproductive health makes issues like menstruation bizarre and discourages women from voicing their doubts and concerns in areas not so welcome by the society. The consequence of this challenge is clear, though women participate in some of the educational programs aimed at raising their awareness were particularly unproductive due to lack of open and genuine participation on the women side.

In addition, there was also family restriction on girls from participating in different social activities. One respondent in explaining this said:

> ‘’I was kept at home all the time. I did not know anything. I had some information on HIV/AIDS but I did not take any measure to protect myself from being infected. I usually spent my time at home and did not have the opportunity to get more information on HIV/AIDS.’’(Woman, age 32)

Repeatedly, others also voiced lack of priority to women education; socially encouraged so called feminine virtues and early marriage also have direct or indirect impact on women’s access to information on HIV/AIDS. Besides, the virginity norm also hindered women form seeking information on HIV and other related reproductive healthy issues.

Discussion on HIV/AIDS

Along with others, discussion among the community is one of the major sources of information on HIV/AIDS. Interviewees were inquired to explain the level of discussion on HIV/AIDS and related reproductive health issues they had with the community. Most of the women expressed that they did not have open discussion on HIV/AIDS and reproductive health issues with the community.

> ''Since there was no openness, most women lost their life due to unwanted pregnancy and other related reproductive health problems. When such issues were raised, most people did not feel comfortable and did not want to participate in the discussion.''(Woman, age 38)

From this, we can learn that lack of full knowledge on HIV/AIDS might also be explained by the unavailability of discussion among the community on reproductive health and HIV/AIDS issues. Lack of knowledge to discuss on HIV/AIDS, feeling of shame to discuss such issue, shortage of time, lack of acceptance of such issues in the culture and considering the issue as useless were mentioned by the women as major reasons not to raise issues on HIV/AIDS and reproductive health in the community.

Though reproductive and HIV/AIDS issues can be discussed among close friends, they were considered as useless and were not discussion topics in other levels of the community, like family. As pointed out by Mc and Nielsen (1990) though the family is the major socializing agent to teach individuals to develop the appropriate behavior to their sexes, lack of discussion in the family creates gap for women not to have basic knowledge on reproductive heath and HIV/AIDS. One of the respondents', experience in discussing reproductive health and HIV/AIDS issues with her parents is quoted as follows:

> ''I did not talk on such issues with anyone. Even when I had my first menstruation, I did not tell my parents. No one told me about

> menstruation and other reproductive health issues. There was no open discussion. I learned all by my own. If I raised such an issue I might be expelled from home. They might also think that I dishonored them. ''
> (Woman, age 20)

If a woman tried to discuss such an issue in the community, the community might consider her rude. One respondent affirmed that it was disgusting for her to raise such an issue in public; even if she did she said would feel shy and afraid. Correspondingly, another respondent added:

> ''It is not allowed to discuss such issue in the community. If I raised them, they would be sarcastic about it as they are considered taboos. I could face discrimination and the community might also suspect me of having HIV/AIDS'' (Woman, age 36)

Though there is a norm of silence surrounding sexual issues, especially women were strictly forbidden not to discuss such issues. That partly explains their vulnerability to HIV/AIDS.

> ''I felt shy to discuss such issues with others. Especially we women did not feel comfortable discussing such issue in public. Men do not have any feeling of shyness. They are free to discuss any issue that they like. If I discussed such issues, I would have lost respect in the community.''
> (Woman, age 32)

Women who have the courage to raise issues on reproductive health also face discrimination and they are considered as promiscuous by the community. That totally discouraged them from questioning similar issues.

There were some issues in the community which were not supposed to be raised by women. Avoiding discussing and questioning important issues like reproductive health in the community greatly obstructed women from having full knowledge on HIV/AIDS and its prevention methods. Moreover, the community also has a method of sanctioning, like labeling one as rude and promiscuous which in effect warned women not to think of such

issues. Those women who abide by the rule of the community are rewarded by the recognition they receive as polite and good. As Lindsey (2005) indicated, this can be also explained by the social learning theory where gender roles are learned through direct process of socialization through reward and punishment.

