

**Addis Ababa University  
School of Graduate Studies  
Institute of Gender Studies**

**The Interface between Violence against Women and HIV/AIDS  
The Experiences of HIV Positive Women Beneficiaries of the Society for Women and  
AIDS in Africa -Ethiopia in Kebeles 03/09 and 04/05, Arada Sub-city, Addis Ababa**

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**Addis Ababa University**  
**School of Graduate Studies**

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**INSTITUTE OF GENDER STUDIES**

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## **Dedication**

**This thesis is dedicated to my husband, Girma Makonnen, an educator, a librarian and most of all a kind, patient, caring and sensitive person who unfailingly believes in me.**

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## Glossary

<i>Arekie</i>	Locally prepared distilled alcoholic drink
<i>Chat</i>	Leaves of the plant <i>Cathea edulis</i> that are grown locally and chewed. Chat acts as a stimulant/euphoriant when taken (Dawit Abebe et al, 2005).
<i>Damakese</i>	An indigenous Ethiopian herb used for treatment of several ailments.
<i>Debal/ Tigegna</i>	Co-resident
<i>Edir</i>	“Indigenous voluntary associations established primarily to provide mutual aid on burial matters but also to address other community matters” (Pankhurst and Damen, 2000: 36).
<i>Injera</i>	Staple food of Ethiopians, it is a kind of pancake. Most of the time, it is made from teff (it could also be prepared from other grains such as barley, wheat, maize and sorghum) and eaten with different sauces.
<i>Grocery</i>	A kind of liquor store that also serves drinks to its customers. Usually, it has long bench seats and usually employs male waiting staff to serve drinks to customers (FHI, 2002).
<i>Gulit</i>	Small market stall where items such as fruits and vegetables, spices, charcoal, injera, breads rolls and the like are sold.
<i>Kebele</i>	The smallest administrative unit of the local government structure in Ethiopia.
<i>Kolo</i>	A snack made of roasted grains, usually barley, wheat, peas and beans.

<i>Shisha</i>	“A mixture that may include tobacco, honey, hashish and spices; it is smoked from an oriental tobacco pipe, which has a long, flexible tube that draws the smoke through a water-filled container” (FDRE Ministry of Health, 2002: xvi).
<i>Sub-city</i>	“the second administrative tier of the City (Addis Ababa) Administration” (Proclamation for the Establishment of Sub-cities and Kebeles, Number 1/1995).
<i>Teff</i>	Indigenous Ethiopian grain out of which injera is prepared.
<i>Tella</i>	Locally brewed beer-like drink made from grains and hops.
<i>Wereda</i>	The second administrative tier in local government in Ethiopia above the kebele. A wereda is composed of two or more kebeles.
<i>Tsebel</i>	Holy Water

## List of Acronyms

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>CEDAW</b>	Convention on the Elimination of Discrimination against Women
<b>CSA</b>	Central Statistical Authority
<b>CSW</b>	Commercial Sex Worker
<b>EWLA</b>	Ethiopian Women Lawyers Association
<b>FDRE</b>	Federal Democratic Republic of Ethiopia
<b>HAPCO</b>	HIV/AIDS Prevention and Control Office
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information, Education, and Communication
<b>MOH</b>	Ministry of Health
<b>NCTPE</b>	National Committee on Traditional Practices of Ethiopia
<b>NEWA</b>	Network of Ethiopian Women's Associations
<b>NGO</b>	Non-Governmental Organization
<b>OVC</b>	Orphans and Vulnerable Children
<b>PLWHA</b>	People Living with HIV/AIDS
<b>PMTCT</b>	Prevention of Mother to Child Transmission of HIV
<b>STD</b>	Sexually Transmitted Diseases
<b>STI</b>	Sexually Transmitted Infections
<b>SWAA</b>	Society for Women and AIDS in Africa
<b>SWAA-E</b>	Society for Women and AIDS in Africa – Ethiopia
<b>TGE</b>	Transitional Government of Ethiopia
<b>UNAIDS</b>	United Nations Joint Program on HIV/AIDS
<b>VCT</b>	Voluntary Counseling and Testing
<b>WAO</b>	Women's Affairs Office
<b>WHO</b>	World Health Organization

## Abstract

*This research focuses mainly on women who reportedly became HIV infected as a result of sexual violence. It examines the women's experiences of sexual violence and HIV/AIDS from their perspectives and explores the connection between sexual violence and HIV/AIDS in the context of the women's lives. It also investigates how victims of the double trauma of sexual violence and HIV disclose their victimization and HIV positive status to others, their coping strategies and the stigma they are facing and their agency in overcoming these adverse situations.*

*The approach used for this research is mainly a qualitative one which is suitable for the issue of sexual violence and HIV/AIDS. In-depth interviews and focus group discussions were conducted. Two small surveys were conducted to triangulate findings from the interviews, for this, two sets of questionnaires were prepared. Drawing on data collected through these methods, the study describes the experiences of the women by means of cases of five women, and it demonstrates how the nature and scale of sexual violence impacts on women's vulnerability to HIV/AIDS and the coping mechanisms they adopted. Participants were drawn from the Society for Women and AIDS in Africa-Ethiopia (SWAA-E) in Arada sub city in Addis Ababa, a non governmental organization mainly concerned with women and children that gives care and support to those infected and affected by HIV/AIDS.*

*The five women reported that the reason for their HIV positive status was sexual violence. All of them did not report their victimization to legal bodies; instead, they opted to keep silent about it. Their reason was that they were ashamed and did not know where to go. The research has also indicated that even though there are laws affirming women's rights, the reality is far from it. Women also are not aware of their legal rights. The women's victimization has resulted in their being HIV positive and three of them were forced to bear and single-handedly raise children of their perpetrators. This has added to their burden and further impoverished them.*

*The women came to know their HIV positive status because of persistent illness, testing at antenatal clinics during pregnancy and testing for HIV as a requirement for visas abroad. Their reactions to their HIV positive diagnosis varied from acknowledgement to shock even attempted suicide. They were secretive about their HIV positive status apparently for fear of stigma especially for fear of being evicted from the houses they rented. Then again, they selectively disclosed their HIV positive statuses to the non governmental organization that assists them. This is indicative of the need to address HIV/AIDS related stigma in HIV prevention and control efforts.*

*Among the stigma they have experienced are being evicted from their homes, being refused clothesline to hang their clothes and insults from those closest to them. The coping mechanisms adopted by PLWHA are taking the Holy Water (Tsebel), using traditional herbalists, caring for their children and hoping that they will see their children grow up. In the mean time, all five are engaged in productive works such as taking skill acquisition trainings, gainful employment and pursuing college education.*

# CHAPTER I

## 1.1 INTRODUCTION

Violence against women is widespread almost in all societies. It is the most pervasive but least acknowledged human rights violation around the globe. It is also a profound health problem, depleting women's energy, adversely affecting their physical health, and undermining their self-esteem (Abane, 1997; Heise et al., 1999). Obviously, violence against women is a serious problem whose magnitude is often neglected, underestimated and not given priority as a crime and since violence by its nature isolates and terrifies women, many women are silenced.

Violence against women has gained recognition from a private matter to that of a violation of human rights and an impediment to the attainment of equality, development and peace (United Nations, 1993). It became an agenda on international fora such as the United Nations, where it was clearly defined as: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life"(United Nations, 1993, Article 1). This has placed violence against women within the discourses of human rights and broadened the context of violence against women to reflect the realities of women. It also clearly spelt out that the female gender was the intended target of violence (Bunch et al., 1998).

Forms of violence against women are usually classified as:

- **Physical violence:** harmed physically (for example, slapping, hitting, kicking, beating, and battering);
- **Sexual violence:** (for example, forced sexual intercourse and other forms of coerced sex which women find degrading and humiliating);
- **Emotional or psychological violence:** (for example, belittling, derogatory remarks about a woman's appearance or sexuality, verbal abuse, intimidation and humiliation in front of other people, plus controlling behaviors including acts to constrain a woman's mobility or her access to friends and relatives, extreme jealousy, etc.) (García-Moreno et al., 2005).

These forms of violence are pervasive and interconnected often occurring simultaneously (Kelly, 1999). There is growing evidence indicating the linkage of violence against women to the HIV/AIDS pandemic. As a result, women are increasingly becoming infected and affected by HIV/AIDS (UNAIDS, 2005). Since its first appearance in the 1980's, HIV/AIDS has claimed millions of lives, devastated people in unprecedented proportions and has left many widows, widowers, orphans and potential parents childless. The AIDS pandemic is more devastating in poor countries. For example, Sub Saharan Africa is the hardest hit in the past decade, and where 10% of the world's population lives in this region and accounts for two thirds of the people living with AIDS globally (UNAIDS, 2005).

The most common forms of violence against women are perpetuated by persons known to the women and intimate partners, often accompanied by sexual violence (Heise et al., 1999). Violent acts directed at women such as domestic violence, rape, harmful traditional practices, and especially deliberate rape in areas of conflict, trafficking of women and children and other forms of the sex trade have increased women's vulnerability to HIV/AIDS. Even though both women and men are likely to be infected by HIV/AIDS; it was found out that women are more vulnerable to the infection for biological, socio-cultural, gender and political reasons (Fikerte, 2004). In addition, women's low status in society predisposes them to high risks of HIV transmission. Women's vulnerability to HIV/AIDS coupled with the AIDS pandemic has also brought attention to the issue of violence against women and its recognition as a public health, human rights and development issue.

In Ethiopia, since the first case of HIV/AIDS in 1986, the prevalence of HIV/AIDS has increased. The Ethiopian government established a National Task Force in 1985. In 1987, the National AIDS Control Program was launched to design and implement two medium term AIDS prevention and control plans. Eventually, the National HIV/AIDS Policy was issued by the Ethiopian government in 1998. In 2000, the Ethiopian government established the National AIDS Council, elevating the HIV/AIDS prevention effort from a departmental level to a national level. The Council was entrusted with the implementation of the five-year multi-sectoral HIV/AIDS strategic plan.

In 2002, the HIV/AIDS Prevention and Control Office (HAPCO) was established under the Prime Minister's Office (Federal Democratic Republic of Ethiopia, 1998; FDRE, Ministry of Health, 2004). HAPCO developed the National Strategic Framework with priority given to interventions such as: condom promotion and distribution, voluntary counseling and testing, blood safety, prevention of mother-to-child transmission of HIV and care and support to those infected and affected by HIV/AIDS (FDRE, Ministry of Health, 2004).

According to the National Sentinel Surveillance Survey (NSSS), national estimated adult HIV prevalence in 2005 was 3.5%. There was a marked gender disparity in the prevalence where there is a higher prevalence in females who constituted 4% when compared to that of males, which is 3%. Urban HIV prevalence was estimated at 10.5%. Here also the prevalence in females was 11.9% whereas it was 9.1% in that of males. In the rural areas, prevalence of HIV was 1.9% that is 2.2% for females and 1.7% for males (FDRE, Ministry of Health 2006:6).

Age wise, HIV prevalence in 2005 was more pronounced in the youth age group of 15–29 years, where there were more women living with HIV/AIDS than men; in the age group 30+ years, there were more men living with HIV/AIDS than women.

It was estimated that 1.32 million people are living with HIV/AIDS, of these, 55 percent (730,000) are females. Females also accounted for 54.5% of AIDS deaths and 53.2% of newly infected persons in 2005 (FDRE, Ministry of Health, 2006).

The direct causes for the rapid spread of the HIV/AIDS epidemic in Ethiopia are unprotected sex practices and a high prevalence of engaging in casual sex partners (FDRE, Ministry of Health, 2004), which are aggravated by violence against women. Also, harmful traditional practices like female genital mutilation, early marriage and abduction expose girls to HIV/AIDS at a very young age.

In Ethiopia, the number of HIV-infected pregnant women is high. In 2003 in Addis Ababa, it was 12.4 % and in Bahir Dar it was 20.2% (FDRE, Ministry of Health, 2004). HIV transmission from mother-to-child is the main means of HIV infection in children below 15 years of age (UNAIDS, 1999). However, the mothers' needs are regarded as

secondary to that of their babies (Amaro, Raj and Reed, 2001). Little or no interest at all is shown to the women as the main focus is on preventing the transmission of the virus to the baby. But, when an HIV positive woman is pregnant, the acceleration of the progression of the disease and complications of pregnancy and delivery are increased (Baylies, 2000). Thus pregnant HIV positive women have risky pregnancies which are exacerbated by unavailability of health service nearby<sup>1</sup> and their limited access to health care facilities. According to UNAIDS, in Ethiopia less than 1% of the HIV-infected mothers who gave birth in 2003, had access to regimen to prevent mother-to-child transmission of HIV/AIDS (UNAIDS, 2004: 89).

Globally, more than 630,000 children are infected (UNAIDS, 2005). In Ethiopia, 120,000 children are expected to be infected by HIV/AIDS. The average prevalence of HIV/AIDS among pregnant women is estimated to be 13% in urban areas and 5% in rural areas. In 2005, in Addis Ababa, 11% of the pregnant women were estimated to be HIV positive (UNAIDS, 2005). Thus it is believed that the prevention of transmission of HIV infection from mother-to-child will greatly reduce infant mortality and HIV infection in children.

The activism toward alleviating this problem and the care and support provided to victims is not commensurate to the gravity of the situation. Literature on the issue of violence against women and the spread of HIV/AIDS mostly deals with the extent of the AIDS pandemic or issue of violence against women where they deal with the issues in separation and not in relation to one another. This research will look into this aspect and will show that violence against women also has its share in the spread of HIV/AIDS from the point of view of the women victims<sup>2</sup>.

## **1.2 STATEMENT OF THE PROBLEM**

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<sup>1</sup> World Bank (2005) estimates that in Ethiopia only 75% of urban households and 4.2% of the rural households have a health facility within 10 kilometers

<sup>2</sup> The term 'victim' in the context of violence against women is a contentious term and often criticized by feminists because it implies characteristics such as weakness, helplessness and passivity. Instead, they opted for the word 'survivor' to signify "women's agency in coping with both victimization and its consequences.", however "the context in which their actions takes place involves victimization" (Kelly, 1999: 113).

In Sub-Saharan Africa, heterosexual transmission is by far the predominant mode of HIV transmission (UNAIDS, 2004). When compared to men, women get infected by HIV/AIDS at a much younger age (EDHS, 2006). This gap in prevalence shows an increasing trend. Earlier, in Sub-Saharan Africa, the number of men living with HIV was greater than women. Currently, however, there are, on the average, 13 infected women for every 10 infected men. The difference is very pronounced in urban areas, with 14 women for every 10 men, than in rural areas, where 12 women are infected for every 10 men (UNAIDS, 2004).

Ethiopia is one of the countries in the world hardest hit by the HIV/AIDS epidemic. It is classified by the World Bank as a country with a generalized epidemic<sup>3</sup> (World Bank, 2005). Even though HIV/AIDS affects all segments of the Ethiopian population, as indicated earlier, there is a high prevalence among the young age group of 15 to 24 year olds. The epidemic is disproportionately affecting females than males. Heterosexual contact and mother-to-child transmission<sup>4</sup> of HIV/AIDS are the main modes of transmission of the AIDS virus in Ethiopia (FDRE, Ministry of Health, 2006; UNAIDS, 2005).

Violence against women contributes to women's increased risk of HIV infection (Maman et al., 2000; UNAIDS, 2005). However, there is a scanty literature on the intersection of violence against women and the transmission of HIV/AIDS. This paper contributes to fill the gap in knowledge in this area.

In spite of Ethiopian Government's commitment at national level; as reflected on the constitution that ensures gender equality, issuance of women's policy, revision of family code which provides for improved women's situation, criminal code which placed more severe penalties on some crimes of violence against women, and the ratification of conventions on human rights and on the elimination of discrimination against women such as CEDAW , the condition of Ethiopian women still leaves a lot to be desired.

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<sup>3</sup> The World Bank (2005) classifies a generalized HIV/AIDS epidemic as a situation where HIV has spread beyond the original high risk populations, which are already infected.

<sup>4</sup> Transmission of HIV from a mother to her child is referred to as "mother-to-child transmission". However, the use of this term has been criticized for placing the blame of HIV transmission to the child solely on the mother not on both parents. Acknowledging the role of both parents in the transmission of the virus to the child, the term mother-to-child transmission has been used in this research for clarity's sake.

Here, the majority of women are uneducated, poor, victims of violence and HIV/AIDS (NEWA, 2003), and harmful traditional practices. Harmful traditional practices such as early marriage, abduction, female genital mutilation and wife inheritance are still practiced in spite of legal sanctions. These practices adversely affect women particularly young girls, curtailing their educational aspirations and compromising their health and unduly exposing them to ill health including HIV/AIDS (NCTPE, 2003; Wuleta, 2002; Yegomawork et al., 2003).

With this foreground, this research will look into the intersection of violence against women and HIV/AIDS. It will focus on sexual violence. There is paucity in research on experience and meaning of sexual violence and HIV/AIDS to women victims who have experienced both. These women must cope with the physical and psychological effects and symptoms of their trauma as well as the anticipated reactions of those close to them. The following questions will be examined:

- What are the structural factors that predispose women to gender based violence and HIV/AIDS?
- How do women victims of sexual violence and HIV/AIDS come to terms with the double trauma and
- How do they disclose their HIV positive status to their family, friends, neighbors and those who matter most to them?
- And how do society, government and non-governmental organizations and the women address the issue?

The study aims to contribute towards the knowledge base of HIV/AIDS with respect to the daily lives and experiences of HIV positive women and also hopefully fill the gap in existing knowledge on the issue. Furthermore, it will also increase awareness among policy makers on violence against women and the social dimensions of the HIV/AIDS pandemic.

### **1.3 OBJECTIVE OF THE RESEARCH**

The general and specific objectives of the research are:

#### **1.3.1 General Objective**

The overall objective is to find out information concerning the lived experiences of women who reportedly became HIV positive as a result of sexual violence; ultimately, to obtain information on the coping mechanisms of these women.

### **1. 3.2 Specific Objectives**

1. To identify the intersection between violence against women and HIV/AIDS.
2. To find out the contributing factors to violence against women and HIV/AIDS.
3. To describe the victims' experiences and perceptions of violence and HIV
4. To find out the coping mechanisms used by women living with HIV/AIDS.

## **1.4 RESEARCH DESIGN AND METHODOLOGY**

Feminist research is woman focused (Reinharz, 1992; Webb, 1993) and draws on the lived experiences of women with the purpose of empowering them and informing policy makers on the issues of women from their perspectives. Reinharz also asserts that a “shared assumption of feminist research is that women's lives are important” (Reinharz, 1992:241). She further elaborates;

*Making the invisible visible, bringing the margin to the center, rendering the trivial important, putting the spotlight on women as competent actors, understanding women as subjects in their own right rather than objects for men—all continue to be elements of feminist research (Reinharz, 1992:248).*

Time and again, women's experiences have been deemed trivial or only important insofar as they relate to the experiences of men and the questions they typically ask.

This research aims to explore hidden lives of women who became HIV positive after being sexually violated, with the intention of giving them voice. Towards this end, a primarily qualitative approach has been used as it is “particularly appropriate for exploring women’s lives” (Dyck, 1993: 52) in their own terms and from their own standpoint. It also enables the researcher to give proper attention to the women in the research and also investigate the problem from their perspective; taking their interests and experiences into account. Creswell (2003) asserts that, among other things, qualitative research occurs in a natural setting enabling the researcher to understand

participants' perspective from their standpoint. It is also versatile with multiple methods of data collection that are interactive and humanistic.