Access to Different Services on HIV/AIDS

Access To and Use of Condom

One's access to different services like condom, directly determines the level of HIV susceptibility. Regarding condom, a considerable number of informants stated that they have access to it. However, some informants specified that they do not use condoms due to various reasons like fear and shyness to buy, religious factors, lack of information and the like. One respondent explained the barrier as follows:

> ''most of the time, the community considers such services as those for prostitutes. Mostly it is also prostitutes who are freely using these services. Because of this, we are frightened to get HIV/AIDS related services freely. In addition, we are afraid of not being caught by someone while buying condoms''. (Woman, age 23)

As has been observed from the finding, women are not free to buy condoms. If they were seen buying condoms, the community may label them as promiscuous. They had also the influence of religion not to widely use different HIV/AIDS related services like condoms. Among other reasons, their restriction to home and limited communication opportunities, not knowing where to go and how to get the services were also mentioned as strong reason for not widely using the easily accessible and affordable services.

A number of women who have access to condom however, witnessed that they were not using it. In relation to this one interviewee said that:

> ''there is no experience of using condoms. There is also a feeling of shyness to use it. Besides, even if we tried, our partners would not accept that. Most men think using condoms reduces sexual gratification.'' (Woman, age 33)

Shyness; which is one behavioral threat adored by many as virtue of decent women, restricts women from using different RH services like condom. The societal expectation of women to be shy in sexual issue greatly shapes their behavior to the extent of avoiding condom use. Another woman also explained her lack of power in deciding condom use.

> ''Most of the time decisions are made by men. Women are not allowed to decide on big issues like using contraceptives and condom. Because of this, most of the time we do not decide to use condom. Mostly it is men who can decide for using condom. ''(Woman, age 30)

Women's decision power also determines their use of condoms. Weak decision making power in the community highly influences their level of using different services on HIV/AIDS such as condoms. One interviewee, while sharing her experience said:

> ''Since I was expelled from home, I was working in different bars. I knew much about HIV/AIDS. I also discussed with my friends about HIV/AIDS. I was also constantly used condoms. But it was my boyfriend who physically forced me to have unprotected sexual intercourse. '' (Woman, age 23)

As indicated in Stets and Burke (2002) in most societies masculinity is usually defined in terms of aggressiveness and violence. This usually encourages men to use physical power to get whatever they want. This is also one factor for the high vulnerability of women to HIV/AIDS.

Access to Education and Educational Materials on HIV/AIDS

Having education on HIV/AIDS and its means of transmission as well as prevention methods is important in effective prevention strategy. Besides, accessing reliable information materials on HIV/AIDS also increases the level of awareness on the pandemic.

In the effort made to assess the research participants' access to education and educational materials on HIV/AIDS, the majority of the informants specified that they do not have access to the educational materials. In other circumstances, even though most of the respondents admitted that they had the opportunity to get education on HIV/AIDS, most of them pointed out that they were not using such services. The major reasons for lack educational materials and education on HIV/AIDS are lack of knowledge on where to get the services, lack of network to have access to such services, unavailability of the service and lack of friendly service provisions. Besides these, lack of freedom to move and time were also mentioned as reasons by the informants.

> ''I had strict follow up from my parents not to go anywhere except school. They usually control where I am going. My brother did not have such kind of control. This restriction was for me and my younger sister. We were not allowed to go anywhere except school. The company of our parents was a must to go other places. Because of this it was difficult for me to have access to different educational materials and services on HIV/AIDS.'' (Woman, age 32)

Unlike men, women are not able to get different educational materials and education on HIV/AIDS. They have a number of barriers that hold them back from having access to these services. Their lack of knowledge restricts them from understanding the importance of such materials and they are not in a position to use such services. Due to their limited networks, they are not also able to locate where to get such services. Besides, from the finding it is clear that the societal influence forced the women to seek more friendly places to get services. While one interviewee elaborated the difficulty in getting such services she said:

> ''I spent most of my time at home and could not get such services. It was also the responsibility of men to participate in such programs. If I tried to participate in such programs I might be considered as prostitute and it certainly degrades me'' (Woman, age 22)

Moreover, women do not have the freedom to go wherever they like. They are usually dependent on their family or their partners. Without the much needed liberty it is impossible to access educational materials and education on HIV/AIDS. Attending such educational programs was left for men and women were labeled as promiscuous if they tried to attend such programs. One informant, while comparing men's and women's access to different HIV/AIDS services stated:

> ''Unlike women, men have the opportunity to see different films and have ample experience. They are also free to practice what they learn. They do not have that much burden of the influence of the community. They have the opportunity to participate in different events.''(Woman, age 26)

Summary

In this study, the way different societal constructions of femininity influence the vulnerability of women to HIV/AIDS was reviewed. The study has tried to analyze how these societal explanations affected the sexual behavior of women and their access to information and services in relation to their vulnerability to HIV/AIDS.