A case study strategy is adopted as it would permit in-depth exploration of the lives of sexually violated HIV positive women. Case study method is also favored by feminists, the reason being, in the words of Reinharz, "Feminist interest in case studies stems from the desire to document aspects of women's lives and achievements for future secondary analysis and future action on behalf of women" (Reinharz, 1992:171). This is because there is paucity of case studies on women's experiences which had contributed to the invisibility and distorted understanding of women. Reinharz concludes by saying,

*The case study is a tool for feminist research that...defies the social science convention of seeking generalization by looking instead for specificity, exceptions and completeness. Social science's emphasis on generalizations has obscured phenomenon important to...women. Thus case studies are essential for putting women on the map of social life (Reinharz, 1992:174).*

The selection of research participants was purposive because of the sensitive and personal nature of the subject to be studied. The requirement to participate in the research was being raped and becoming HIV positive. As a result five women who were willing to participate in the research were selected. The full detail of their cases is presented in Chapter IV. Their names have been changed to ensure confidentiality and anonymity. They are referred to as Senait, Mulunesh, Workitu, Alemitu and Beza which are not their real names. Their ages ranged from twenty to thirty-five.

Two small surveys were conducted as well to supplement data collected qualitatively; one on HIV positive beneficiaries of SWAAE and the other on selected households. In view of that, two sets of questionnaires were prepared for each category. Questions were formulated to draw information on the socio-demographic profile of respondents, perception and experiences of violence and HIV/AIDS, vulnerability, disclosure, stigma, coping, and care and support.

#### **1.4.1 Data Collection Instruments**

Sexual violence and HIV/AIDS are tainted with negative stereotyping, myths and stigma (Anania, 2001; De Bruyn, 1992) and particularly traumatic for women. This deters women in such situations from coming out in the open and letting their status

be known. This has made use of gatekeepers in organizations providing care and support to access women in such situations imperative.

In order to obtain information, combinations of both primary and secondary sources of data collection methods were used. Primary data were obtained through:

#### **1.4.1.1 In-Depth Interviews**

To get women's perspectives on experiences of violence and HIV/AIDS in-depth interviews were carried out. This method is appealing to feminist researchers as it

*...offers researchers access to people's ideas, thoughts and memories in their words rather than the words of the researcher. This asset is particularly important for the study of women because in this way learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women (Reinharz, 1992:19).*

The sensitivity of the issue has made in-depth interview preferable, as participants may not be able to talk freely in groups. In addition the researcher's interest is their lived experience of being victims of violence as well as HIV/AIDS. This will enable the women to articulate their situation in their own words; and giving them voice.

The interviews took place at the office of SWAA-E in Amharic after getting informed consent from the participants. One person was interviewed at a time and a tape recorder was used after requesting their permission. The women were asked questions based on the prepared interview guiding questions. They were encouraged to elaborate on issues that appeared to contain information relevant to the study.

The interviews with these women were intended to draw out how the women came to the situations that they are in at present; how they came to know their HIV status, their disclosure of their status to others, the consequences of their disclosure, support mechanism and future outlook. Key informants in SWAA-E, Kebele, Edir, police stations, and religious institutions were also interviewed.

#### **1.4.1.2 Observation**

Observation complemented the research as it enabled the researcher to observe firsthand the way the participants mix with others, interact and speak and their body language. It also gave the researcher clues about their level of adjustment to the trauma that may not be apparent in the interview. In addition, non-verbal cues were also observed and noted during interviews as the women struggled to articulate their experiences—often emotionally trying to stifle their tears.

#### **1.4.1.3 Focus Group Discussions**

Focus group discussions were undertaken to obtain more qualitative data. The discussions were guided through a prepared set of questions. The researcher was the moderator. Tape recorder was used and notes were taken. The discussions were held at SWAA-E and the discussions were participatory and interactive and the group's contribution was valuable. Three focus group discussions were held. The first was conducted with five women who were sexually abused. The second was conducted with five HIV positive women and the third involved a group of five persons comprising of, Kebele HIV Desk (one person), home based care provider (two persons) and staff of SWAA-E (two persons). Those invited from Kebele and edirs did not come to the focus group discussion.

#### **1.4.1.4 Survey**

Two small surveys were undertaken to assess attitudes of people living with HIV and the community towards gender based violence, HIV/AIDS and women. The selection of survey participants was purposive. Foss and Ellefsen (2002), characterize triangulation as “the use of multiple methods or perspectives for the collection and interpretation of data to obtain representative of reality” (Foss and Ellefsen, 2002:242). Accordingly, the surveys were also used to triangulate the information obtained from the interviews. The first survey was conducted on the community. A total of two hundred questionnaires were prepared and distributed with the help of enumerators; out of the two hundred questionnaires, one hundred were filled by respondents residing in Kebele 03/09 and the other one hundred were filled by respondents residing in Kebele 04/05. Both women and men filled the questionnaires. The enumerators were given thorough orientation prior to data collection.

The second survey was conducted on fifty HIV positive beneficiaries of SWAAE; it was done at Mekdim Ethiopia<sup>5</sup>, when the beneficiaries came to collect their food-aid. This enabled the researcher to meet potential survey participants at a certain time. The researcher personally distributed, gave briefing and made further clarification regarding the questionnaires to respondents and collected the completed questionnaires. Fifty questionnaires were distributed and all were filled out and returned. Both men and women of different age groups participated in the survey even though the number of female respondents is more than those of male respondents, because the majority of food-aid recipients were female.

Secondary data was gathered from archival sources such as books, journals, and other published and unpublished materials, documents and electronic resources.

#### **1.4.2 Data Analysis**

Originally, the researcher conducted the interviews, focus group discussions and surveys in Amharic due to the varied levels of education of participants. After data collection, transcribed the interviews in Amharic and then translated them to English. Read the transcripts thoroughly and identified emergent themes. Then arranged the data in themes and also translated the questionnaires to English and converted to quantitative data using the Microsoft Excel. The data generated was used to substantiate qualitative findings.

#### **1.4.3 Method of Entry**

Women who experienced violence are not readily willing to discuss about their traumatic experiences openly. According to Smith, this is due to several reasons:

*An abused woman may not reveal her victimization to an interviewer for a variety of reasons. She may feel that the subject is too personal to discuss, she may be embarrassed or ashamed, she may fear reprisal by her abuser should he find out about the interview, she may misunderstand the question, or she may think the abuse was too minor to mention. She may even have forgotten about it, particularly if it was minor and happened*

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<sup>5</sup> Mekdim Ethiopia is an organization of people living with HIV/AIDS (PLWHA)

*long ago. If the abuse was especially traumatic, she may not want or be able to recall it (1994:109).*

Similar situation may be encountered in interview with HIV positive women due to stigma and discrimination or perceived stigma and discrimination that might entail. Thus entry had to be negotiated. Entry was made possible through gatekeepers at SWAA-E, who made access to these women possible and smooth, as “an intermediary or go between can open doors otherwise locked to outsiders....The trust the group places in the intermediary will approximate the trust it extends to the ethnographer at the beginning of the study” (Fetterman, 1998: 33). Thus, the researcher was able to access the research participants, which would have been otherwise very difficult.

#### **1.4.4 Ethical Consideration**

It is clear that any research raises ethical issues. However; research on violence against women and HIV/AIDS is a sensitive one and requires special ethical consideration to ensure the safety of the participants as well as the researcher (WHO, 2001).

Accordingly, care was taken and WHO guidelines on ethical issues related to research on violence as well as the guidelines on the Ethiopian National Policy on HIV/AIDS research were adhered to. That is, the nature of the research and its benefits and the process of the interview were clearly explained to participants, they were also informed that enrollment was voluntary and they can withdraw at any time during the course of the research, they were assured of confidentiality of information that they give and finally, consent was asked prior to the interview and privacy was promoted.

This is also in line with the Ethiopian Government Policy on HIV/AIDS, which states that researchers should obtain informed consent from research participants and that they have rights to withdraw from the research any time (FDRE HIV/AIDS Policy, 1998).

### **1.5 SIGNIFICANCE OF THE STUDY**

HIV/AIDS is so far an incurable anti-immune disease predominantly affecting the young productive segment of society (Barnett and Blaikie, 1994; UNAIDS, 2005). In Ethiopia HIV/AIDS is recognized as one of the leading causes of death. However, there are few studies and data on the effect of the HIV/AIDS epidemic on the country and on its human resources. It was found out that HIV/AIDS has significantly reduced life expectancy of the population (Garbus, 2003). It also creates burden on the already scarce health care services.

As a result of the death of parents, in 2005, it was estimated that there were a total of 744,100 orphans due to AIDS aged 0 to 17 years in Ethiopia (FDRE, Ministry of Health, 2006). As there are insufficient social services for orphans, many orphans are forced to become street children (Garbus, 2003). This also adds up to the already existing social problems and affects the younger segment of the Ethiopian population which accounts for nearly half of the population (FDRE Central Statistics Agency, 2006).

In light of the AIDS pandemic's disproportionate impact on young girls and women, violence against women is increasingly becoming an issue of real concern as it affects the health and human rights of women (Amnesty International, 2004; Heise, 1999). This research aims to shed light on the link between sexual violence and HIV/AIDS because the two are viewed separately. The study will make its share of contribution towards the issue and provide baseline information for further studies; this hopefully will inspire further research into the subject matter.

The research findings will give better insights into the understanding of the lives of women who experienced sexual violence and live with HIV/AIDS and the problems they encounter, as "...to speak from experience has authority" (Thompson, 1992:1). It will also make possible for others to share the experiences of HIV positive women. What's more is the research's contribution to knowledge on the least addressed women's perspectives of gender based violence and HIV/AIDS. It also informs policymakers, those providing care and support to these women and advocates on the needs of women with HIV/AIDS. Their special needs in turn can be a basis for development of appropriate policies and intervention by concerned authorities, governmental and non-governmental organizations.

## **1.6 LIMITATIONS OF THE STUDY**

This research is based on women's experiences of violence and HIV/AIDS in a particular setting. It also does not include the experiences of all women as many women do not report incidents of abuse or disclose their HIV status. Economically well-off women do not seek the services of NGOs such as SWAA-E. Thus these groups of women were not included in this study. Nevertheless, this research will hopefully provide insight into how women experience violence and HIV/AIDS.

## **1.7 RESEARCH SETTING**

The study, took place at the Society for Women and AIDS in Africa-Ethiopia (SWAA-E). It concentrated on participants selected from SWAA-E located in Arada sub-city, in Addis Ababa. SWAA-E is a non-governmental organization providing integrated care and support to women and families infected and affected by HIV/AIDS.

The reason for choosing SWAA-E was to enable the researcher to have access to women who actually experienced sexual violence and living with HIV/AIDS. In addition, the eagerness of the Program Coordinator and staff members of SWAA-E to assist the researcher was one of the factors for selecting the site; the proximity of the site was another factor for the selection of the site.

### **1.7.1 Society for Women and AIDS in Africa-Ethiopia (SWAA-E)**

Society for Women and AIDS in Africa-Ethiopia (SWAA-E) is the Ethiopian chapter of the Society for Women and AIDS in Africa (SWAA), based in Dakar, Senegal, with a membership of forty African countries. It is mainly concerned with women and children. Its main objective is “to promote the reduction of HIV/AIDS and its associated psycho-social and economic impacts on the lives of infected, affected and marginalized people” (SWAA-E flier, June 2006).

SWAA-E operates in Kebeles 03/09 and 04/05 of Arada sub-city in Addis Ababa. It is currently extending its services to Gulele sub-city in Addis Ababa and Fiche town, ninety kilometers north of Addis Ababa. The governing body of SWAA-E is the general assembly. It has an executive board, which controls the overall activities of the organization, and a secretariat, which runs the day-to-day activities of

SWAA-E. In addition to the twelve staff working for the organization, there are also forty–two volunteers.

SWAA-E works with various partners by providing integrated care and support to orphans and vulnerable children (OVC) and people living with HIV/AIDS (PLWHA), income generating activities, vocational skill training for HIV-infected, affected and marginalized community members, commercial sex workers and sexually abused girls (SWAA-E flier, June 2006). Care and support is given to HIV positive women by providing them with nutritious food, medical supplies and home based care through its 38 home based care providers. It also provides children of poor and HIV-infected and affected families with clothing and school gear. The home based care providers are also entrusted with the close follow-up of these children's living conditions and educational performance.

Since its establishment in 1992, SWAA-E has targeted HIV positive women and their families. It also has profile of its beneficiaries, which facilitated the researcher's access to the research participants, which would not have been otherwise possible had the researcher approached these women individually, or personally due to the sensitivity of the matter. The location of the site in terms of proximity and easy access has also made it convenient for the researcher.

In addition, beneficiaries are selected by a committee composed of community based organization, such as Edirs, Kebele, religious leaders and members of the organization, This has also given the researcher additional benefit and easy access to the community in gaining information on the community's attitude towards violence against women and HIV/AIDS as well as its response to the issues.

### **1.7.2 Arada Sub-City**

The Arada sub-city was established by the revised Addis Ababa City Charter of 2002 (Proclamation for the Establishment of Sub-cities and Kebeles Number 1/1995). It is composed of 2 administrative strata and 5 executive organs to give municipality service. Located at the center point of Addis Ababa, it is bordered by Gulele sub-city in the north, Yeka sub-city in the east, Addis Ketema sub-city on the West, Kirkos sub-city on South and Lideta sub-city on the south west. It covers a

total area of 1,155 hectares (The map of the city government of Addis Ababa is attached as the annex).

It comprises of ten Kebeles, which are characterized by, trading areas such as Piazza and Arat Kilo, parks like the Lion Zoo and the Ambassador Park, historical sites like the National Museum, various health facilities, schools and higher education institutions with a student population of 60, 693. There are also government institutions like the parliament and various ministries. It is reported that there is widespread poverty and unemployment and a chronic housing problem amongst the multitude of problems in the sub-city. The total population of the sub-city is 330,053 and the total number of houses is 64,211 (Arada Sub-City Public Relations Office, 2005).

**A Bird's Eye View of Kebeles 04/05 and 03/09 Arada Sub-City:** Kebele 04/ 05 is located on the western side of Arada sub-city, between Piazza and Merkato. It encompasses the Talian Sefer and Montrare (Atkilt Tera). The dominant economic activity is fruit and vegetable business. It is characterized by high rate of street vending and commercial sex activity. There are many street children. There is a high rate of unemployment (49.8%) and many residents are engaged as daily laborers as they do not have regular employment. The majority of those employed are engaged in gultit,<sup>6</sup> petty retail trade, grocery (alcoholic beverage sale), tella<sup>7</sup> and areki<sup>8</sup> selling, and chat<sup>9</sup> selling. Of the households 44% are female headed. Due to the transitory nature of the area it is common to find beds for rent at a cheap rate (Arada Sub City Eco-City Project, 2004). In an interview with a Kebele key informant, it was disclosed that it is common to see small houses where a kind of a deck is put up above their living quarters which is called “qØ” “Kot”. The Kot is rented for various purposes such as chat chewing and shisha<sup>10</sup> smoking and also for

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<sup>6</sup> Gultit is a small market stall where items such as fruits and vegetables, spices, charcoal, injera, bread rolls and the like are sold

<sup>7</sup> Arekie is a locally prepared distilled alcoholic drink.

<sup>8</sup> Tella is a locally brewed beer-like drink

<sup>9</sup> Chat is the leaf of the plant *Cathea edulis*, which are grown locally and chewed. Chat acts as a stimulant/euphoriant when taken (Dawit Abebe et al, 2005).

<sup>10</sup> Shisha “A mixture that may include tobacco, honey, hashish and spices; it is smoked from an oriental tobacco pipe, which has a long, flexible tube that draws the smoke through a water-filled container” (FDRE Ministry of Health, 2002: xvi).



(Orthodox), Saint George's Church (Orthodox), the Lutheran Mission (Protestant) and Saint Gabriel's Church (Catholic). The Anwar mosque is also found near the sub-city.

In close proximity there are also several schools and a big referral hospital (Ras Desta Damtew Hospital). Many children and young people pass through this area daily; whether or not they observe what goes on is another matter. This could be a reflection of the spontaneous nature of urban settlement in Addis Ababa; where residential, school and entertainment districts are not clearly delineated. Obviously, this exposure is bound to have an unwanted impact on children, young women and young men. Poverty and unemployment also exacerbate the situation. Out of the lack of options this has become a means of survival. This culture is still prevailing (Arada Sub-city Eco Project, 2004).

## **1.8 FIELDWORK**

The field work was conducted from August 2006 up to December 2006. I had not thought that doing a research on HIV positive women would result in such a revelation. As a woman, it is painful to listen to another female tell you of her painful, traumatic experience of being raped. Not only sexually violated but also contracting a lethal disease that is painful physically as well as psychologically.

The women think twice before telling those closest to them of their predicament. They are forced to bear the children of their perpetrators and raise them adding to their burdened poor lives. These women are poor and some of them do not know if they will have the next meal or not. However they struggle in their daily lives. Their children are their center of attention; they always worry about what will happen to their children when they pass away.

When I went to the organization (SWAA-E) I was met with enthusiasm at the prospect of having someone doing a research on their beneficiaries. The staff went out of their way to keep me in contact with the beneficiaries. I was also introduced to the staff of SWAA-E, home based care providers and beneficiaries of the organization. It was an enlightening experience almost all women I came in contact with had children. I was able to see young girls carrying babies and children. Their reasons for having children was varied, some became pregnant through casual encounters, some rape, others through marriage. These women were unemployed or were low income earners engaged in petty trade such as gultit.

The other site I went to was Mekdim Ethiopia where food-aid comprising of wheat grain, fortified cereal and oil were distributed to the beneficiaries once a month. Here, almost all were women and young children but very few men. These women sat in groups chatting lively and exchanged information on mutual concerns. I was able to observe how poor these women are and some sick as well.

In another occasion, I also attended a ceremony where the school achievement award of the year was given to young children who were AIDS orphans and it was a pleasurable sight where these orphans against all odds stacked against them were able to achieve academically. Here, I noticed a large number of orphans. I also observed that these young people were in the care of their grand parents, older siblings, relatives and neighbors. This clearly shows the generation gap marked by the absence of parents due to death. The burden of the consequence of HIV/AIDS falls on the elderly.

I also encountered the two recently orphaned children aged 8 and 12. Their father had died previously and their mother died of complications of childbirth recently, what shocked me was that these two children were alone. They were unable to cook so they ate their meals at a nearby hotel. Upon visiting them in the evening, the home based care provider saw men who were drunk coming to the house where the orphans lived, inquiring if there was room for rent for the evening. I later learned that their relatives have taken them under their care.

In the course of the research, I had interviewed HIV positive women who not only shared their life stories but also have devoted their time as well. Some have left their small children under the care of neighbors and other family members; others have brought their children along when they came for the interviews as they were unable to leave them behind at home. At times, staff members of SWAA-E have also minded small children during interview sessions so that the women could freely talk to me without distraction.

The women were cooperative and for this I am grateful and indebted to them. I cannot fully reciprocate their efforts in any other kind. However, researchers cannot always be on the receiving end. Hence, in addition to encouraging them and raising their consciousness, in my capacity I gave free gender basics training to staff of SWAA-E with colleagues and volunteered to serve as member on the board of SWAA-E.