As per the research finding, societal values attached to femininity greatly shaped the sexual behavior of the women who participated in the study towards developing risky behaviors to HIV/AIDS. Women are expected to be reserve, ignorant of their feelings, fearful, tolerant, and passive, obey their partners, and focus on their daily chores and taking care of children. Most of these behaviors influence women to be passive and ignorant on different issues including HIV/AIDS. These behaviors in general, do not encourage them to be assertive, thus exacerbating the hazard of being infected.

In similar area, the societal consideration of sexual issue as taboo highly restricted the women from discussing, practicing and expressing their sexual feelings. Beyond the societal influence, factors like age difference, arranged marriage, economic and educational difference, lack of closeness and the like between partners indirectly influence the level of discussion and practice about sexual issues. The societal expectation of women to be inferior to men in sexual relationship, women's reservation to raise sexual issues and the existing power imbalance between partners also highly influence women's negotiating power on safe sexual relationship and practicing safe sex.

In addition, women have a number of barriers that hold them back from having access to HIV/AIDS services. Factors like lack of knowledge on where to get the services, lack of

network to have access to such services, unavailability of the service and lack of friendly service provisions also limit their access to different information and services on HIV/AIDS.

Discussion

Similar to the social learning theory, which explains sex typing can be learned through a process of socialization, the women included in the study also shaped their behavior according to the societal expectations through different socialization processes. As a result, most of the women had distinct sexual behaviors which were shaped by the social forces.

The majority of the women exhibited behavior attached to being feminine in the community that further shaped their sexual behaviors. The dominant observed behaviors were passivity, ignorance, dependence, repression, reservation, timidity, over tolerance and the like. Because of these feminine behaviors, the women were not in a position to develop their knowledge on reproductive health/HIV/AIDS, expressing their feelings, practicing their knowledge, negotiating and practicing safe sex. As a result, the women's sexual rights are violated and they are not in a position to make decisions that help them adopt a healthy sexual life. In addition, as stated in Stets and Burke (2002), similar to the Freudian Psychoanalytic theory that considers women as incomplete men, there are also some social values for women like marrying someone who is rich and older which forces them to be involved in an imbalanced relationship intensifying their susceptibility to HIV infection.

The participants' response explicitly demonstrated the women's dedication to live up to the set expectations. Though they mostly resent what society imposed on them, they took it just because it seems better than the rejection and harsh criticism which might be caused by their resistance to the convention. Not to make their life an open battle with the society, many convicted themselves to play by the rule. Accordingly, they behave as the expectation of the

society and preferred to go extra miles to make their life simple. From what is evident, these all could not able to immune them from the risk of contracting the pandemic.

Even though most of the women are residing in Bahirdar city, one of the biggest in the nation, where many may perceive loose old traditional practices, like strong influence of parents in the decision making of their daughters choice of partner, contrarily what was found out in the research women were highly influenced by their parents in their choice of partners. The strong view of socialization as indicated in Mc and Nielsen (1990) emphasizes, in individuals' personality and behavior can be shaped and molded by social forces and can be heavily internalized. Similarly, the fact that women have highly internalized and are influenced by the values of their parents, who came from different adjacent districts of Bahirdar that do not promote freely choosing one's partner might indirectly explain their vulnerability to HIV infection.

Further more, behaviors attached to being feminine also interfere with women's decision making power, use of modern technologies, choice of partner and the like which aggravated their vulnerability to HIV infection. Moreover, these behaviors indirectly interplayed with other socio economic issues and hold them back from fully participating and accessing different resources in the community and consequently, made them more dependent on men.