## **CHAPTER II**

### **2.1 REVIEW OF RELATED LITERATURE AND THEORETICAL BACKGROUND**

Yodanis (2004) asserts that the concept of status of women is complex and multi dimensional. It has political, economic and social dimensions.

The overall status of women in Ethiopia is low (Women's Affairs Office, 2005). Politically they are underrepresented in decision-making positions at all levels, thus they have little access to power and representation in the state. Economically they are poor; their access to productive resources such as land is limited. In terms of employment, the number of women employed in the formal sector is low; the majority of women are engaged in petty trade in the informal sector. (Women's Affairs Office, 2005). This is because of their low level of educational attainment. Women's social status, reflected by their low participation in education where the gender gap in education still prevails (EDHS, 2006; Women's Affairs Office, 2005). This increases their economic dependency. This low status of women makes them vulnerable to violence as all social, and political institutions are controlled by men, where male power will be the norm (Yodanis, 2004).

### **2.1.1 Gender Based Violence**

In virtually every nation, violence or the fear of it affects more women than men (Bunch et al., 1998; Kelly, 1999; Rozee and Koss, 2001; Stanko, 1997; Yodanis, 2004). This acts as a barrier to women's full participation in society by restricting their movement and involvement in public life (Bunch et al., 1998; Kelly, 1999; Stanko, 1997; Rozee and Koss, 2001), and their ability to control their own lives (Bunch et al., 1998).

Violence against women occurs across all societies. Irrespective of their status, women are subjected to violence perpetuated by men due to their gender. Feminists refer to violence against women as gender based violence to emphasize that the female gender is target of male violence and abuse (Alem, 2004; Blen, 2002; Negussie, 2002). Gender based violence encompasses several manifestations of abuse against women that are gendered; as violence or the risk of experiencing it is linked with being female. Violence against women is responsible for the loss of many women's lives. Statistics from different countries indicates that present or former partners commit more than half of the murders of women (Bunch et al., 1998). Cultural practices such as female infanticides, honor killings, dowry related murders still prevalent put women and girls' lives in danger (Bunch et al., 1998).

Gender based violence occurs in all facets of women's lives; in the family, the community and even by the state. Within the family, women suffer intimate partner violence or domestic violence including but not limited to homicide, battery, marital rape and incest. Women are also victims of violence occurring within the community such as sexual harassment, rape, forced prostitution, trafficking of women and girls for domestic labor and prostitution, stalking, pornography and harmful traditional practices such as early marriage, abduction, female genital mutilation. At the level of the state, violence against women takes the forms of rape and sexual assault and abuses in prisons, schools, refugee camps and borders, rape in armed conflict situations.

Women are also physically and sexually assaulted, threatened and humiliated within the confines of their homes by men with whom they live and trust (Davies 1997:4). Not only are women hurt physically they experience psychological trauma, unwanted pregnancy and also sexually transmitted infections including HIV/AIDS as they are unable to protect themselves and unable to use contraceptive including condoms and other forms of sexual behavior with their partner (Dixon-Mueller,1993; Ellsberg, 2001; Hirut, 2004).

Despite the legal minimum age for marriage set by law, girls are married off at a very young age (NCTPE, 2003). Even though the Federal Democratic Republic of Ethiopia's Constitution in article 34(2)<sup>12</sup> and article 35(4)<sup>13</sup> and the Revised Family Law of 2000, article 6 and 7<sup>14</sup> clearly stipulate that marriage is consensual and the age for marriage for both sexes is 18 years of age, young girls as young as 10 years are married off to older men (Erulkar et al., 2004a; Wuleta, 2002). This is mainly to ensure the virginity of girls before marriage and conformity to tradition, where older unmarried girls are stigmatized as unwanted.

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<sup>12</sup> Article 34(2) states that "Marriage shall be entered into only with the free and full consent of the intending spouses."

<sup>13</sup> Article 35(4) states that "Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited."

<sup>14</sup> Article 6 states " a valid marriage shall take place only where the spouses have given their free and full consent" and Article 7(1) provides that "Neither a man nor a woman who has not attained the full age of 18 years shall conclude marriage"

Abduction of young girls is also another practice where young girls are taken forcefully against their wishes. They are physically assaulted and sexual assault ensues, girls are forced to live with their assailants after mediation by elders and the perpetrator made to pay the parents 'compensation' (NCTPE, 2003). These young girls are traumatized by adult sex and are forced to bear children before their bodies mature, resulting in maternal mortality and fistula which is stigmatizing, leads to abandonment and divorce (Heise et al., 1994; Wuleta, 2002). This leaves young women with psychological trauma of their experience and their prospect for education and a better future abruptly halted.

The widespread belief that very young girls are free from HIV persists thus older men to be safe marry very young girls. In some societies there is a belief that having sex with a very young girl cleanses of AIDS (De Bruyn, 1992; Jewkes et al. 2003 ) thus older men seek out very young girls. On the other hand, the young girls are powerless in sexual relationship with older men to insist on condom and contraceptive use, heightening their risk of HIV contraction (De Bruyn, 1992).

Rape is one of the most pervasive crimes committed against women. In Ethiopia, the actual figure and extent of this crime is not fully known. Though rape is a punishable crime, victims do not want to report the crime or to proceed with their legal case as most of them fear the stigma attached to such a report or believe that the case will leave a mark of shame on them (Alem, 2004; Anania, 2001; Original et al., 2004). The Ethiopian law does not recognize marital rape as a crime.

Wife inheritance too is practiced in some societies; the brother of a deceased inherits his brother's wife even if the husband died of AIDS or the wife is HIV positive. This practice increases the vulnerability of women as well as men to HIV/AIDS.

Such situations lead to unprotected sexual encounters where women are unprepared for and not in a position to negotiate safe sex. Thus increased risk of exposure to HIV; young girls are most vulnerable.

Reasons for women's vulnerability to violence are:

1. Due to the fact that they are female in that a woman is subjected to female genital mutilation, female infanticide. This type of violence is rooted in society's construction of female sexuality and its role in social hierarchy.
2. Because of a woman's inferior relation to a man, a woman is vulnerable to domestic violence. Sometimes taking culturally rooted forms such as dowry. Again, society's concept of a woman as the property and dependent of a male protector, father, husband, brother, son etc. becomes powerful justifier of the violence.
3. Because of the social group in which she belongs in times of war, riots or ethnic, caste or class violence, a woman may be raped and brutalized as a means of humiliating the community to which she belongs (Ellsberg. et al., 2005: 10).

Even though there are researches conducted on women in Ethiopia, in-depth studies of the situation of women covering the whole nation are scarce (TGE, National Policy on Women, 1993:23). However, Habtamu Wondimu et al.'s (2004) study *Gender and Cross-cultural Dynamics in Ethiopia: the Case of Eleven Ethnic Groups* is a pioneer research covering 84 % of the Ethiopian population and the first comprehensive work to throw light on the situation of women and extent of violence in Ethiopia.

Research on violence against women has also been conducted in various disciplines such as medicine, law and sociology. These multidisciplinary researches have entailed a diversity of definitions of violence, research design and the development of multiple theoretical frameworks in addressing the issue. Thus uniform data on violence against women is unavailable making it difficult to comprehend the magnitude of the issue (Ellsberg, 2001; Maman, 2000; Smith, 1994).

Data on violence against women is scarce (Maman et al., 2000) and incomplete. This limits the "full understanding of the issues and the magnitudes of the potential impacts it has on the lives of women affected" (Yemane, 2004:1). One of the factors that contribute to the non-addressing of the issue of violence against women is the underreporting and inaccurate recording of violence against women (Blen, 2002; Bunch et al., 1998; Heise, 1999; Kelly, 1988; Original et al., 2004; Smith, 1994). It is also

considered shameful to expose personal matters to outsiders. Victims are ridiculed, fingers pointed at them and become subject of gossip. So they keep silent about issues such as violence particularly in intimate and private settings (Habtamu, 2003; Natarajan, 2002; Yegomawork et al., 2003).

On the other hand women do not expect to be treated sensitively and seriously by the judicial system (Walby, 1994). The fact that only a small proportion of assault is reported of which not all reports are recorded as crimes against women (for example crimes such as domestic violence are entered under the category of ‘social crimes’, whereby the issue is masked), results in the absence of crimes against women in crime statistics. In addition, some forms of sexual violence such as sexual harassment and marital rape are not defined as crimes in some countries. This has made the issue of violence against women less visible to policy makers and thus few interventions are made regarding the issue, which would otherwise have benefited women.

However more reliable estimates have been obtained from specific surveys. Smith (1994) asserts that in order to get accurate data on victimization, violence should be broadly defined to enable women correctly define their victimization as women in surveys and interviews may not consider some acts as violent. Most data is obtained from health service institutions, police, non-governmental organizations and individual survey researches on the issue.

In Ethiopia, there is a paucity of a comprehensive nationwide prevalence study on violence against women (Original et al., 2004). Even so, the limited data available is often incomplete and gender insensitive. Such a serious crime is not given due attention. For instance, the only crime against women recorded in the Ethiopian Statistical Abstract is rape, even so, in English it is recorded as “Rape” and the Amharic version says, “ገገገ ስገገ ስገገ” “kibre nitsihinan medifer” in English means deflowering (Central Statistical Agency, 2006).

In the statistical report of crimes of the Arada sub-city Police, the researcher was informed that crime statistics was compiled according to the format given by the Addis Ababa Police Commission. Accordingly, all crimes were recorded under 46 categories of crimes (Attached as the annex). Though the data is sex disaggregated, the only

crimes specifically given category concerning crimes committed against women were the crimes of rape. It is very interesting to note here that the crime of rape was put into two categories; item 38, “ገደብ ለገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “kibre nitsihinan yaleidmie woyem yalefekad medifer” translated to English means deflowering of minors (underage) or deflowering without consent and item 39 “ረገጥ ለገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “seitin bemasgeded yegibresiga ginugnet madreg” in English means having a forced sexual intercourse with a woman.

Other crimes were categorized under, “ገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “hone bilo sew megdel” translated to English means, intentional homicide (number 16), “ገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “hone bilo lemegdel mukera” translated to English means attempted murder, (number 17), “ገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “lieloch yezimut wonjeloch” in English means other sexual crimes (number 40) “ገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “lieloch liyou liyou mahiberawi nek wonjeloch” translated to English means other social crimes (number 42), and “ገገግ ልጅ ለገገግ ልጅ ስብከት ስብከት” “denb metelalef” translated to English means petty offenses (number 43).

To address these shortcomings, the WHO advocated a "multi-country study with consistent measures and sampling frames that will provide a more accurate comparison" of violence globally (Garcia-Moreno, 2005: 463).

According to the 2005 WHO *Multi-Country Study on Women's Health and Domestic Violence against Women* conducted between the years 2000 and 2003, where 24,000 women from ten different countries including Ethiopia took part in the study to assess women's experience of violence. In Ethiopia, it was found that of the 3,016 women interviewed, 49% of ever partnered women experienced physical violence in the hands of a partner at one point in their lives (29% during past 12 months). 59% of ever partnered women experienced sexual violence at some point (44% during past 12 months) and 71% of ever partnered women experienced physical violence or sexual violence or both at some point. The injury they sustained was severe that one in three women injured required medical attention.

Contrary to the belief that they are to be protected, even pregnant women were not spared from violence. In the aforementioned study, 8% of pregnant women experienced

physical violence during pregnancy; of which 98% of the violence was inflicted by the father of the child. For 17% of the women their first sexual experience was forced.

In the study, apart from physical injury, women who experienced physical or sexual violence were twice likely to report lower health status than non-abused women and the abused pregnant women had more induced abortion than the non abused women. Sadly, 39% of the women never talked to anyone about their experience of violence (Garcia-Moreno, 2005).

### **2.1.2 The Feminization of HIV/AIDS**

Women are more vulnerable to HIV infection than men (Baylies, 2000; Fikerte, 2004). Women's increased risk also reflects the gender inequalities. In most societies including Ethiopia, the norms governing sexual relationships differ for men and women, with men holding most of the power. This means that for many women, their male partner's sexual behavior is the most important HIV risk factor. In fact, 80% of newly infected women are married or in long term relationships (Newsweek 2006: 66). In Sub-Saharan Africa, 57% of adults infected are women, out of this, 75% of the infected young people are women and girls (UNAIDS, 2005: 4).

The AIDS pandemic also has a disproportionate impact on women. Their socially defined roles as caregivers, wives, mothers and grandmothers mean that they bear the greatest part of AIDS care burden. When illness and death lead to household or community impoverishment, women and girls are more affected than men due to either their low social status or lack of equal economic opportunity. Girls are also forced to drop out of school to care for sick parents as well as younger siblings (UNAIDS, 2005).

According to the AIDS Epidemic Update (UNAIDS, 2006), over 10% of the world's population lives in Sub-Saharan Africa and out of this, close to two-thirds of all people living with HIV, that is, some 24.5 million are found in this region. In addition, 77% of all women living with HIV are found in Sub-Saharan Africa. In 2005 alone, 2.7 million people in this region became newly infected with HIV and 2 million died of it. Among young people 15–24 years of age, 4.6% of women and 1.7% of men were living with HIV in 2005 (UNAIDS, 2006:15).

Furthermore, in Sub-Saharan Africa, 59% of adults living with the virus are women, (UNAIDS, 2006:15). Survey data indicate a gender disproportionate impact of HIV/AIDS where women are highly affected; among young people, there are three HIV-infected young women for every HIV-infected young man (UNAIDS, 2006:8).

Several factors have contributed to this trend, among them are;

**a. Physiological (Biological):-**

Female bodies are efficient in the transmission of HIV than male because female reproductive surface area is larger, in addition, men's semen can have a high concentration of HIV virus thus women have a high risk of HIV transmission in sexual relationship especially during coerced sexual intercourse, the virus enters directly into the blood stream (Baylies, 2000; Fikerte, 2004; Wuleta, 2002). Studies also indicate that women are three to five times more likely to be infected than men in a heterosexual relationship (Amaro, Raj and Reed, 2001; Baylies, 2000).

The presence of untreated sexually transmitted infection increases the likelihood of HIV transmission as it facilitates entrance of the virus into the bloodstream. Because infected women are asymptomatic, they are not aware of their sexually transmitted infection and are less likely to seek treatment (Fikerte, 2004). In addition, the stigma attached to sexually transmitted diseases deters women from seeking medical treatment (Baylies, 2000).

Women are pressurized to prove their womanhood by bearing children. This undermines women's capacity to protect themselves through methods of contraception such as condoms and makes them most liable to pass their HIV to their babies (Wuleta, 2002).

**b. Socio- cultural:-**

Women's vulnerability to HIV is compounded by socio-cultural factors such as the gender roles assigned to women and men. The social position of women is subordinate. Women have little control over their sex life and their HIV risk (De Bruyn, 1992).

Young women due to traditional practices such as early marriage and poverty tend to have male partners much older than themselves—partners who are more likely than young men to be HIV-infected due to their multiple sexual experience with other women (Baylies, 2000; Tallis, 2002). Male promiscuity is tolerated by society attributing to cultural norms of masculinity, thus women have a high rate of being infected by their partners and husbands. Gender inequalities do not allow women to have decision making power over sexual relationships (Anania, 2000). A number of practices increasing women's risks of HIV infection are often justified in the name of cultural value such as harmful traditional practices like early marriage, female genital mutilation, wife inheritance and polygamy which add to and aggravate women's HIV infection.

**c. Economic:-**

Women have limited access to resources such as education, employment, property and credit which makes them economically dependent on men. Baylies (2000:7) contends that “The specific way in which economic dependence figures in sexual relations affects the extent women are able to exert control and in particular to ensure protection against HIV.”

Poverty and inequality in access to resources also makes young girls prone to trafficking and sexual exploitation (Fikerte, 2004; Jewkes et al., 2003). In addition, economically vulnerable women are highly dependent on men's financial contributions and are less likely to succeed in negotiating protection and less likely to leave relationships they perceive risky (Baylies, 2000; Jewkes et al., 2003).

**d. Political and Legal:-**

Women have low level of political participation. Added to the fact, women are frequently excluded from participation in policy making and implementation including in issues that primarily affect them. Thus there is a general lack of awareness about women's human rights.

**e. War and Displacement:-**

Violence against women such as rape by armed forces during armed conflict, forced sterilization, torture in custody and violence by officials including UN peace

keepers against women and girls in addition to the physical and psychological trauma exposes women and girls to HIV.

The gravity of rape in conflict situations has been recognized at international level that the International Criminal Court considers rape as a crime against humanity and the offences constitute war crimes (Amnesty International, 2004).

On the other hand, the presence of a large and mobile military population has also increased women's vulnerability to HIV (Fikerte, 2004; Kloos and Damen, 2000; UNAIDS, 2004). Troops stationed in various cities in the country had exposures to multi-partnered sexual contact. Nearly half a million Ethiopian soldiers had been demobilized and reintegrated into the rural economy in the 1990's. Studies have indicated that these demobilized soldiers had not changed their sexual behaviors to protect themselves or their partners (Kloos and Damen, 2000). This has played a role in the exposure of rural communities especially rural women to HIV/AIDS.

Women's multiple vulnerabilities to HIV/AIDS have not been adequately addressed in public policies which have mainly focused on regulating women's sexuality by advising commercial sex workers to use condoms and girls to abstain from sex (Long and Messersmith, 1998). This has not taken into consideration the reality of girls and women's role in sexual decision making (Kloos and Damen, 2000).

Women are isolated from the world of information and interaction with people other than their immediate family members. The majority of women are uneducated, unemployed (EDHS, 2006) and house-bound; they are distant from much information including about HIV-its risks, transmission and prevention. In addition, HIV/AIDS prevention campaigns rely mostly on print media and even if it reaches them, women may not be able to read it. In places where there are radios, it is the men who listen to them (De Bruyn, 1992).

This is clearly depicted in the 2005 Ethiopian Demographic Health Survey, where it was found out that in urban areas of Ethiopia, the percentage of those who read newspapers was 8.8 percent for women while it was 27.3 percent for men. In rural areas 3.9 percent of the men read newspapers whereas only 1.2 percent of the women read

newspapers. In urban areas, 40.4 percent of the women listened to radios while the figure for men was 62.8 percent. In rural areas, 10.7 percent of the women listened to the radio and 25.7 percent of the men listened to the radio (EDHS, 2006:38).

This is a clear indication of the marked gender disparity in access to information both in rural as well as urban areas in Ethiopia. Hence, women are less informed of HIV related issues. This is clearly indicated in the Ethiopian Demographic and Health Survey of 2005 where there is a marked gender disparity in awareness about HIV/AIDS (EDHS, 2006:26). In spite of the above factors, the radio is the most widely used mass media, thus it can be instrumental in dissemination of HIV related information to a large number of audiences.

### **2.1.3 The Intersection of Violence against Women and HIV/AIDS**

Women in developing countries are fast becoming newly infected with HIV/AIDS. The underlying reason for this is the imbalance of power between women and men which favors men (Jewkes et al., 2003). This inequality has adverse effects on women and has enhanced men's violence against them (UNAIDS, 2006; Yodanis, 2004).

Violence against women has permeated all structures of society and women experience violence in intimate relationships, in their family, their community and beyond. This also has made them susceptible to HIV/AIDS. Research is increasingly showing association between violence against women and HIV/AIDS (De Bruyn, 1992; Dunkle et al., 2004; Ellsberg 2005; Maman et al., 2002).

Sexual violence directly contributes to women's vulnerability to HIV/AIDS through rape and sexual coercion. The violent nature of rape creates genital injury and bleeding, which facilitates HIV transmission. Women experience sexual coercion at home, in the community, in conflict and war situations and even refugee camps, and sexual trafficking. Moreover, violence or the threat of violence indirectly makes women vulnerable to HIV because it limits women's ability to negotiate safer sexual behaviors (Heise, 1999) and get out of relationships that put them at risk of contracting HIV/AIDS. Violence or the fear of violence also limits women's access to HIV prevention and treatment services.

Suggesting condom use for women may be seen as tantamount to implying or admitting infidelity, as condoms are associated with prostitution, promiscuity and disease. It might also be seen as a challenge to the “male” right to have many women (Heise, 1999; Jewkes et al., 2003).

Due to the prevalence of violence against women such as early marriage and abduction which are widespread in Ethiopia (NCTPE, 2003) many young girls are placed at risk of HIV contraction at a young age (NCTPE, 2003; Yegomawork et al., 2003). This is illustrated by the fact that more young girls are infected than boys of the same age (FDRE, Ministry of Health, 2006; UNAIDS, 2005).

There is also evidence that physical and sexual abuse in childhood is related to high sexual risk taking including these women taking multiple partners and engaging in transactional sex (Dunkle et al., 2004; Maman et al., 2000).

On the other hand, studies are showing that HIV induces violence against women in that HIV positive women are becoming subjected to violence due to their disclosures of their HIV positive status (Maman et al., 2000). Women, fearful of their partner’s reaction do not share their HIV positive status with their partners. This has also kept them away from voluntary counseling and testing services, which has adversely affected the control and transmission of the virus. HIV positive pregnant women are reluctant to use prevention of mother-to-child transmission services for fear of violence or do not take antiretroviral treatment to prevent mother-to-child transmission of the virus. They breastfeed their babies in order to avoid suspicion of being HIV positive. This also deters them from getting counseling on future child bearing. Widows of HIV positive spouses are highly stigmatized as well as subjected to violence. AIDS orphans, especially girls, are also at high risk of violence.

Research is also indicating that violence against women limits the impact of HIV prevention strategies that are promoted globally. HIV prevention programs emphasize abstinence, condom use and limited number of sexual partners. However, these strategies do not take into account women victims of sexual violence or the threats of violence are not in a position to enforce these strategies (Maman et al., 2000). That is the condition under which sexual intercourse takes place is not dictated by the women.

Care of HIV-infected family members is falling on extended family of which older women form an important part of the support system. A large burden of caring for and raising the growing number of AIDS orphans is increasingly falling on grandparents especially grandmothers.

Sexual violence is a major cause and a consequence of HIV/AIDS. When young children and adolescents are abused or forced to have sex, not only are they at direct risk of contracting HIV during the sexual assault, but evidence has also shown that this leads them to subsequently behave in a manner more likely to contract HIV/AIDS. This means that an initial experience of sexual abuse can place a victim at high risk of repeated and multiple abusive experiences (Mitike et al., 2002).

Conversely, research demonstrates that men with a record of violence are more likely to engage in extramarital sex, are at higher risk of contracting sexually transmitted infections, and are more likely to place their partners at risk, possibly through sexually transmitted infections (Jewkes et al., 2003).

#### **2.1.4 Poverty Violence against Women and HIV/AIDS**

*“Poverty is the worst form of violence.” Gandhi*

Women constitute 70 percent of the world's poor (Beneria, 1996; Tizita, 2004). They work longer hours than men (Beneria, 1996) Researches indicate that Ethiopian women typically work up to 18 hours daily (Habtamu et al., 2004; Hirut, 2004) but much of their work is not valued, recognized nor appreciated (Hirut, 2004; Yelfigne, 2004). This can be seen from the fact that women's economic contributions are not reflected in national account statistics (Hanna, 1990). It has also led to the statistical invisibility of women's work, which would have helped in the analysis of differential impact of poverty on men and women. This has contributed to difficulties in addressing gender in poverty reduction strategies (Beneria, 1996; Yelfigne, 2004).

Poverty is multidimensional; it exists where basic needs are not fulfilled and there is little power, limited choice and lack of control of resources (Beneria, 1996). Poverty is more strongly related to human rights than welfare alone (Aster et al., 2002).

Zhibin (2006) has developed an analytical framework for understanding and addressing the gender angle of poverty. In the framework, three factors were considered; income poverty, time poverty and asset poverty.

### Income Poverty

Women throughout the world are overworked and underpaid; they contribute to two thirds of the world's work hours yet they get only ten percent of the income and own less than one percent of the property (Hess and Ferree, 1987). Since this situation persists globally, women earn less than men and dominate the categories of unemployed and low income earners. There are fewer women than men in higher paid jobs.

Even within households, due to their subordinate status women do not have equal access to resources, that is, within the same household, women are poorer than men. That is why women are said to be poorest of the poor (Beneria 1996, Yelfigne, 2004). In a survey of Chinese women's social status, it was found out that average yearly income of female urban employees was 70.1 percent of the average annual salary of male employees. In rural areas, average yearly income of female employees was 59.6 percent of the average salary paid to male employees. (Zhibin, 2006) This situation persists globally; women tend to have lower incomes than men, for this reason women experience poverty differently than men (Beneria, 1996).

### Time Poverty

Rigid gender division of labor forces women to be engaged in unpaid work (Aster et al., 2002). As in most countries in the world, women in Ethiopia are expected to work at home. Their chores include but are not limited to the following: bake and cook, deliver food to farmers, childcare, and care for the sick and elderly, wash, pound, milk cows, sweep house and barn, collect firewood and fetch water.

In addition to this backbreaking work, women also participate in community and farm activities. This pressures women's available time, energy and reduces their human development capacity and affects their health status and delays their health care seeking. It also hampers girls' education as girls are expected to help their mothers at home; girls as young as six years old to take care of household chores (NCTPE, 2003).

Time poverty contributes to income poverty, and asset poverty (Zhibin, 2006). This leads to women's engagement in the informal sector where it is less secure, pays less and involves poor and strenuous working condition (Aster et al., 2002).

### Asset Poverty

Women have limited access to resources such as health, education, natural and economic resources and network of social relations (Zhibin, 2006). This is directly linked to women's social, economic and political disempowerment and poverty.

When a woman marries, and goes to live with her husband's family; her previous social relation network is severed and she is forced to adopt her husband's social relation network (Zhibin, 2006). As women are heavily engaged in household activities, they have limited time for socialization and thus they are unable to continue the relationship they cultivated before their marriage. If they are divorced, they go back to their parents' homes; again, however, they lose the social relation network they formed during their marriage.

Early marriage and abduction of young girls is still prevalent in Ethiopia (NCTPE, 2003). These young girls have children at an earlier age (Erulkar et al., 2004a). They are burdened with household work that they are unable to pursue their education or acquire skills that would enable them to be gainfully employed. In addition, the belief that males should be the breadwinners, while women raise children at home is dominant (Habtamu et al., 2004). This has further distanced women from gaining access to resources. Thus it was found out that the majority of Ethiopian women were propertyless with no ownership of assets like land, cattle or houses (Habtamu et al., 2004; Hirut, 1997). Even though the law permits property ownership, the reality goes in opposition (Hirut, 1997). This has made women dependent on men "as land is the main source of shelter and livelihood and these women are highly disadvantaged due to their lack of access to farm income during marriage and especially in case of divorce" (Aster et al., 2002:59).

Therefore the burden of poverty falls disproportionately on women and they face greater difficulties than men in surviving and overcoming poverty (NCTPE, 2003).

Yodanis (2004), in a cross-national study on the relationship between gender inequality and violence found that the status of women is related to the prevalence of violence against women. Violence against women tended to be higher where the status of women was low. Stromquist (1987) also asserts that women regarded as autonomous in their societies were less likely to be beaten. In fact, violence is more likely in societies where only men control resources and conflicts are resolved by physical violence.

This was also the case in Ethiopia, where it was found in the research on nine ethnic groups that women were perceived to have low social status, all ethnic groups had proverbs degrading women and beating wives and children was also common in all ethnic groups studied (Habtamu et al., 2004). As women are economically dependent on men, they are forced to stay in abusive relations since they have few other options.

Other studies also make it clear that violence against women is exacerbated by poverty and poverty related stress (Bunch et al., 1998).

It is a well known fact that poverty not only predisposes women to violence, but also to HIV/AIDS (Beneria, 1996; De Bruyn, 1992). Due to the absence of sustainable livelihoods, there is a high rural to urban migration in search of work (Cohen, 1998). In areas where there are food shortages, efforts are geared towards obtaining food instead of treating and preventing HIV. Ethiopia has recurrently been hit by droughts and the poverty situation is aggravated. As a result starving mother begging with their children is commonly seen in the streets of Addis Ababa and elsewhere. Since most women are uneducated, they will find employment only as housemaids, bar and commercial work, which increases their vulnerability to HIV/AIDS.

Women due to poverty exchange sexual services for money where they forego safer sex concerns for monetary gain (Tallis, 2002). This increases their vulnerability to HIV; it also reduces their ability to negotiate safer sex and provides dynamics for partner change which is even riskier. Sex is also driven by economic reasons, where young girls and women due to poverty become engaged in transactional sex, (Dixon Mueller, 1993) fuelling the AIDS epidemic.

In a study on commercial sex workers in Addis Ababa, it was estimated that there are between few thousand to hundred thousand female commercial sex workers in the city. This figure has a wide range, which the study attributed to the absence of prior estimates of the total size of the commercial worker population. These groups are vulnerable to HIV. In spite of their high condom usage, their sex clients' resistance to condoms has made it difficult for them to use condoms regularly. It was also found out that most of the sex workers were young (between 15–25 years) and their sole reason for being engaged in sex work was economic, linking poverty with sex work (FHI, 2002).

As explained earlier, time poverty of women delays women's health seeking. Women do not have adequate time to take care of themselves, they are usually malnourished (EDHS, 2006; World Bank, 2005). This also increases their risk of infection (Tallis, 2002) including HIV/AIDS as their ability to withstand diseases including HIV is diminished.

On the other hand, poor HIV positive women with babies cannot afford infant formulas and have little access to clean water thus they breast feed their babies even if they are aware of the risks of transmitting the virus to their babies. In any case, traditionally, women are expected to breastfeed their children. As poor women live in crowded residential areas, they fear that if they do not breastfeed, their neighbors will suspect that they are HIV positive and therefore they breastfeed their children (Tallis, 2002).

Not only does poverty lead to HIV but also HIV leads to poverty as well which Cohen (1998) refers to as a 'bi-causal relationship' in that HIV entails the impoverishment of those infected and affected in that resources are diverted to the care of those infected by HIV. HIV affects the productive segment of the population, depleting nations of their economic forces, which entail negative effects on labor productivity and output and thus intensifies poverty (World Bank, 2005).

### **2.1.5 The Social Construction of Sexuality**

**The AIDS pandemic has brought attention to the subject of sexuality (Dixon-Mueller, 1993; McFadden, 1992). Sexuality is a broad term not only limited to biological factors but the perceptions and belief of people considered appropriate, normal and desirable (Holland et al., 1990: 339). It is a social construction.**

Gupta (2000) defines sexuality as:

*...distinct from gender yet intimately linked to it. It is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behavior; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality*  
(2000:2)

Gupta goes on to elaborate that power is fundamental to both sexual and gender relations. In heterosexual relations, power relation between women and men is significant in negotiating safe sexual behavior (Holland et al., 1990: 339). The unequal balance of power in gender relations favors men and translates into unequal power balance in heterosexual relations, as men have greater control than women over when, where and how sex takes place.

Thus the power imbalance between men and women in gender relations curtails women's sexual autonomy and enhances male sexual freedom, thereby increasing both genders' risk and vulnerability to the HIV epidemic (Gupta, 2000). It also affects women ability to obtain treatment and support when a health concern arises (Amaro, Raj and Reed 2001; Gupta, 2000; Holland et al., 1990).

In the unequal relation between women and men, men's drive and needs are identified as natural (Amaro, Raj and Reed, 2001). Women who assert their desires and needs are considered as unnatural (Holland et al., 1990:340) and are given different names. Consequently, to avert this, women suppress their feelings and comply with the demands of men, even if it poses a health threat.

Representation of a woman's sexuality have been dualistic (Faunce and Phipps–Yonas, 1979) in that either a woman's lust is considered as insatiable and dangerous to man (such as wicked Eve tempting Adam) or a woman as having little or no sex drive with motherhood as her only responsibility. This dualistic view or sexual double standard has resulted in dichotomizing women as either a 'good woman' or a 'bad woman' with 'good woman' (mother and wife) being disinterested in sex and ignorant about sexual matters and 'bad woman' as being sexually available and knowledgeable. Whether they are considered as more sexual than men or less sexual than men, "women's sexuality is defined only in relation to men...either way, biology is their destiny" (Faunce and Phipps–Yonas, 1979: 229).

This sexual double standard expects women to be virgins, ignorant about sex and passive in sexual interaction (Gupta, 2000; Holland et al., 1990). The expectation of virginity before marriage is exclusively emphasized on women (Stromquist, 1987).

As in most cultures in Ethiopia, a girl is required to be virgin upon her first marriage. On the wedding night, the groom is expected to deflower the bride and announce his conquest by a piece of cloth with the blood to the waiting crowd. Under such circumstances, the girls are usually forcefully deflowered. "Thus the first sexual experience for a girl is an institutionalized rape" (NCTPE, 2003: 133). On the other hand, in her first marriage if a bride is not found to be virgin on her wedding night, she is beaten, tortured and disgracefully sent to her parents, returning the dowry she was given, with a consequence of shame on them. However, her husband is not expected to be virgin before marriage (Wuleta, 2002).

To ensure virginity before their marriage, girls are married off at a very young age. The pervasiveness of harmful traditional practices such as early marriage and abduction in addition to the risk of child bearing at a very young age is associated with high prevalence of sexually transmitted diseases, divorce and partner changes thus increasing the vulnerability of young girls to HIV/AIDS (Dixon-Mueller, 1993). In addition, myths surrounding virginity put very young girls at risk of sexual coercion thereby increasing their vulnerability to HIV/AIDS.

In countries where a significant portion of the population is illiterate, proverbs and songs convey the societies' beliefs and attitudes towards women and their sexuality. Sexual violence is even perpetuated through proverbs and songs. For instance, it is frequently cited that “ጎረቤት ለጎረቤት ሆኖ ለጎረቤት ሆኖ” “yeseit ina yemasero tinish yelewim” translated to English it means, there is no such thing as a small clay pot nor a small woman. It means even though a pot is perceived to be small, it can hold more and no matter how young she is a girl is capable of sexual intercourse. This saying condones sexual violence against very young girls and attempts to rationalize sexual violence. It also dehumanizes women using the analogy of a woman compared to an object— a clay pot. It also portrays a woman as a passive recipient of male sexual act.

Songs also perpetuate sexual violence especially against minors. One such example is, “ጎረቤት ለጎረቤት ሆኖ ለጎረቤት ሆኖ” “Beasramist ametwa tignegn beneberech, inde damakese medhanit neberech” Translated to English, it means had she been found when she was fifteen years old; she would have been as medicinal as *damakese*<sup>15</sup>. This song implies how a person had enjoyed having sex with a 15 year old girl. This song perpetuates that sex with young girls is enjoyable to the extent that it is medicinal.

Stromquist (1987) asserts that the discrimination and subordination of women has its ideological foundation in the social construction of sexuality. The social construction of sexuality is linked with concepts of masculinity and femininity. Both women and men are molded by ‘feminine’ and ‘masculine’ roles through socialization; as to what women and men should and shouldn’t do. These different prevailing ideas about sexuality contribute very significantly to the spread of HIV/AIDS.

Men are very often made to believe that male sexual needs are strong and because of this they can easily succumb to the seduction of women. Such notions make men appear governed by instincts, unable to control their sexual behavior and are depicted as victims of female power. As a result, men are excused for not behaving responsibly (for example not using condom). Women in comparison are supposed to be passive in sexual interactions and responsible for the consequence (Amaro, Raj and Reed, 2001; Negussie et al., 2002). In reality, researches have found that the frequency and type of

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<sup>15</sup> An indigenous Ethiopian herb used for treatment of several ailments.

sex women engage in are mostly determined by men. Such behavior condone sexual coercion on women by men including rape as part of masculine behavior.

Thus, female sexuality has been deliberately ignored, hidden and regarded as a private matter and not even discussed openly within or outside families (Stromquist, 1987). As in many countries, in Ethiopia teenagers are not informed about sexuality (Dixon-Mueller, 1993; NCTPE, 2003). The culture of virginity before marriage also restricts young women from inquiring about sex for fear of being labeled promiscuous by the society. This keeps many young girls ignorant about issues related to sexuality (Gupta, 2000). Thus, many young people lack vital information regarding safe sexual behaviors in general and sexual decision making in particular (Dixon-Mueller, 1993; Negussie et al., 2002).

At institutional level, sex education is rarely given, when given “provide knowledge about reproduction but avoid sexuality by translating the phenomenon of procreation into dry biological processes” (Stromquist, 1987:40). It is also considered vulgar, offensive and culturally inappropriate to explicitly mention words associated with human sexuality such as genitals and sexual acts.

It is interesting to note that there is a wide practice of commercial sex work which has a long history and is not considered a crime in Ethiopia. It is implicitly tolerated and accepted as a way of life (Arada Sub-city Eco Project, 2004; Family Health International, 2002).

On the other hand, women in relationships are powerless to decide if and when to have sexual intercourse as well as discuss condom use with their partners. Women usually meet their female friends at church and when they make appointments to meet the next day at church they usually say “”ፎታ ማሳሰቢያ” ” “wondochu indasaderun” which means it depends on the men (as it is forbidden to go into church compounds if they had sexual intercourse the previous night). This clearly indicates that men dictate and women are powerless to refuse sex. Due to the fear of being accused of infidelity and ensuing retribution (Dixon Mueller, 1993), women are reluctant to buy condoms because they fear being accused of wanting to entice or seduce men.

## 2.2 THEORETICAL BACKGROUND

*A theory in the broadest sense offers a general account of how a range of phenomena are systematically interconnected; by placing individual items in a larger context, it increases our understanding of both the whole and of the parts constituting that whole. Because people want to make sense of their worlds, for the sake of intellectual satisfaction as well as practical control, every human society develops theories designed to organize reality in ways that make it intelligible*

(Jaggar and Rothenberg, 1993: 75)

Many studies have been conducted on the issue of gender based violence from different disciplines such as anthropology, criminology, psychology, public health, social work and sociology (Ahuja, 1979; Jasinski, 2001). These multitudes of studies have enhanced awareness of the issue of violence against women as well as contributed to the development of different methodologies they deemed appropriate to address the issue (Gelles 1985; Jasinski 2001). In addition, it has helped researchers towards developing theoretical explanations that will assist in the understanding of violence against women (Jasinski, 2001).

These theoretical frameworks for studying and understanding the issue have helped to dispel some long held myths that place the blame on women for violence perpetrated against them, such as, women dressing provocatively or triggering abuse from their partners (Jasinski, 2001). Multi-disciplinary efforts with multitudes of competing methodologies and theories led to different analysis conclusions and prescriptions for its elimination (Ahuja, 1979; Jasinski, 2001; Kruz, 1989) with no definitive singular solution to the problem.