Even though most of the women who participated in the study had a certain level of education, but this does not seem to help them much in having proper awareness/ knowledge on HIV/AIDS. The study has found out that women's awareness level on HIV/AIDS, apart from their educational status, is greatly influenced by other societal factors. Though the role of education can not be undermined in any way, the findings of this study showed other societal

factors like taboo surrounding sexual issues, lack of discussion and lack of openness including between partners play major roles in determining the level of women's awareness on HIV/AIDS.

Besides, it was taboo for women to raise sexual issues in the community. As indicated in Mc and Nielsen (1990), similar to the social learning theory, individuals develop femininity and masculinity directly through rewards and punishments, or indirectly through acting as models. In the research target area, there were societal punishment and sanctions to penalize and reward behaviors and issues appropriate to women. Fear of the societal punishments like labeling forced the women to avoid discussing and questioning on different important sexual issues leading them to have partial knowledge on HIV/AIDS.

As stated in Lindsey (2005), like the social learning theory, the society assigned different roles and responsibilities for men and women. Mostly, women are expected to be involved in household activities that greatly limit their access to different information and services on HIV/AIDS. Besides, the disproportionate societal role division of labor forced women to have tremendous workload that further limits their access to different Media and information.

Concerning service utilization on HIV/AIDS, most of the feminine behaviors hinder women from having full knowledge on HIV/AIDS and also constrained women from using different services. Women, because of their limited network, are not in a position to locate and use different services. They also lack freedom of movement which minimizes their level of use of different services on HIV/AIDS. In addition, due to the different societal influences, they do not feel comfortable to use different services freely. This inquired them to have friendly service delivery centers that reduce their utilization level.

In general, the shaped sexual behavior of women like shyness, ignorance and repression and the societal interference in establishing sexual relation, their low level of knowledge on HIV/AIDS and their limited access to different HIV/AIDS services; shaped the women's decision, with whom they have sex with, in what ways, why and under what circumstances with the outcome of vulnerability to HIV infection.

Limitations of the Study

The scope of this study is limited to women living with HIV/AIDS residing in Bahirdar town. As, the study deals with societal explanations of femininity that vary across cultures, the results of this study is more applicable to the study area. Therefore, the study and the all the results and conclusions drawn from it refer to Bahirdar.

Recommendations for Further Research

In addressing the problem of HIV/AIDS, conducting different studies in the area is critical. There are a number of issues that need to be studied towards alleviating the problem of HIV/AIDS and its impact. Empirical researches can also help in the effort towards reducing the spread of the virus.

Based on this study and existing literature, the following major areas of research are recommended for further researches. Researches, focusing on gender and HIV/AIDS in different cultural context are important. This research focuses only on one cultural context, carrying out similar researches in different cultural contexts contribute a lot in understanding gender relations related to HIV/AIDS based on the cultural perspective. This can add weight to the perception and address the problem properly.

Apart form expanding similar researches, it is important to give emphasis to women in general to gain more understanding on the social construction of femininity and its influence

on the vulnerability of women to HIV/AIDS. There are a number of social and cultural factors affecting the vulnerability of women to HIV/AIDS. Apart from studying the how aspect of the issue, exhaustively recognize the social and cultural factors is very important. Appropriately understanding theses gender norms related to women is important in properly understanding the gender dimension of HIV /AIDS as well as designing applicable strategies in reducing the prevalence rate.

Implications for Social Work Intervention

The experience of the women living with HIV/AIDS included in this study with regard to their exposure to HIV/AIDS has great importance in providing important issues that needs to be addressed by different policy makers and program designers towards addressing the problem of HIV/AIDS. Especially, it has great importance for different bodies operating in the area of HIV/AIDS in Bahirdar area thereby proving real life experience of women living with HIV/AIDS and pinpointing major areas of intervention. Moreover, this research has great value in filling some literature gap in the area of gender and HIV/AIDS.

Dealing with the gender dimension of the epidemic requires the full concern and devotion of policy makers, program designers and the overall community. Interventions should start from the micro to macro levels. Based on the finding of this study, the following major intervention areas are proposed from a social work perspective.