Theories on gender based violence have been grouped into three broad categories: intra-individual, socio-psychological and socio-cultural (Abane, 1997; Ahuja, 1979; Gelles, 1985; Habtamu, 2003; Jasinski, 2001). That is intra individual, focusing on the offender's characteristics linking the analysis to mental illness, alcohol and drugs, hormones and other intra individual phenomena; socio-psychological, examining "the interaction of the individual with the social environment"(Abane, 1997). Socio-cultural explanations of violence against women explain violence against women on a macro level, in terms of socially structured inequality and socio-cultural norms. They focus on

“Influence of social location on violence against women” (Jasinski, 2001:12). Feminist theory falls under this category. This research is guided by feminist perspective.

### **2.2.1 Feminist Perspectives on Violence against Women**

Feminist perspective places women’s subordination at the center of its analysis of violence against women (Jasinsky, 2001; Kelly, 1988; Kruz, 1989). Feminists were the first to bring about the issue of violence against women from a “private, largely invisible matter to one viewed as a social problem for which appropriate remedies should be sought” (Kruz; 1989:489) to public attention and recognition of the various forms of violence directed at women which were not named let alone recognized as a fundamental violation of human rights (Kelly, 1999).

Earlier, feminists such as Susan Brownmiller (1976), have clearly defined rape and were instrumental in its recognition as a deliberate “conscious process of intimidation by which *all* men keep *all* women in a state of fear” (256) rather than random acts of violence committed by discorded strangers as it was previously perceived to be (Kelly, 1999).

Kelly (1999), contends that feminist theories are not monolithic, hence, a multitude of feminist definitions and analysis. Nevertheless, feminist activists have led to the recognition and naming of acts of violence directed at women such as sexual harassment. Kelly further affirms this as:

*This absence of name and social definition meant that in terms of formal knowledge these realities of women’s lives did not exist...(the) creation of knowledge has, therefore given social recognition to hidden and silenced experiences. In the process, many mythologies which served as a veil to mask the extent and circumstances of men’s violence in women’s lives were challenged...it is precisely these facts and the challenges they carry, which makes the issue of violence against women so profound and disturbing (1999:121).*

Feminist perspective shows how gender inequality is a key factor in violence against women (Kruz, 1989; Yodanis, 2004). It focuses on the concept of patriarchy (Jasinski 2001; Walby, 1994), where structures of society are male dominated with men wielding

power over women and having differential access to material and symbolic resources (Bograd, 1988). On the other hand, the patriarchal ordering of society has relegated women to a secondary status and provided men with the ultimate authority (Ferraro and Johnson, 1983). Due to this, women and men are socialized in such a manner that encourages males to associate power, dominance, strength, and virility and superiority with masculinity and submissiveness, passivity weakness and inferiority with femininity (Scully and Marolla, 1993).

According to Scully and Marolla (1993), males are taught that they have sexual needs and that there is corresponding female accessibility, this serves as an excuse for forcible sexual access. Thus this “justification for forced sexual access is buttressed by legal, social, and religious definitions of women as male property and sex as an exchange of goods” (253) Furthermore, this socialization of men and women also “prepares women to be ‘legitimate’ victims and men to be potential offenders”. Such gender socialization consequently leads male aggression to be viewed “as natural and normal part of sexual intercourse” (Scully and Marolla, 1993: 253).

Consequently, violence against women is a result of the subordinate position of women in the social structure (Jasinski, 2001), and it is used to maintain social control and male power over women (Bograd, 1988; Jasinski, 2001; Kelly, 1999; Kruz, 1989).

Structural factors of patriarchy institutionalize violence against women in that violence is condoned and inadequately addressed. The patriarchal gender division of labor is such that it assigns men to the role of provider and decision maker to the family whereas women are held responsible for domestic work and child care (Kruz, 1989).

This inequality makes women dependent on men which makes them vulnerable to violence (Habtamu, 2003) thus making it difficult for women to leave abusive relationships as they are dependent on men.

Legal institutions are dominated by men such that women encountering violence are met with legal bodies such as police, prosecutors and judges who make it difficult for the women to seek legal redress (Original et al., 2004; Walby, 1994).

### **2.2.2 Feminist Perspectives on HIV/AIDS**

HIV/AIDS so far has no potential cure. Worldwide, many people are affected and infected by HIV/AIDS. The devastation that it has caused has generated AIDS as the most debated, misunderstood and feared diseases in human experience (Treichler, 1999). Fears of HIV continue to haunt society at large. AIDS is multidimensional affecting every facet of people's lives. Treichler (1999) asserts this by saying "In multiple, fragmentary and often contradictory ways, we struggle to achieve some sort of understanding of AIDS, a reality that is frightening, widely publicized and yet finally neither directly nor fully acknowledgeable" (1999:10).

She continues to argue that AIDS is not only constructed through medical discourses but also through language. The meanings given to it with "its genuine potential for global devastation, the AIDS epidemic is simultaneously and epidemic of transmissible lethal disease and an epidemic of meanings and signification" (Treichler, 1999:10).

It is increasingly becoming apparent that AIDS is affecting more women especially young women. It has made a big impact on women's lives. It has infected and affected them and has become a leading cause of death for women (Amaro et. Al., 2001).

Various researches have been conducted regarding women and there are different articles and books written about HIV/AIDS. However, women's perspectives were not included in HIV researches. These researches were male centered with little regard for women; when they included women, they focused on women in relation to their partners as infecting their sexual partners or children as transmitting the virus to their children. This has also resulted in limited understanding of HIV in women. As a consequence, the needs of HIV positive women were regarded as secondary to men and children (Amaro et.al. 2001). In addition, AIDS symptoms were based on the manifestations of the disease in men and symptoms of the disease in women especially gynecological ones were not given due attention. This has led to the late detection of HIV in women (McFadden, 1992).

Long and Messersmith (1998), have asserted that there is no integrated feminist theory on HIV/AIDS, but argue that HIV/AIDS addresses the critical feminist concern for women's control over their bodies and it is socially constructed. The fact that AIDS is socially constructed reveals the gender disparity in societies and shows HIV as it stems

out of gender inequality which automatically qualifies it as a feminist agenda. The AIDS pandemic has clearly demonstrated that women's low status in society increases their risk of HIV and decreased their ability to obtain treatment and support when a sexual health concern arises (Amaro, Raj and Reed, 2001).

## **CHAPTER III**

### **3. FINDINGS AND DISCUSSION**

#### **3.1 Socio-Economic Background of Survey Participants**

This chapter explores the perceptions of violence against women and HIV/AIDS by the community, families and women themselves. It also looks into sexual violence and HIV/AIDS from women who experienced it, their disclosure, and response and support they received. This chapter is, therefore, based on the in-depth interviews, questionnaires, focus group discussions and observations, conducted. It also highlights the socio-economic background of survey participants to give the personal, family background and living conditions of the participants.

##### **3.1.1 Socio-Economic Background of HIV Positive Participants**

As shown in Table 3.1, the majority (60%) of the questionnaire respondents were female while 30% were male. This marked gender disparity due to the fact that SWAA-E mainly targets HIV positive women and their families. Hence food-aid recipients were mostly women and orphans and included only fewer men.

Considering age composition, though there were respondents from different age groups, the majority fell within the 25–34 year old age bracket. Again, young women make up the majority in the age group of 18–34. It is apparent that young women in their prime age of reproductive years are becoming infected by the virus and make up the majority of the HIV-infected group. Obviously, this has adverse reproductive consequences for these women in the prime age of their reproductive years.

The education level of respondents varied from secondary education to those not able to read and write. Of all respondents (both female and male), thirteen had secondary education (grades 9–12); ten have completed elementary education (grades 1–8); one is able to read and write, and four of them are illiterate. The education level of female respondents is mostly elementary (28.57%); three of them had no education and only one is able to read and write. Women make up the majority in the category of those who are merely able to read and write only and not educated.

The occupational profile of the respondents indicates that they were mainly engaged in the informal sector, clustered in low-paying occupations such as daily laborer and petty trader. Seven female respondents were housewives and three were students and ten were unemployed. The main reason for these people's joining an organization that assists people living with HIV/AIDS (PLWHA) is poverty. Their occupational distribution is a clear indication of their low economic capacity in dealing with the effects of HIV/AIDS.

As for marital status, twenty-five respondents were married, divorced or widowed (with married and widowed categories dominating this group) while seven respondents were single. The majority of the respondents had children to take care of, which depicts that they have dependents and are in need of additional resources to sustain them. The immediate need of these people is food, which is why they are enrolled in the food-aid program.

Their living arrangement is such that majority of the respondents (twenty) live alone, while seven respondents live with their spouses, another seven respondents live with their siblings, seven respondents live with their children, six of the respondents live with their parents and two respondents live with their friends.

The following table summarizes the socio-economic background of HIV positive questionnaire respondents.

**Table 3.1 Socio-Economic Background of HIV Positive Participants**

No	Item		Female	Percentage	Male	Percentage	Total	Percentage
1	Sex		30	<b>61.22%</b>	19	<b>38.78%</b>	49	<b>100.00%</b>
2	Age	18–24	7	14.58%	1	2.08%	8	16.67%
		25–29	9	18.75%	8	16.67%	17	35.42%
		30–34	9	18.75%	7	14.58%	16	33.33%
		35–39	1	2.08%	4	8.33%	5	10.42%
		40–44	0	0.00%	1	2.08%	1	2.08%
		45–49	0	0.00%	0	0.00%	0	0.00%
		50+	1	2.08%	0	0.00%	1	2.08%
3	Place of Birth	Urban	19	40.43%	7	14.89%	26	55.32%
		Rural	9	19.15%	12	25.53%	21	44.68%
4	Education	No Education	3	10.71%	1	3.57%	4	14.29%
		Read and Write	1	3.57%	0	0.00%	1	3.57%
		Grades 1–8	7	25.00%	3	10.71%	10	35.71%
		Grades 9–10	4	14.29%	2	7.14%	6	21.43%
		Grades 11–12	3	10.71%	4	14.29%	7	25.00%
		College	0	0.00%	0	0.00%	0	0.00%
5	Marital Status	Single	5	15.63%	2	6.25%	7	21.88%
		Married	3	9.38%	7	21.88%	10	31.25%
		Divorced	3	9.38%	1	3.13%	4	12.50%
		Widow/er	7	21.88%	4	12.50%	11	34.38%
6	Occupation	Housewife	7	14.00%	0	0.00%	7	14.00%
		Daily Laborer	10	20.00%	10	20.00%	20	40.00%
		Student	3	6.00%	0	0.00%	3	6.00%
		Private Trader	4	8.00%	6	12.00%	10	20.00%
		Unemployed	6	12.00%	4	8.00%	10	20.00%
7	Children	None	9	18.00%	9	18.00%	18	36.00%
		One	12	24.00%	6	12.00%	18	36.00%
		Two	6	12.00%	3	6.00%	9	18.00%
		Three or More	5	10.00%	0	0.00%	5	10.00%
8	Currently Live	Alone	10	20.41%	10	20.41%	20	40.82%

	Husband/ Wife	4	8.16%	3	6.12%	7	14.29%
	Brother / Sister	5	10.20%	2	4.08%	7	14.29%
	Mother /Father Parents	4	8.16%	2	4.08%	6	12.24%
	Children	7	14.29%	0	0.00%	7	14.29%
	Friends	0	0.00%	2	4.08%	2	4.08%

\* Respondents did not reply to all questions

The Living condition of HIV positive questionnaire respondents is presented in Table 3.2 below. As can be seen from the table, the housing condition<sup>16</sup> of the respondents shows that nineteen respondents live in houses they rented from individuals, eleven live on a co-resident arrangement (*debal/ tigezna*), fourteen live in Kebele houses and five live in their own houses.

**Table 3.2 Living Condition of HIV Positive Participants**

No.	Item		Frequency	Percentage
1	Housing condition	Own Home	5	10.2%
		From Individual	19	38.78 %
		Kebele	14	28.57 %
		Co-resident	11	22.45%
			<b>49</b>	<b>100%</b>
2	Number of rooms in the house	One	34	73.91%
		Two	9	19.57
		Three	0	0.00
		More than four	3	6.52
			<b>46</b>	<b>100.00</b>
3	Do you have running water in your house?	Yes	13	27.66
		No	34	72.34
			<b>47</b>	<b>100.00</b>
4	Do you have a toilet in your house?	Yes	29	<b>65.91</b>
		No	15	<b>34.09</b>
			<b>44</b>	<b>100.00</b>
5.	Do you have electricity in your house?	Yes	37	77.08
		No	11	22.92
			<b>48</b>	<b>100.00</b>

NB. Respondents did not give replies to some questions.

<sup>16</sup> One can rent a house in Addis Ababa from the government, the Kebele ( it is cheaper and reliable), individuals (commonly known as private individual), co-resident (commonly referred to as *debal/ tigezna*)

From the above table it can be seen that the majority of respondents live in houses they rented from individuals. Most live in one room houses since most replied that they had children they are bound to live in one room with their children or others.

The majority have also indicated they have no running water in their homes. Those who did not have running water in their homes replied they buy the water for their daily use. The majority of respondents also said they had toilets in their homes. The majority of respondents have also indicated that they have electric light in their homes; only 11 respondents did not have electricity in their homes. Living in the middle of the capital city and not having the basic facilities such running water and toilets at home is a clear indication that of their poor living conditions.

### 3.1.2 Socio-Economic Background of Respondents of Kebeles 03/09 and 04/05

The profile of respondents from Kebeles 03/09 and 04/05 is presented in the following table:

**Table 3.3 Socio-Economic Background of Participants from Kebeles 03/09 and 04/05**

No	Item	Respondent	Frequency	Percentage
1	Sex	Male	98	49%
		Female	102	51%
			<b>200</b>	<b>100%</b>
2	Age	18–24	57	29.08%
		25–29	30	15.31%
		30–34	37	18.88%
		35–39	22	11.22%
		40–44	23	11.73%
		45–49	0	0
		50+	27	13.78%
		<b>196</b>	<b>100%</b>	
3	Education	No Education	20	10.64%
		Read and Write	18	9.57%
		Grade 1–8	36	19.15%
		Grade 9–10	37	19.68%
		Grade 11–12	46	24.47%
		Diploma	6	3.19%
		Degree	25	13.30%
		<b>188</b>	<b>100.00%</b>	
4	Marital Status	Single	86	43.22%
		Married	76	38.19%
		Divorced	12	6.03%
		Widow/er	15	7.54%
		With Partner	10	5.02%
		<b>199</b>	<b>100%</b>	

5	Occupation	Civil Servant	35	17.86%
		Commercial Sex worker	3	1.53%
		Daily Laborer	39	19.90%
		Housewife	31	15.82%
		Pensioner	6	3.06%
		Petty Trade	28	14.28%
		Student	35	17.86%
		Unemployed	19	9.69%
			<b>196</b>	<b>100.00%</b>

NB. Respondents did not give replies to some questions.

As can be seen from the above table, an almost equal number of males and females participated in the survey where the number of females is greater by four persons. This survey was conducted based on willingness of respondents to participate in the survey; an absolute number in the sex composition respondents was not achieved.

The respondents are from varied age groups but, majority were in the younger age group between 18–34. The respondents' educational attainments varied from elementary to college education; 16.49% had college level education while the majority (44.15%) had secondary education, 19.15% had elementary education and 9.57% were able to read and write and the remaining 10.64% had no education.

Among the respondents, 43% currently live with their partners, whereas 43% were single, 8% are widowed and 6% are divorced. Their occupations are varied 19.90 % work as daily laborers, 17.86% are civil servants, 17.86 %, are students, 15.82 % are housewives, 14.28 % are engaged in petty trade, 9.69 % are unemployed and 3.06 % are pensioners, while 1.53 % are commercial sex workers.

### **3.2 What Can A Woman Do? Women's Experiences of Sexual Violence**

Though the extent of violence against women especially sexual violence is not fully known in Ethiopia, there is evidence to indicate that it is widely prevalent (Original et al., 2004; WHO, 2002; Yemane, 2004) but grossly underreported. Sexual violence also directly increases women's vulnerability to HIV/AIDS.

Poverty is another factor that contributes to women's vulnerability to sexual violence. Poor girls and women are particularly at risk because they are forced to work in situations that make them vulnerable to sexual violence and abuse (WHO, 2002), such as working late at night. Typical examples are very young girls (especially in Addis

Ababa) who sell *Kolo*<sup>17</sup>, tissues and chewing gum after school on streets and in bars, groceries and drinking houses to help their needy families.

Poverty drives young girls and women from rural areas to migrate to cities in search of better opportunities and lives for themselves as well as to help their families (Erulkar et al., 2004). Since many of them are uneducated, they have limited options available to them, such as commercial sex work (Yegomawork et al., 2003) or domestic employment (Erulkar et al., 2004). They are forced to be engaged in high risk behaviors for economic reasons. Young female street adolescents are also at risk of sexual violence; for example, a study on sexual violence against female street adolescents in Addis Ababa revealed that there was high prevalence of rape of female street children (Mitike et al., 2002).

Women and girls are also exposed to harmful traditional practices such as early marriage and abduction, which are still prevalent in Ethiopia (EDHS, 2006; NCTPE, 2003; WHO, 2002) According to the Ethiopian Demographic and Health Survey of 2005, 12.7 % of women are married at the age of 15 (EDHS, 2006). In their study “The Experience of Adolescence in Rural Amhara Region Ethiopia” Erulkar et al., (2004a) found out that girls were married by the age of ten, the majority did not know they were given away through marriage until the eleventh hour when the groom comes to take them away— nor did they know their husbands beforehand. The marriage was mostly non-consensual. It was also found that the girls’ first sexual encounters were often early, unwanted, and forced. Their husbands were usually much older than themselves and sexually more experienced.

Young girls, when going out of their homes to fetch water, to the market or to school (NCTPE, 2003) are abducted, raped and made to marry the perpetrators. This is because once they lose their virginity without marrying; they are considered non-marriageable (NCTPE, 2003). Hence, with least prospect for marriage, for fear of stigma and through social pressures, these young girls consent to the marriage to their abductors. On the other hand, to preserve their family honor, parents readily agree to such marriages of their daughters to their abductors. Thus, cases of abduction are resolved through

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<sup>17</sup> Kolo is a snack made of roasted grains, usually barley, wheat, peas and beans.



physical trauma as a result of sexual violence, women experience various psychological symptoms such as depression (Mitike et al., 2000; Yegomawork et al., 2003).

Despite the fact that men are responsible for such criminal acts, women still cover up the incidents and blame themselves and have feelings of shame or embarrassment about being sexually violated and avoid disclosing their victimization. This will have a negative impact on their recovery from the trauma they experienced (Littleton and Radecki, 2006).

In Ethiopia, as in many parts of the world, the extent of sexual violence is not fully known (WHO, 2002). As also mentioned, previously, the police, health service institutions, non-governmental organizations (NGOs) and survey researches are sources of data on sexual violence. This paucity of data is mainly attributed to the small portion of women who report their sexual victimization (Original et al., 2004; Rozee and Koss, 2000; Smith, 1994; WHO, 2002; Yemane, 2004).

Anannia (2000) pointed out that it is “traumatic” and “difficult” for women to report rape and secure conviction. Their reluctance to report sexual abuse according to him is their fear that it might affect their place in society if it was known that they were sexually abused. They would as a result become outcast in their community or fear of embarrassment of people pointing their fingers at them.

*The fact that so many women do not discuss the violence with anyone else indicates either that they consider it such a normal feature of life that is not worth mentioning or that they are ashamed of the violence and therefore prefer to suffer in silence ... women who experience violence receive little support to help them cope with their situation (Yegomawork et al., 2003:27).*

Reid (1993) as quoted in Amaro and Raj (2000), described being silenced for women as “having no access to dialog and decision-making” (Amaro and Raj, 2000:7). All in all, researches indicate that women’s silence about sexual violence emanates from “...fear, embarrassment, self-blame, confusion and ignorance of their legal rights” (Original et al., 2004:251).

Focus group discussants also confirmed that there was indeed sexual violence; most victims of sexual violence were young girls and mentally disabled girls and women. They also voiced that there are few supports for women victims of violence especially sexual violence. However, when sexual violence occurred at home, the victims having no where else to go and since the families were economically dependent on the perpetrator, they were unable to report such cases. Victims were also blamed for having brought it on themselves by citing anecdotes about the issues. It was also found out that women withdraw their cases because “most of them are economically dependent on their husbands and are afraid of being chased out of their homes if they persisted on pursuing their cases” (Original et al., 2004: 125).

Other factors for victims of sexual violence’s non-disclosure of abuse are the attitudes of the society towards sexual victimization and the lack of institutional support extended to these women. One of the most enduring misconceptions, commonly expressed, is that sexual violence is the fault of the woman, due to her behavior or her way of dressing. Such attitudes also increase the likelihood that perpetrators do not have to face the consequences of their crimes, and that women will be disbelieved when reporting the crime if it ever goes to court.

**Table 3.4 Kebele Residents’ Attitudes towards Women who Encountered Sexual Violence**

No.	Why Do Women Encounter Sexual Violence?*	Frequency	Percentage
1.	Because they are weak	76	39.38 %
2.	Their way of dressing	61	31.61 %
3.	They asked for it	32	16.58 %
4.	They went out alone at night	21	10.88 %
5.	Other	3	1.55 %
		193	100%

\* Some respondents did not reply

When asked why women encounter sexual violence 39.38 percent of the questionnaire respondents of Kebeles 03/09 and 04/05 thought it was because they were weak, 31.61 percent of respondents thought it was because of their way of dressing, 16.58 percent

believed the women asked for it and 10.88 percent thought it is because women went out alone at night 1.55 percent gave other reasons. This clearly indicates that the community places the blame of sexual violence squarely on women. Which is usually the stereotypical image of women victims of sexual violence by communities worldwide (Heise, 1999).

Violence is condoned and accepted in Ethiopia (EDHS, 2006). This is illustrated in the 2005 Ethiopian Demographic Health Survey, when survey participants were asked whether a husband is justified in beating his wife; a high proportion of respondents agreed that wife beating is acceptable to them. Interestingly, three-fifths of female respondents believed that a husband is justified in hitting his wife if she burns the food or argues with him (EDHS, 2006).

Not only this attitude but also the assistance given to women encountering violence is such that people are reluctant to interfere if they think that a man and a woman are related.

This is illustrated by responses from residents of Kebeles 03/09 and 04/05. When asked, “What do you do if your neighbor’s wife was beaten by her husband and came to you for assistance?”, the majority of respondents 39.57% said they will mediate, 32% said they’ll take her to the police, whereas 10.70% said it is none of their business, and 9.09% said they will beat the perpetrator. Typically crimes committed on women are concluded through arbitration usually by ገጠናው ‘shimagilewoch’ male elders as it is a “culturally accepted practice” (Original et al., 2004), and the elders being men lean towards the perpetrator and even if their victimization is apparent, women are pressurized to reconcile on the pretext of saving the marriage and ‘for the sake of the children’. This one focus group discussant whose husband deliberately infected her with HIV encountered:

*After I told them what happened, they did not say anything to him, instead they said to me “እኛን ነው ማሸነፍ” “anchin new yeminashenifew” (translated to English, it is you whom we can win over), after what he did. (W/o M, a focus group discussant)*

Women’s voices are silenced – not only by the discrimination and violence they face, but also by the failure of the state to protect them, investigate abuses and punish perpetrators (Original et al., 2004). In fact, 56.5% of both female and male questionnaire respondents of Kebeles 03/09 and 04/05 agreed that perpetrators of sexual violence do not get punishment commensurate to the gravity of the crime they committed. This is also explicitly illustrated by Original et al (2004) as: “In majority of cases of sexual violence against women the penalties pronounced by the courts are unfitting to the crime because they tended to be on the lower side” (2004:237).

In a focus group discussion, women discussants also clearly stated that concerned authorities like the Kebele and police are not of help to them when they encounter violence. This opinion is also shared by respondents of Kebele 03/09 and 04/05; it is illustrated in Table 4.2 below.

**Table 3.5 Kebele Residents’ Opinions on Institutional Responses to Sexual Violence**

No.	Questions	Responses		
		Yes	No	Total
1.	Do you depend on police for your protection?	49.74%	50.26 %	100.00%
2.	Do Kebeles assist women victims of sexual violence	63.04%	36.96 %	100.00%
3.	Do health care services give adequate services to women victims of violence	65.24%	34.76%	100.00%
4.	Do perpetrators get due punishment	43.5%	56.5%	99.10%

The majority (50.26%) responded that they do not depend on police for their protection. On the other hand, 63.04 % and 65.24% believed that Kebeles and health care services respectively gave assistance to victims of sexual violence.

The fact that women are victimized does not necessarily mean that they are passive victims or powerless, “in fact women have proven incredibly capable of exerting agency even within constrained social conditions” (Heise, 1995:125). Women often

devise different strategies to reduce male violence directed at them and their children, W/o Elfinesh, a key informant has this to say of her husband who used to be abusive:

*He used to come home drunk and beat me for no reason. I could not stand his beatings so I went to my aunt and stayed there. However, my children suffered due to my absence. As a result I reconciled with my husband and came back. But he did not stop his abuses. He beat me only when he was drunk, thus I hid outside when he came home and did not return until he was asleep. This way I avoided being beaten (W/o Elfinesh, key informant).*

### **3.3 Life with HIV/AIDS**

As discussed earlier, women and girls are most vulnerable to HIV/AIDS. Ethiopia has one of the highest numbers of people living with HIV/AIDS (Kumsa, 2004; Shinn, 2001). Women constitute the majority of people living with HIV/AIDS in Ethiopia (Kumsa, 2004; FDRE, Ministry of Health, 2006).

#### **3.3.1 Coming to the Experience of AIDS**

As stated earlier, in Ethiopia, sexuality issues are not openly discussed (Wuleta, 2002). HIV being mainly transmitted through heterosexual contact is laden with negative traits such as promiscuity, involvement with commercial sex workers and immorality where the persons are shunned by families and the community at large (Anania, 2000). This has contributed to the reluctance on the part of the general public to take HIV tests. However circumstances such as persistent illness, partners' or children's illness and when processing visas for travel abroad have made testing unavoidable for some women.

For Mulunesh, (her case is detailed in chapter 4) it was her life threatening persistent illness. Workitu on the other hand was ravaged by sores on her body and she had to

seek cure for it. Other PLWHA too disclosed that they had “ጎጠጥ ህጽቅ”<sup>18</sup> ‘Almaz balechira’ herpes and took “Mamo’s<sup>19</sup> medications” for this condition.

For Beza ,(her case is detailed in chapter 4) her reason for testing for HIV was that she was going abroad and the test was required for securing visa. This is also the case for many young women who come to know of their HIV status.

**Unfortunately, Beza did not get the necessary counselling before and after testing for HIV, which would have made her diagnosis less traumatic. This clearly illustrates the benefits of HIV awareness campaigns such as information education and communication (IEC) given to the masses which will not only raise people’s awareness of HIV/AIDS but also motivates people to test for HIV and know their HIV status. It is exactly this environment that influenced Senait’s to decision to test for HIV.**

**Women’s decision to test for HIV/AIDS, as indicated above is also motivated by the illness or death of a husband or child as illustrated by the story of the following woman:**

*My husband and I were married through ስጋ “kurban” (Holy Communion)<sup>20</sup>. We had two children, we led a comfortable life. Then my husband started getting sick, He went to the hospital, however he could not get well. I took care of him. I spent all our assets for nursing him. However he died, a few months after his death, as I was sorting his personal belongings, I found his ID card which stated he was a*

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<sup>18</sup> Persons who have this affliction have sores all over their bodies.

<sup>19</sup> He is a renowned traditional herbalist who is believed to have a cure for “ጎጠጥ ህጽቅ” herpes.

<sup>20</sup> In the Ethiopian Orthodox Church, marriage with Holy Communion cannot be broken. Both the couple cannot remarry unless one of the couple dies. If one of the couple marries otherwise, it is considered adultery. In other words, couples married through Holy Communion are married for life with no room for divorce.

*member of Tesfa Goh<sup>21</sup>. I went to Tesfa Goh and they told me he was indeed their member..... I even went to his doctor .... He told me he was sorry .....Eventually I tested for HIV and found I was HIV positive.*

(W/o Tamir, a Food-aid Recipient)

### 3.3.2 Reaction to HIV Positive Diagnosis

**Women are aware of societal misconceptions of HIV/AIDS. Diagnosis with HIV/AIDS is a traumatic event for any person especially women, as they had not envisioned a life with HIV. The women disclosed their reaction when they received their HIV positive diagnosis. Their reaction varied from disbelief, hopelessness, attempted suicide, social isolation and worry for their children's future. For example, Senait's reaction was shock. Mulunesh took her HIV positive diagnosis with stride.**

**On the other hand, some women reacted violently when learning of their HIV positive status Beza's reaction was severe. Even after going home she could not be consoled. Workitu's reaction was also one of shock as Beza's.**

Thus people come to know of their HIV positive status under different circumstances and due to different reasons. HIV positive questionnaire respondents also affirm this fact. As can be seen from the table below, the majority (twenty) took the HIV test because they wanted to know their serostatus, fourteen people did so because of their

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<sup>21</sup> Tesfa Goh or Dawn of Hope is an organization which cares for people living with HIV/AIDS (PLWHA)

illness, seven people tested because they were advised to take it, and four did so for visa requirements to go abroad, one for marriage and two because of illness / death of their partners. Two people did not give any reply.

**Table 3.6 Reasons Given for Taking the HIV Test**

<i>Reason</i>	<b>Frequency</b>	<b>Percentage</b>
1. Wanted to know HIV serostatus	20	40%
2. Because of Illness	14	28%
3. Advised to take the test	7	14%
4. Going abroad	4	8%
5. Marriage	1	2%
6. Sickness/Death of spouse	2	4%
7. No response	2	4%
	50	1.00%

In taking their HIV test, 80 percent of the respondents confirmed that they were given appropriate counseling before and after they took the HIV test while 6 percent responded they did not get any counseling before and after they took the HIV test fourteen percent did not give reply.

This is a clear indication that much work remains to be done on this matter. That is, HIV information should be openly discussed and disseminated among the community on a continuous and sustained manner.

### 3.3.3 Disclosure of HIV Positive Status

As it is well known, HIV/AIDS is a fatal disease that has meanings beyond illness or health. It also has social meanings as it is strongly associated with death and sexuality (Anannia, 2000) and also death, which are both sensitive topics and not usually openly discussed.

Thus disclosure of HIV positive status is difficult for people living with AIDS, as it might entail in either positive or negative reactions. Among resultant positive reactions

are adoption of safe sexual behavior that would reduce further risk of infection (such as STDs), greater access to social, medical psychological and financial support, act as positive influence on other PLWHA and also appropriate care and support. Or it might entail negative reaction such as rejection, stigma and discrimination (WHO, 2002).

Disclosure of HIV positive status is a dilemma especially in the lives of women in that most women are unemployed and dependent on men thus at risk of losing their homes and status as well as stigmatization. This also deters HIV positive women from accessing services targeting HIV positive persons. This also contributes to the invisibility of women in the AIDS epidemic and which would have paved way to the development of intervention tailor-made to their needs (Maman et al, 2001).

Some circumstances prohibit HIV positive women from disclosing their HIV status, among which is being evicted from their houses; such is the case for Beza and Workitu.

Among HIV positive questionnaire respondents, asked whom they told about their HIV positive status, 21 told family members; 12 told friends; 2 told neighbors; 12 did not tell anyone while one told family friends and neighbors, one person did not respond to the question.

**Table 3.7 Disclosure of HIV Status of HIV Positive Respondents**

<i>Reason</i>	<b>Frequency</b>	<b>Percentage</b>
1. Family members only	21	42%
2. Friends only	12	24%
3. Neighbors only	2	4%
4 No one	12	24%
5. Family, friends and neighbors	1	2%
6. No response	2	4%
	50	100%

All in all the HIV positive persons did not fully disclose their HIV status. In fact most were selective in their disclosure in that they disclose where they deemed it less stigmatizing and with positive outcomes. All disclosed their status to the organization

staff as this would enable them to gain psychological (counseling) material and financial assistance.

In this light, these people have encountered positive outcomes due to disclosure not only do they get material and financial aid through the organization, it has also provided them with the unique opportunity to be self reliant through the income generation scheme of the organization that provides them with and also created for them a platform where they are able to meet and interact amongst themselves and share experiences. This makes them feel they are not the only ones in this situation.

This researcher has observed these people in the setting of the organization as well as at Mekdim Ethiopia, where they received their food-aid. They seem to have a high level of interaction amongst themselves and share information and also giving reassurances as well as how to deal with issues in their daily lives. This was also revealed by a key informant in the organization who affirmed that.

*It takes them (HIV positive beneficiaries) a few months to adjust to their situation and many have become self-reliant as a result of participating in income generation schemes.*

Not all HIV positive persons encountered negative reactions. In the focus group discussions conducted, some women also revealed that the stigma and discrimination has lessened and even neighbors and people in surrounding areas are sympathetic and helpful towards them. As one focus group discussant put it:

*There was no one who did not sympathize and cry with me in my anguish; they were with me in my worst moments. God bless them all! I do not get any differential treatment —we eat and drink together. We share everything. They eat and drink what I prepare; I also eat and drink what they prepare....*

(W/o Mitin, a focus group discussant)

Changes of attitude takes time, it is a gradual process. This is clearly illustrated by survey participants, where the majority of respondents believed that PLWHA are supported by the community.

### **3.3.4 Effect of HIV on Daily Lives: HIV/AIDS Related Stigma and Discrimination**

In Ethiopia as in many African countries, HIV/AIDS is transmitted through heterosexual contact (FDRE, Ministry of Health, 2006; UNAIDS, 2006; Wuleta, 2002). Issues related to sexuality are usually considered taboo and also dirty thus not openly discussed. Thus the association of HIV with sexuality has conveyed a negative connotation such as immorality of the person who contracted the virus (Anannia, 2000).

Stigma has been described as the quality that “significantly discredits” an individual in the eyes of others. It also has important consequences for the way in which individuals come to see themselves. Stigmatization is a process, quality of the way stigma adheres (color, way of talking, deformity – etc). “HIV related stigma refers to all unfavorable attitudes, beliefs, and policies directed towards people perceived to have HIV/AIDS as well as towards their significant others and loved ones.” (Health Resources and Services Administration, 2003)

Based on the renowned sociologist Erving Goffman’s classic work, Alonzo and Reynolds elaborated on the concept of stigma as:

*...a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons. When individuals fail to meet normative expectations because of attributes that are different and/or undesirable, they are reduced from accepted people to discounted ones. Thus the discrepancy between what is desired and what is actual “spoils” the social identity isolating the individual from self, as well as societal acceptance (1995: 304).*

Typically, discussions of stigma, especially in relation to HIV, have taken off from the classic work of Erving Goffman, drawing on research on people with mental illness or physical deformities or practicing behaviors that are considered deviant (such as

homosexuality). The concept of stigma has been applied to an enormous array of different circumstances such as mental illness and leprosy, and has been studied from the perspective of different disciplines (Parker and Aggleton, 2003).

Stigma and discrimination in many ways aggravate suffering from illness. It affects health seeking and even leads to the termination of treatment of a treatable health problem (Yonas et al., 2004:2). Much theory about stigma is uninformed by the lived experience of people being studied and research on stigma has an individualistic focus (Yonas et al., 2004).

HIV infection fits the profile of a condition that carries a high level of stigmatization in that people infected with HIV are blamed for their condition by people who think that HIV could have been avoided had these individuals made better moral decisions. Even though it is treatable, HIV is a progressive and incurable disease. It is poorly understood by many people in the population and that they feel threatened by it.

As a result, not only HIV positive persons but also their families and even their caregivers are treated differentially. This are manifested as rejection by community and their being forced out of their homes or losing their jobs.

In order to prevent further spread of new HIV infection, counseling and testing and early diagnosis and treatment both help the individual and society in that reduction in health care cost, early treatment of the disease and decrease in transmission from person to person and adoption of safe sexual behavior of individuals after diagnosis (Yonas et al, 2004:2)

### **3.3.5 Women's Experiences of HIV AIDS Stigma and Discrimination**

One of the barriers to disclosure of HIV positive status is stigma. Stigma whether perceived or real deters HIV positive persons from disclosing their serostatus to others including those closest to them such as families (spouses, parents and children) as well as from accessing services beneficial to HIV positive persons such as health services, support groups and organizations offering care and support to PLWHA. It poses a challenge to HIV prevention and care efforts.

AIDS related stigma is widespread around the world that it was termed as the “third phase of the AIDS epidemic” by Jonathan Mann<sup>22</sup> (Parker and Aggleton, 2003); AIDS stigma is more severe than for other chronic illnesses such as cancer (Anania, 2001).

It is increasingly becoming apparent that women experience more stigma than men (Nyblade et al, 2003; Visser, Makin and Lehobye, 2006) because women are vulnerable to HIV due to socio-economic conditions and their lack of access to resources.

In Ethiopia, PLWHA face various forms of stigma and discrimination primarily from those closest to them such as family members, friends and neighbors (Anannia, 2000) Due to the fear of stigma or fear of being hurt, many just do not disclose their HIV positive status.

PLWHA are hurt by such acts as not being allowed to share common toilets or when toilets are deliberately thoroughly cleaned immediately after the PLWHA used them creates a feeling of being dirty or unclean by the PLWHA.

Not only PLWHA but also people suspected of being HIV positive are closely scrutinized. People do not want to come in close contact with belongings of PLWHA for fear of contamination for example HIV positive women are forbidden to use clothesline as other people. Apart from the houses they rented, some women also find it difficult to sell their wares—for example, as is the case for Alemitu. In Nyblade et al’s (2003) study it was also found out that almost two thirds of survey respondents replied they will not buy food from PLWHA vendors.

Another hurtful action is verbal abuse that hurts PLWHA very much especially when it comes from close family members. One day, the researcher encountered an HIV positive home based care provides in tears. The reason was, she had a minor disagreement with her brother, whereupon her brother went out of the house and loudly said “ኃላ ስኞ ስኞ ስኞ” “ yeijishin agegnesh anchi aidsam” translated to English it means, you got what you deserved, you AIDS infested woman. Apparently the woman,

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<sup>22</sup> Founding Director of Global Program on AIDS

a recent widow had not disclosed her HIV positive status to anyone except for her immediate family to protect her eleven year old daughter.