Policy and Program Level

As indicated in Women's Affairs Office, (2005), though Ethiopia has ratified a number of international conventions on women's right and adopted different policies like women's policy aimed at equal rights for women, the implementation of these policies and programs have not gained full attention. Therefore, it is important to design different programs and

strategies in line with the policies and follow the proper implementation. Full awareness and consensus need to be reached on the policies and laws available in the area of women's equal rights by all concerned bodies.

Apart from the existing policies, policy makers need to give due consideration to identify new areas that need to be addressed and design conducive legal and policy environment towards the empowerment of women. More importantly, it requires the government and other bodies' commitment to increase access to resources and information of women and increase their literacy level. All sectors and development programs need to take gender and HIV/AIDS into account. Besides mainstreaming gender, different programs need to design a gendered approach to HIV/AIDS.

Practice

In implementing different policies and programs and adopting appropriate practice with regard to women's equal rights, it is imperative to work at the grass root level. The active involvement of different NGOs, civil societies and the community at large towards adopting the appropriate practice is also important. Apart from women, it is significant to actively involve men in all intervention programs to bring equality in women's rights in the community.

Creating massive awareness on gender and HIV/AIDS and working towards changing the unbalanced gender relation is crucial. In doing so, closely working with religious and community leaders is advantageous. There is also a need to find ways to intervene early to influence the socialization of children to foster healthy sexual relation and behavior. Besides, designing and making available women friendly service delivery centers in providing different information and services for women is important.

In all these processes, it is vital to take into consideration the importance of designing different interlinked programs and strategies that can address the overall economic, social, political and educational status of women.

Conclusions

In a country like Ethiopia, where millions are dying due to HIV/AIDS, prioritizing the issue has great importance. Apart from saving the lives of millions, this effort has enormous value in the national development of the country.

In the process of addressing the problem of HIV/AIDS, providing special attention to the most vulnerable groups like women is advantageous. Women, due to various reasons, are the major group of the community exposed to the HIV virus. They are also the most important segment of the community towards fully addressing the problem of HIV/AIDS and reducing its spread. There are widely spread gender norms and practices degrading the reproductive health of women as well as increase their exposure to HIV infection. Societal constructions of being feminine, enforces women to be more passive on different reproductive health issues. It also restricts them from adopting safe sexual practice and use different important services. All these accounts for the high infection rate of women to HIV/AIDS.

In effectively dealing with the problem of HIV/AIDS, the national effort towards reducing the spread of the virus and minimizing its impact should continue in a more coordinated and planned manner. More importantly, the gender dimension of the epidemic should get special place and attention to comprehensively address the problem.

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Annex I

I. Questionnaire/ Interview guide for People living with HIV/AIDS

(To be used flexibly and adopted to type of informants)

1. Introduction

My name is Beza Bekele. I am attending second year graduate school of social work at Addis Ababa University. This interview is part of the study and aims at exploring and understanding different gender explanations of femininity determining the vulnerability of women to HIV/AIDS in our society. Your contribution in this interview could help in successfully accomplishing my study and future intervention pertaining to this concern. Your opinion and views in this interview will be used only for this study and will be confidential. Any personal identification like name and the like will not be included in the study. During the interview I will use tape recorder not to miss any points raised during the discussion. The tape recorder will also be confidential and will be used for analytical purpose only. Your honest and genuine answer to the issues will be great value for the study as well as addressing the problem of HIV/AIDS in our society. I would greatly appreciate your help in responding to this study. Your participation is voluntary, you may stop any time.

A. *Identification of Informants*

1. Age_____________
2. Religion________________
3. Educational level____________
4. Marital status______________
5. Occupation________________
6. No of children______________

B. *Sexual behavior and attitude of women*

1. What is your perception of being as women in our society?

2. Please explain to me what do you feel in discussing sexual issues with your partner? (if you have a partner)

3.In what ways can this relate to your vulnerability to HIV/AIDS?

4. Please discuss to me what you feel in practicing sex with your partner?

5.Do you have interest to know about sexual issues?
6.In what ways does this influence your vulnerability to HIV/AIDS?

7. Please elaborate to me what you feel in expressing/practicing your sexual knowledge?

8.Do you express your sexual feelings to your partner freely?

9.Do you negotiate safe sex with your partner?