Even religious persons are not free from acts of stigma, as illustrated by Workitu's experience with the elderly nun. Such negative reactions have forced PLWHA to internalize the stigmatizing attitudes, and heightened their sense of shame and self-hatred. Nyblade et al (2003), in their study of HIV related stigma in Ethiopia found that PLWHA often internalized the negative stigma and discrimination directed at them and feel inferior, easily lose hope and isolate themselves.

When asked how the community treats PLWHA who disclose that they are living with the virus, the majority (37.5%) of questionnaire respondents in Kebeles 03/09 and 04/05 believed that they are supported by the community, 28% believed that they are not supported and 17.5% replied that they encountered stigma and discrimination.

However, focus group discussants confirmed that the community's attitudes are changing due to the changes in the messages conveyed by the media about PLWHA. They also stated that they followed programs about PLWHA on the radio.

### **3.3.6 Coping with Life with the Virus**

When people are faced with an event especially a traumatic one such as a sudden illness, they consciously or unconsciously develop strategies to deal with their situation.

As discussed earlier in this paper, HIV/AIDS is a disease with medical as well as social dimensions. To deal with the consequences of HIV, PLWHA use various coping strategies to come to terms and adjust to their situation.

Coping is a process (Barnett and Blaike, 1994) that varies from situation to situation for any one individual. PLWHA have used different coping strategies to deal with their situation. Some have turned to religion. They went to church and prayed and took the Tsebel<sup>23</sup> as many believed it cured people of AIDS. In Ethiopia, there is a widely held belief that the Tsebel is a cure for a variety of ailments including HIV/AIDS. In

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<sup>23</sup> Tsebel is the Holy Water.

addition, in a country like Ethiopia where there are inadequate health services, the Tsebel is bound to be taken as an alternative treatment for illnesses.

Focus group discussants also believed that the Tsebel is the cure for HIV/AIDS. They even encouraged others to take it by citing anecdotes of people healed of AIDS by taking it. However, out of HIV positive questionnaire respondents, when asked what treatment they used when they were ill; 33 (66%) replied they used medical treatment, 10 (20%) said they took the Tsebel and one respondent took medications as well as Tsebel.

Still, many women come to organizations that give assistance to PLWHA. These organizations are usually accessed by women with low incomes as they have the least resources to deal with their circumstances. These organizations not only provide them materially but also give them emotional support such as listening and empathizing with them. This is revealed by Beza.

Organizations assisting PLWHA also make these women feel they are not alone in their situation. This helps them to adjust to life with the virus.

Women also cope with their illness by taking care of themselves and taking antiretroviral medications. Home based care providers interviewed asserted that due to the antiretroviral drugs many of their bedridden patients have gotten well and resumed their normal daily lives and that they have very few bedridden patients to look after.

Looking forward to the future is also another coping mechanism for the women. The concerns of the HIV positive women are primarily their children. The uncertainty of their lives worries them of what will happen to their children after they pass away (die). Nevertheless, their lives revolve around their children; they want to live to see their children grow. All respondents with children expressed their will to live for the sake of their children.

## **Chapter IV**

### **4. LIVED EXPERIENCE OF SEXUAL VIOLENCE AND HIV/AIDS: CASES OF FIVE WOMEN**

This chapter gives a view of the lives of five HIV positive women. As explained in chapter I, these women were selected from SWAA-E. All five women reportedly became HIV positive due to sexual violence. The names of all women have been changed to maintain confidentiality.

Four of the interviewees were in their twenties while one was in her thirties. This clearly depicts the vulnerability of young women in their reproductive age to sexual violence as well as HIV/AIDS.

Education wise, one has a college education, one elementary education and three were uneducated. All five women came from the rural areas to live with their relatives in town. It is apparent that all five women came to the city in search of a better future only to follow a path that they did not intend to follow. One was a student while the other four worked as housemaids before they discovered that they were HIV positive.

Four of the women had children. They conceived as a result of rape; one lost her child however; three are currently raising the children of their perpetrators with added burden and poverty. Luckily, two children were free from the virus because their mothers were tested for HIV during pregnancy and thanks to the intervention of the antiretroviral drugs and persistent medical follow-up of the mothers by health care providers. The HIV status of one child had not been disclosed.

Only one person is married, while three were never married. One fled from her husband whom she was married to at the tender age of eight. One lives in a Kebele house while three live in houses they rented from individuals, one lives rent free due to the living arrangement she made with the owner.

The commonality among all five women is their low economic status which made them access non-governmental organizations for support. Women are driven by poverty to

migrate from rural to urban areas in search of employment. Due to their low level of schooling, a common form of available employment for these poor women is domestic work. Domestic work mostly requires women to live in the same house as their employers. This living arrangement seems a solution to these women's problem of accommodation and employment simultaneously (Motsei, 1990).

Residing and working in the same place as well as their lack of economic resources makes these women vulnerable to exploitation, physical, emotional and sexual violence. Violence within the domestic sphere is "hidden" from public view (Motsei, 1990), and violence against domestic workers even more so.

Domestic employment of women is common in Ethiopia. Even very young girls as young as five and six years are employed to do various household chores as housemaids as well as nannies ( $V\acute{O}^2=f$ ) (Abiy, 2002:2). These domestic workers are powerless and dependent on their employers not only for their wages but also for food and shelter.

Their being in the private sphere also places them far from view of law. They are not protected by the laws which regulate wages, hours of work and other conditions of work (Motsei, 1990). In Ethiopia so far there are no laws regulating domestic workers.

#### **4.1 Case One**

Case Senait is a young petite person. She was selected based on her profile in the organization, which indicated that she was raped. However, Senait did not disclose this episode in the interview despite the fact that she was asked in different ways such as; if she knew of any woman who encountered sexual violence or if she had faced a situation where she was forced to do something she did not want.

*I came from the countryside in Wollo. I am 28 years old. It was my aunt who brought me to Addis Ababa. My aunt had two children. I did not get any schooling. After some time, my aunt got me employment as a housemaid. While I was working as a housemaid, my aunt died and I started living with my two cousins.*

*I continued to work in different places as a non-residential (JSLI) housemaid<sup>24</sup>, however I was not able to make it in the domestic service. Then I started to meet men I started befriending them. I stopped working as a housemaid, and started commercial sex work. I was a commercial sex worker for two years.*

*Then, I got pregnant. When I told the father of my child about my pregnancy, he told me to get lost. I single handedly raise my son, he is now five years old. I stayed at my aunt's house. I did casual works such as washing clothes, baking injera and preparing spices as a daily laborer.*

*In the mean time, I started participating in the Kebele. In a meeting at the kebele, they gave us awareness raising education on women and HIV/AIDS. They also informed us that we can take HIV tests free of charge if we wanted to. We went to be tested, there, they spoke to us before we took the test. I got tested for HIV and knew of my HIV positive status I took the test by coincidence, otherwise I would never have thought about getting tested for HIV/AIDS. I was shocked for the time being, but then, I knew that nothing will happen to me. I have not informed anyone of my HIV positive status, not even my relatives I know they eventually will know “ፍገሳ ስንገሳ ለገላ ለገላ” “baweku gize yiwoku biye” meaning let them know at their own time ... I did not tell my mother. However, my neighbors, because they were with me when I received my HIV test result know about my HIV positive status. It has been three years since I was diagnosed as HIV positive.*

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<sup>24</sup> Most housemaids work on a live-in arrangement, some work on a non residential arrangement, that is, they come in the morning and leave in the evening and go to their own homes.

*I came to this organization (SWAA-E) to get help. They give me wheat and oil. They also gave me training on starting and running my own small business. They also gave me some seed money for my business with that, I started baking injera and selling at the gulit and at my home. Now, my son has started school. I pay for his education.*

*I have not been ill so far but I take Tsebel, I have not experienced any changes in my body as well.*

*I live in a Kebele house with a communal toilet. There is no running water in the house, so I buy the water that I need for my daily use.*

*I live in a crowded neighborhood. I meet frequently with my neighbors, we eat together they know my HIV status luckily, they do not treat me differently because of my HIV positive status.*

Senait came to the city hoping for a better future. She was not aware of the danger that lied ahead. Like many women in rural areas, she did not have the opportunity to have education. As an uneducated person, she was unable to secure employment. The only employment option for uneducated women is as housemaid or commercial sex work. Senait was no different. She was consequently employed as a housemaid which was for her no better from her previous life. In fact, she encountered worse situations and became a commercial sex worker. This in turn exposed her to rape, unwanted pregnancy and eventually she contracted HIV/AIDS thereby shattering her dream of a better life. This put her into a situation of deepen poverty and helplessness.

She also has a son to raise and care for in addition to her own predicament. Despite her HIV positive status and the hardship she went through, presently she confirmed that she has not experienced the adverse ill health effects of her HIV positive status.

#### **4.2 Case Two**

**Mulunesh is a soft-spoken, woman. As she recounted her story, I could hear the tears in her voice, though it is not visibly falling down her cheeks.**

*I was born in Jiru (North Shoa). I am about 35 years old and I was educated up to sixth grade. I came to Addis Ababa about 23 years ago. Then I gave birth to my daughter. In order to raise my daughter, I worked for many years as a housemaid. At last, I got employment at the home of a "ÅLÖ? "wondelatie"*

*bachelor. One day when we were alone, my employer came and raped me ...I did not scream I kept quiet—whom would I tell? — I kept quiet.*

*When we were alone, my employer raped me— and later cajoled me and told me he will marry me. My only fear at the time was I might get pregnant not this disease. My worst fears were confirmed and I got pregnant. After some time, the man fell ill and was admitted to the hospital where he died. Upon his death his former wife and children came, since I was only a housemaid, I was forced to leave. I gave birth to a boy six months after the death of his father. My son did not live much longer; he too died after six months. I gave my daughter to a female relative and started to work by washing clothes at people's homes.*

***A year after the death of the man who raped me, I started getting sick, I went to the hospital, where I was told that I have tuberculosis (TB) and I was given medication. I still could not get better. At the health center they gave me advise that I need not worry and that I can live. When they told me about my HIV positive diagnosis, I did not feel anything ... I have God on my side, I will live.***

*I concealed information about my HIV positive status. I did not tell a single soul that I am HIV positive. I did this because I know from my surroundings how people contemptuously treat HIV positive people to the extent of denying them to use clothesline to hang their washed clothes. People are not happy about HIV positive persons; they do not want HIV positive people close to them.*

*I live in a house that I rented from an elderly widow the rent is cheap, so, many people come and stay the night, it is communal living. We live in a crowded one-room house where the toilet is also communal Living in one room with many people and not having privacy eats me up (it bothers me). Under the circumstances, I have nowhere else to go since I do not have any means to rent a room of my own. Besides, if I get sick, the idea of getting ill and lying down in*

*sickness in the same room with several people around bothers me too. This situation worries me very much.*

*If my roommates knew about my HIV positive status, it is unimaginable how they would react towards me in my most vulnerable state. Thus anticipation of this situation bothers me a lot and keeps me sleepless.*

*As the days passed by, I still did not disclose my HIV positive status to anyone living with me except the organization that helps me (SWAA-E). At present, I frequently get sick and am getting weaker, so I do not do the other work that I usually did. I only work at the dry waste disposal work (À[p qhh T'df RW). I barely manage to perform my work. These days, when you get even a common cold, people suspect you of being HIV positive. It is worse especially if you lose weight. Fearing this, I bundle up six to seven clothes so that my weight loss does not become apparent.*

*When I am in worse shape, I quietly go to private clinics as I find it difficult to go to government clinics and queue in the wee hours of the morning. Thus I save from my meager earnings to pay for my medical treatment at private clinics. They give me tablets, which gives me temporary relief but obviously not a cure. I still do not tell my health care providers at the private clinics about my HIV positive status. On the other hand, when I feel well I wash clothes and bake injera but lately I am getting weaker. I walk with difficulty.*

*Still, my biggest problem is housing. If I had one room of my own where I can sleep alone that would have done for me. As a sick person, I need food, the only food that I get is the wheat and oil the organization (SWAA-E) gives me. It has helped me a lot. A sick person needs nutritious food and it is hard to come by with my income.*

From listening to her story, Mulunesh seemed very fearful of disclosing her HIV positive status due to fear of stigma and discrimination that might follow if she reveals her HIV positive status. The only thing she wants to have is a room (not a house) of her own where she can have privacy and rest.

Her body image is low. She perceives herself as losing weight and does not want others to recognize this. She goes to great length to hide her weight loss behind a bundle of clothes as she emphatically told and showed the researcher.

#### 4.3 Case Three

Workitu is a young quiet girl with a small daughter she has an aura of sadness about her when I saw her.

*I was born in a rural area in Amara Sayint. I was just eight years old when my parents married me off to a priest. My husband and I were married with Holy Communion. I guess my parents wanted to enhance their status to be regarded highly that they allowed my marriage to take place. I was only a child I came running back to my parents and they kept sending me back to my husband. My father blamed my mother for this and he always gave her a hard time... I run away and came to Addis Ababa with my aunt.*

*Eventually, I hid and went to the nearest town, Dessie with sheep traders to my aunt. My aunt brought me with her to Addis Ababa. When I came to Addis Ababa, my aunt got me employed as a house maid. I changed many homes. I was really fed up I work in people's homes and send the money to my parents. Finally a man who worked as a guard in the house where I worked as a housemaid proposed to me. I agreed and we rented a house and started living together. We were unable to agree so we broke up and I resumed my work as a housemaid. I found this employment through a broker (ÁLL) it was at the house of a "wondelatie" bachelor. The man was living alone after he separated from his wife.*

*One evening the man telephoned and informed me that he had work to do so he will be late and ordered me to sleep near the telephone in the living room*

*so that he will telephone when he arrives and I will open the gate door for him.*

*He came home drunk at 2 o'clock in the morning and I opened the door for him. Later, he came and raped me. I could not do anything. He threatened to kill me if I mentioned this incident to another soul as it would tarnish his reputation. The main gate was far; there were two dogs in the compound...I did not yell— if I did, who would hear me? I had no witness and I was scared. I had no alternative but to keep quiet. As a result, I became pregnant and when I told him of my pregnancy, he gave me 50 birr, told me to get out and rent a house and promised that he would support me as he feared God and he was a “â?Ö?” that is, a follower of the Pentecostal church. I moved out and rented a house and started working. Eventually, I learned that he has moved out of the house to another place and reconciled with his wife. So I started living with my aunt and started working.*

*After some time, I started getting sick I had “>MT' vKB^” (herpes). I went to the traditional herbalist called Mamo. He gave me some medications, while I was taking the medications, I met an elderly man, he looked at me and advised me to go to the hospital.*

*I complied and went to the health center. I was advised to take an HIV test. When they told me I was HIV positive, I fainted and later contemplated taking poison. At the time, I can say I was crazy, I did not know where I was going and in many instances I was spared from being run down by cars. Later when*

*I went for checkup, I met pregnant women in the same situation I am in. I talked to the women and I was comforted and exchanged ideas with them. This helped me a lot, I realized I am not alone and I was reassured.*

*When I went for my medical follow-up I was enrolled in the Nigat Project, a project for pregnant HIV positive women. Some months later, I gave birth to my daughter. After a follow up of one year and a half at the Nigat Project<sup>25</sup>, I was told that my daughter is HIV negative — I was jubilant.*

*My aunt eventually learned of my HIV positive status and she moved out without informing me of her whereabouts, when I came back in the evening there were people that I did not know in the house. It was the new occupants of the house who told me that my aunt has gone and they have rented the house. But they were kind enough and allowed me to stay the night at the house.*

*As a homeless destitute woman, I had no option but to go out and beg because I had to feed my daughter and myself. I went to faraway churches where people would least recognize me and begged for alms.*

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<sup>25</sup> The Nigat Project aims to reduce the risk of transmission of HIV from mother to infant through breast feeding. It is a clinical trial to evaluate the effectiveness of the anti-HIV drug Nevirarpine in preventing the transmission of HIV from mothers to infants during pregnancy, delivery and breastfeeding. It also attempts to identify a way of making breastfeeding safe for HIV-infected mothers who opted to breastfeed their babies. Participants are recruited when they go to health centers for their antenatal visit; they are given pre/post counseling prior to joining the program (Hanna Tegegn, “Preventing the Transmission of HIV from Mother-to-child: The Case of the Nigat Project”, Project Paper Presented for the Course Seminar in Gender Studies -IGS 632)

*Eventually, the Tesfa Goh referred me to this organization (SWAA-E), as they were unable to help me. At SWAA-E, I was given food-aid, clothing for my daughter and training on starting my business and even gave me seed money for starting my own business. Had it not been for them, I would not have survived. I would have died a long time ago. I learned to work and do various works such as washing clothes. Now, I do some works when I have the energy, such as washing clothes.*

*I cannot afford to pay rent in this Kebele, so I went to the church. I currently live near the Gorgorios church (south eastern Addis Ababa). I went there because a certain girl told me that rent is cheaper there. I live on a rent free arrangement with the owner at night I sleep in a house that is used as a tearoom during the day. The Lady of the house allowed me to stay the night there free of charge so that I can look after her property during the night. This arrangement has helped me a lot because I do not have to pay rent. I did not tell her of my HIV positive status because I have no where else to go with my daughter during the day I go to the church.*

*When I went there and told the priest that I was HIV positive, the priest allowed me to take the Tsebel. I am given five liters of Tsebel to drink daily while a small amount is given to others. I am also bathed in Tsebel by the priests in the church. I am also given  $\frac{3}{4}$ "ōā " <H 'yenifro wouha'<sup>26</sup>. There are many HIV positive persons taking the Tsebel, there are many women than men here.*

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<sup>26</sup> Water of boiled grains such as wheat and beans which has been prayed upon.

*When I feel stronger, I take up any work that I can find such as washing clothes for people. There was an elderly nun who lived in the compound of the church. She hired me to wash her clothes. Eventually, she learned that I was HIV positive. She immediately made me stop washing her clothes and she told me she prayed that God deliver her from the virus she unknowingly was exposed to by having a person with AIDS wash her clothes.*

*I am now taking the anti AIDS medication so I do not take the Tsebel. I have told the priest and he is aware of this, even though he does not agree with me he has not forbidden me from taking the medicine. I now take only the yenifro wouha' and attend the mass.*

*I do not have much energy. Formerly, I used to lift up to 50 kilograms of teff<sup>27</sup> without a hitch, now; carrying my daughter is a struggle for me. My body itches day and night; sometimes I have sores on my body.*

*I buy water for my daily use and since I do not have access to toilet facilities, I use the nearby river.*

*Looking back in retrospect, I became certain that I contracted the virus from the father of my daughter. This is because when I began the anti-AIDS medication, I recalled the man taking this same medication that I am taking now in the morning and evening as I used to bring him water to take his*

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<sup>27</sup> Indigenous Ethiopian grain for making injera.

*medication with. However since I did not know what medication he was taking I did not understand it at the time.*

*I pray that God grants me my health; I wish to live with my daughter, thanking God for his blessings.*

**Workitu is a classic example of the detrimental outcomes of early marriage practiced in many rural areas in Ethiopia. She was married off at the tender age of eight years against her will. So she had to run off to a town. Her marriage with communion as tradition says cannot be annulled unless one partner dies. She was tied up or condemned to a marriage that she did not choose. Thus she ran away not only to escape from her husband but also anticipating a better way of living. Her case can be considered as a representative one of girls who migrate from rural areas to urban centers. Unfortunately, the fate of such migrant girls is not good. That is, they end up either as housemaids or commercial sex workers, perpetuating the vicious circle of violence against women.**

**Had there not been interventions by NGO's such as SWAA-E, many HIV positive women would have remained helpless and many of them could have died of hunger.**

**This is a clear indication of the prevalence still of HIV/AIDS stigma where even immediate families abandon their own relative/kin like what Workitu's aunt has done, thus HIV positive persons' reluctance to reveal their HIV positive status. It is not surprising if they hide their HIV positive status.**

#### **4.4 Case Four**

Alemitu is a young woman with a forthright manner.