10. Do you have the power to decide on sexual issues with your partner?

11. Do you practice safe sex with your partner?

12. Do you choose your partner?

13. Is your partner beyond your age?

14. How is your partner educational level?

15. How is the economic status of your partner?

C. *Access to education and information on HIV/AIDS*

1.Do you have knowledge on HIV/AIDS transmission and prevention mechanisms?

2. What do you know?

3.In what ways do you get information on HIV/AIDS?

4.Do you feel that men have easy access to information about HIV/AIDS?

5.Do you feel that women have easy access to information about HIV/AIDS?

6.Do you discuss HIV/AIDS issues in your community?

7.Is there any societal influence to you from accessing education and information on HIV/AIDS?

D. *Access to different services of HIV/AIDS*

1) Do you feel that men have easy access to different HIV/AIDS services?

2) Do you feel that women have easy access to different HIV/AIDS services?

3) Do you have access to use condom?
4) Do you use condom?
5) Do you have an opportunity to receive education about HIV/AIDS?
6) Are there any barriers to you from using different HIV/AIDS services?
7) What are the major societal barriers to you from accessing different HIV/AIDS services?
8) What do you suggest to reduce the vulnerability of women to HIV/AIDS?

II. Focus group discussion guiding question

1. Introduction

My name is Beza Bekele. I am attending second year graduate school of social work at Addis Ababa University. This discussion is part of the study and aims at exploring and understanding different gender explanations of femininity determining the vulnerability of women to HIV/AIDS in our society. Your contribution in this discussion could help in successfully accomplishing my study and future interventions pertaining to this concern. Your opinion and views discussed in this discussion will be used only for this study and will be confidential. Any personal identification like name and the like will not be included in the study. During the discussion I will use tape recorder not to miss any points raised during the discussion. The tape recorder will also be confidential and will be used for analytical purpose only. Your honest and genuine answer to the issues will be great value for the study as well as addressing the problem of HIV/AIDS in our society. I would greatly appreciate your help in responding to this study. Your participation is voluntary, you may stop any time.

Introduction of participants

No.	***Name***	***Age***	***Sex***	***Religion***	***Educational level***	***Occupation***

A. *Body of the discussion*

1.What are the major explanations of being a woman in our society?

2. Do women feel shy in discussing sexual issues with their partner?

3.Do women have interest to know about sexual issues?

4.Do women feel comfortable expressing their sexual knowledge?

5.In what ways can this relate to their vulnerability to HIV/AIDS?

6.Do women express their sexual feelings to their partners freely?

7.Do women negotiate safe sex with their partner?

8.Do women practice safe sex?

9. Do women have the power to decide on sexual issues with their partner?

10. Do women freely choose their partner?

11. Do women choose partners similar to their own economic status?

12. Do women choose partners similar to their own educational status?

13. Do men have easy access to learn sexual issue?

14. Do women have easy access to learn sexual issue?

15. Do women discuss sexual issues in the society?

16. Do men have access to information on HIV/AIDS?

17. Do women have access to information on HIV/AIDS?

18. Do men have access to HIV/AIDS services?

19. Do women have access to HIV/AIDS services?

20. What are the barriers to women from accessing education and information on HIV/AIDS?

21. What are the barriers to women from accessing different services on HIV/AIDS?

22. Is there any societal influence to women from accessing information on HIV/AIDS?

23. Is there any societal influence to women from accessing services on HIV/AIDS?

24. What do you suggest to reduce the vulnerability of women to HIV/AIDS?

Annex II

Statement of Informed Consent

I, ________________________, am requested to be part of a study conducted by Beza Bekele, on the exposure of women to HIV/AIDS as a fulfillment of MSW. I understand that the general purpose of the study is to understand how the societal construction of femininity influences the vulnerability of women to HIV/AIDS in Bahirdar town. My opinion and views discussed in this discussion will be used only for this study and will be confidential. Any personal identification like name and the like will not be included in the report of this study.

I also understand that as a participant, my participation in this study is voluntary and I have the right to withdraw from the interview process at any time. Signing in this document, I voluntary consent to be interviewed as a participant in this study.

________________________ ____________

Signature of the participant Date

________________________ ____________

Signature of researcher Date