*I was born in Selale. I am 21 years old. My mother died when I was three months old. When I was nine years old, my father remarried and they had a daughter. When my father was not around, my stepmother used to give me stale injera. In addition, she used to falsely accuse me of stealing and have me beaten. My father and stepmother bought clothes and shoes for my stepsister. When I asked my stepmother whether she bought me clothes, my stepmother would reply, how could I buy you clothes when I have your stomach to fill? When she says this it hurt so much. They bought me clothes only once a year and I was going barefoot, my clothes were tattered and my face was bruised due to the constant beatings I received from my father. It was unbearable. My mother's relatives observed the situation I was in. As a result, they decided to send me to Addis Ababa so that I can work and earn my living. That is why I came to Addis Ababa to my aunt.*

*Sadly however, the treatment I got from my aunt was no better. I was made to work very hard. They said that I was from the countryside and I am used to working more. Again this situation became unbearable. So they found me employment as a housemaid elsewhere. From there I run off and went back to my father. There, they suspected me of being pregnant whereupon I returned to Addis Ababa with my father's relatives. They got me employment as housemaid. I did not last long, I was dismissed from my work, and I went back to my relatives. They would not let me stay even a single night unless I give them my hard-earned money. They also took my new clothes and gave me their old ones. It was terrible.*

*Later, I got employment as a housemaid at a house of ኃይለማርያም displaced people<sup>28</sup>. My employer proposed to me that if I paid for the materials to build a small room, I could stay with her and open a small shop for myself in that room. I agreed and gave her my savings of 350 Birr. The room was constructed with my money. Then the woman said that her children have no place to sleep and forced me to leave one evening without refunding me the money that I contributed towards the construction of the room.*

*Then I got another employment at the house of soldiers where one was married and lived with his wife and the other was single and lived alone. The latter threatened me thus I had to leave and went back to my aunt. I pleaded with my aunt to find me employment at a decent house she knew very well. I explained to her that I was frightened of men in male-only homes and that at the homes of married couples, the husbands bothered me and that I recoiled when they comment about my pointed breasts. After listening to what I said, my aunt promised she would find me a decent employment provided I buy her sandals. I had no choice but to comply.*

*I found employment near the “ሀይለማርያም” “Tor Hayiloch Hospital” Ground Forces Hospital (located on western part of Addis Ababa) when I went there, my prospective employers were moving from their present house to another location. They showed me their new house and told me to come the next day.*

*It was raining and it was getting late. I stopped to take cover from the rain. I had nowhere to go. I hid my suitcase in a nearby tunnel and sat near a stream. Then a drunken man came and asked me what I was doing there I told him I had nowhere to go. He promised me he will get me employment and told me to follow him, I did. After we went some distance, he told me to wait for him there, moments later some men came and forced me to give them my suitcase, then they came and beat me and raped me taking turns.*

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<sup>28</sup> Displaced people are those who left their residences and came and settled in Addis Ababa as a result of the Cessation of Eritrea from Ethiopia and later on as a result of the Ethio-Eritrean war.

*In the morning an elderly lady came by and asked what happened to me. I was ashamed to tell her the truth that I was raped. Instead, I just told her that I was robbed. She gave me clothes and took me to her house. But she was suspicious of me. I overheard her saying since I had no collateral when she took me from the street, she feared that I might rob her and disappear. Thus I was forced to leave again.*

*I was employed as a housemaid around Cherkos Church (southern Addis Ababa). While I was working there, I noticed I was gaining weight. I took leave and went to visit my aunt. My aunt upon looking at me was suspicious and asked me outright if I was pregnant. I denied. She said she would take me to the health center and have me tested to find out. The next day I sneaked out alone and went to the health center. I found out I was pregnant indeed. I did not return to my aunt's house, instead, I went to my employer and told her I had urgent family matter to attend to and that I need to go and asked for my wages. She gave me my money.*

*I took a bus and went to Akaki (a town near the southern outskirts of Addis Ababa). There, I rented a house through a broker at the house of an elderly lady, the same broker found me employment baking injera for a woman. After sometime, I told my employer I was pregnant and requested permission to go to the health center for my checkup. She was not happy. After some time she employed somebody else. After I was fired from my work as injera baker, I tried to do many things; I sold charcoal, prepared spices I also baked and sold bread rolls.*

*When I went for check-up at the health center, I was asked to test for HIV and came to know I was HIV positive. Later, I was enrolled in the Nigat Project. After I learned of my HIV positive status, I told my landlady that I tested for HIV and that I was HIV positive. At first, the woman was sympathetic, she told me not to lose hope, she also told me God willing I will be cured by taking Tsebel of Shenkora Yohannes (a church). However, at the end of the month, she changed her mind and asked me to leave her house.*

*Then I rented another house. Here also I told my landlady that I was HIV positive. And I continued working. After a few months, my labor came. I begged the owners of the house that I rented to call an ambulance for me, they called an ambulance when the ambulance came, nobody was willing to accompany me so the ambulance driver told me that he will not take me unless someone accompanied me to the health center. I pleaded with the ambulance driver at least to take me up to the main road, he refused and left without me, so I went back to my house packed my belongings and slowly walked up to the main road.*

*From the main road, I took a taxi up to Saris (near the southern outskirts of Addis Ababa) and then I took another taxi and went to Gandhi Memorial Hospital. I gave birth to my son at 10 o'clock that same evening; my son was taken to the Black Lion Hospital. The staff and the patients at the Gandhi Memorial Hospital were sympathetic and collected money and gave me. I returned to my house in Akaki with my son. The owners were very distant; they did not want to come close to me they were not willing even to give me water. I overheard the children of my landlady advising their mother to evict me. Consequently, I left Akaki and came back to Addis Ababa. I did not want to live with these cruel people.*

*The doctors at the hospital had advised me to go to Tesfa Goh. When I went to Tesfa Goh, I was told to bring the necessary documents, that is, certificate of my HIV positive status, a Kebele ID and photographs. I did not have the money to have my picture taken nor did I have a Kebele ID. So I went to St George's Church and sat in the compound and begged, when I had collected enough money for paying for the photographs, I paid and got my photograph taken.*

*One day, a lady came and asked me why I was begging. I told her I did not have anything to feed my son and myself and that I was unable to get aid from NGOs because I did not have a Kebele ID. I deliberately did not tell her about my being HIV positive. She gave me the address of her mother's house and told me to go there. When I went there, her mother was selling tella<sup>29</sup>. She proposed that I work in a bar and hire a nanny for my son; I said I would not do such a thing. The woman told me to come the following Saturday. When I went back, she told me that she had an outstanding bill of Birr 50 at the Kebele and if I gave her the money she will pay her debt and get me a Kebele ID. I told her I would get her the money and left.*

*I met another woman and told her my story this woman advised me not to give the tella seller anything instead she advised me to go straight to the Kebele and tell my story to the head of the Kebele. I went and did as she told me. The head of the Kebele was very sympathetic. He facilitated things for me and I was given a Kebele ID. The person was very kind and even collected money and gave me. I went back to Tesfa Goh. There, they told me they can only make me member but they could not give me any financial assistance. I learned of this organization (SWAAE) and I was enrolled.*

*I have changed residences several times; the different people I rented house from gave me food. They do not isolate me outright, but whenever I use the toilet, they immediately come and wash the toilet thoroughly. I*

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<sup>29</sup> Tella is a locally brewed drink made from grains and hops

*once rented a house for 70 Birr. However I was made to use a separate clothesline to hang my washed clothes. I did not feel comfortable.*

*I started my small trade selling onions, avocados and the like. People bought goods from me as long as I did not take these goods inside my house. Once I put them in my house, nobody buys them— as if they get contaminated inside the house.*

*My son is now two years and five months old. I am currently on training I am enrolled in an embroidery class that the NGO arranged for me.*

**Alemitu's story illustrates the adverse effects of the break-up of a family on children especially girls. Had her mother been alive, such things would probably not have happened to her. In a poor country like Ethiopia, there are hardly any social services that would have intervened and helped young people from broken homes until they reach legal age. In the absence of such organized help, young girls are at the mercy of relatives who in turn exploit and physically overwork these young girls. They also solicit employment of these young girls as domestic works and sex work and benefit from their engagement in these works until these young girls handle themselves. These young girls also help out their families by sending their hard-earned money.**

**Alemitu's story also shows the sexual vulnerability of young girls in domestic service and the added burden of having a child. Her experiences of hardship illustrate the reality of many young women migrating to cities. Women are also blamed for the adverse circumstances they are in. She faced problems related to**

her HIV positive status, she was evicted from her home and even nobody was willing to help her when she was in labor and required help and sympathy from a human being. This indicates that the society at large has not fully understood HIV/AIDS and still has fear of HIV positive people. Thus the negative societal construction of HIV/AIDS fuels stigma and discrimination.

#### **4.5 Case Five**

Beza is a very articulate gentle person

*I was born in a peasant association in Wollega. I come from a low-income family. I was exposed to the virus in 1987<sup>30</sup>, I was very young then, I was in sixth grade.*

*In school, I was doing well, my teachers always encouraged me and advised me to pursue my education as they believed I had the potential and they told me not to marry. I considered myself lucky to have escaped this because the girls in my locality were married off at the ages of 13–14; parents hastily married off their daughters especially if they have started their menstruation.*

*There was a man in our locality who wanted to marry me; he was a merchant and well-to-do, so my parents were happy at the prospect of the marriage. The man started buying me small gifts such as lingerie. One day he waited for me after school, took me to his home and deflowered me.*

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<sup>30</sup> All dates she mentioned are in Ethiopian calendar

*After that, I started getting very sick. I got wounds in my genital area but I was ashamed and scared I did not tell my parents the truth. When they asked me what was wrong, I just tell them I had pain in my kidneys and so on. However, my illness got so severe that I spent the entire year at home, I discontinued my education.*

*My older brother was at school in Addis Ababa and when he learned about my sickness, he brought me to Addis Ababa where I was diagnosed and treated for a sexually transmitted infection. After my health was restored, I started to live with my brother in Addis Ababa. I also resumed my studies.*

*In 1991, my brother wanted to get married, and his fiancée was not happy about my being in my brother's house. Seeing this, my cousin wanted to send me abroad he convinced me about going abroad as it would give me opportunity for helping my poor parents. For the Visa, I was required to test for HIV, and he urged me to complete the required medical examination as soon as possible. I went to a private clinic and was told to give my blood sample. I was not given any counseling. When I returned to collect my medical results, I was told to speak to the doctor. The doctor asked me what my occupation was; I told him I was a student. He then asked me if I had a boyfriend, I replied no. He then asked me if I was virgin, I replied that I was. He then commented— "How come you have the virus in your blood? I replied, what virus? At that time I did not know much about HIV/AIDS. The doctor said "you have HIV in your blood." I said what? How come? Then I started screaming "ou ou alkugn" "I screamed" and was out of control, they called my brother he came and comforted me and took me home.*

*He later told me that he will rent me a house and find me work. I did not know of the consequence and I was not normal. I was deeply disturbed at that time that I did not rationalize the consequences, so I agreed to his proposal. I was heartbroken by my brother's action. How could he, my brother, abandon me when I am in such a situation? However he rented me a house for 60 Birr at CMC (east Addis Ababa) and paid me 200 Birr*

*per month for cleaning his office. I used the 200 Birr for transport and food. I did not mix with people I just went home and cried. I lived like this for two years. I cried for a long time, I did not know where to go or what to do.*

*I thought of going to my mother, then I thought how could I take a disease to my mother? “K“, ui }gjT@Lf MH@É?” “leinate beshita teshekimelat lihed?” meaning how can I take a disease to my mother? Then I dissuade myself. I have attempted to commit suicide several times and failed, at one time I went to a kiosk and bought liquid detergent (u[Ÿ=“) and drank it all, but the people called my brother, he took me to the hospital and I survived. I also tried to hang myself and I failed but I still have the rope marks on my neck.*

*In 1992, I heard Zewdu<sup>31</sup> speaking on the radio about Tesfa Goh. I searched for his address and went to Tesfa Goh and met Zewdu, when I tearfully told him of my anguished life, not only did he sympathize with me, he shed tears with me... he consoled me “†Ãµi †K,,” “ayzosh alegn” It was the first time in two years that I found a person that I was able to talk to, then I got hope, I revived. What had happened to me had not happened to anyone... I had spent the two years in tears, my face blackened by torrents of tears shed in loneliness.*

*I moved out of the house that my brother rented me, as it was causing me pain so I moved in with an HIV positive girl I had befriended. I started living with her and also received aid. I also resumed my studies.*

*I met an HIV positive person, he helped me a lot, and we got close and eventually married. I am currently a college 2<sup>nd</sup> year student. My husband too is a University student. I am currently taking the anti AIDS medication and I am in good health. I have even regained all my hair. I was bald as a result of the disease and I used to wear wigs to cover my baldness. The medication has side effects on the shape of my body; it gives one a kind of pot belly and alters the shape of the body. However its benefits outweigh its side effects*

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<sup>31</sup> The late Zewdu Getachew was the founding member of Tesfa Goh (Dawn of Hope) Ethiopia, a pioneer association of people living with HIV/AIDS.

*I do not tell anyone of my HIV positive status. I have every reason for this, look what happened when I told my brother about my HIV positive status, this has hurt me so much. The other person that I told about my HIV positive status was the pastor of my church. When I told him He said to me “you got it (HIV/AIDS) because you have sinned; the payment for sin is death.” I had not intended to hear his sermon about death I wanted him to announce to me of life.*

*I replied to him “have you heard of the woman they took to Jesus to be stoned to death because she committed adultery? Well, Jesus has told these people that the person without a sin can stone her to death and all left because they were all sinners – they also brought the woman alone not with the man who committed adultery!”*

*After telling him this, I left the church I have not gone there since. I did not get the virus from commercial sex work; I did contract the virus as an innocent girl under a condition I could not avert. I am very much aware he (the pastor) said such things to me because I am a woman. He would not have said what he said had I been a man.*

*My husband and I now live in a house we rented from a private individual<sup>32</sup>. People who rent from individuals and are in anyway known to be HIV positive are evicted. The landlords do not tell these people because you are HIV positive leave my house; rather it is by increasing rent and making it impossible to live there. I wish that Kebeles could give houses to HIV positive women. I wish that I had a Kebele house, I worry what will happen to me if I fall ill tomorrow because I have witnessed many people thrown out of the houses they rented when they were sick and bedridden. These people have no choice but to go to Entoto Mariam Church.*

*I have a good life, I would really like to have a child, but then, I worry what if my baby will become HIV positive, what if I lose my baby?...what if I die leaving my baby to lead street life? Having thought these, I control myself in spite of my love for children.*

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<sup>32</sup> One can rent a house from the government, Kebele ( cheaper and reliable), individuals (commonly known as private

Beza grew up in an environment that was not free from harmful traditional practices of detriment to women. She was on the verge of escaping one harmful traditional practice, early marriage. However sexual violence cut her off short, it also exposed her to HIV/AIDS. That is, she was cheated into this situation by an older man and got raped. This resulted in her contracting and suffering from sexually transmitted disease (STD) and came to Addis Ababa as a consequence.

She later learned she was HIV positive. She is one of the many cases of young women who learn of their HIV positive situation when they attempt to go abroad seeking visas. In fact, these pools of young women are one of the sources of information/data on HIV prevalence in the country. Foreign visa applicants are one of the major groups testing for HIV. They are sources of HIV prevalence data for the Ministry of Health. For example, among 68,273 visa applicants testing for HIV in 2003, there was a prevalence rate of 3.6% (FDRE, Ministry of Health, 2004).

Beza also did not tell her parents the cause of her illness when she was sick and in bed for one year due to sexually transmitted disease (STD). This is a clear indication that sexual violence is hidden. Victims, due to fear of repercussions from their parents and society at large do not disclose such offences. In a study exploring the relationship between HIV and violence in Tanzania, it was found out that women place a great value on the community's perceptions of their character and fear being the source of community gossip (Lary et al, 2004) Victims of violence do not readily report incidents of abuse especially sexual abuse (Lary et al, 2004; Mitike et al, 2000) In fact; all five women did not report their sexual victimization. Their reasons were that they did not know where to go (Mulunesh and Workitu), they were threatened and their fear of not being believed (Workitu). This was also similar to the findings of Mitike et al's (2000) study on female street adolescents, where the reasons given by the sexually victimized girls for not reporting to legal bodies was that they did not know what to do, threat from the perpetrators and fear of not being accepted by the police.

Even the society would rather mediate than intervene in instances of violence. This is in agreement with Habtamu (2003), in his study of family violence in Addis Ababa, he also found out that the majority of victims suffer in silence and matters are settled by elders.

Her situation also depicts the significant role played by support groups for people living with HIV/AIDS in giving the care and support they need most.

One of the coping mechanisms of people living with HIV/AIDS is faith focused. Thus the role of religious leaders is of paramount importance as people in their quest for religious support, turn to religious leaders and Tsebel.

However, Beza's sad encounter with her pastor is a clear indication of the general notion that HIV is associated with immorality, sin and a punishment from God for transgression/sin. Even though one cannot fully conclude that all people living with HIV/AIDS meet such response from religious leaders, however, such cases are encountered and not exceptions.

She was blamed for her “sin” by her pastor instead of being consoled and advised to give her spiritual strength.

On the other hand, when asked “Do you believe HIV/AIDS is a punishment from God?” 62.58% of questionnaire respondents from Kebeles 03/09 and 04/05 who gave their answers believed that HIV is a punishment from God, whereas 37.42% responded it was not. Respondents also indicated that their source of information on HIV/AIDS was mass media (radio, TV, newspapers) not religious leaders or their teachings. This can lead us to the conclusion that religious leaders themselves need to be well versed on issues of causes, transmission and prevention of HIV/AIDS and eventual care and support of people living with HIV/AIDS.

The reasons for testing for HIV was different for all cases, Senait tested because of the awareness raising information received. For Mulunesh it was because of her persistent illness. Workitu and Alemitu tested because of their pregnancy and Beza tested for the visa requirement to go abroad. All came to the experience of HIV/AIDS from different directions and went through a painful journey of adjusting to life with the virus.

Regarding then health status two of the women are currently taking anti retroviral drugs. Four of the women in addition to getting treatment take the Tsebel and one takes the ‘*yenifro wouha*’ as well. This is because there is a strong belief in the healing power of the Tsebel. As cited in the earlier chapter, faith is one of the coping mechanisms of PLWHA. In focus group discussions also, the women strongly favored the Tsebel as a cure for HIV by citing anecdotes of people cured from HIV.

Body images of PLWHA are often envisaged as thin, frail people with thinning hair by society. Though very much aware of these societal images of them, the women also had images of themselves after becoming aware of their HIV positive status. Senait stated that she had not experienced any bodily changes. However, Mulunesh believes that she has lost weight and goes to great lengths to hide this fact by wearing six to seven clothes. Beza on the other hand has said she had experienced changes in her body shape after taking the antiretroviral drug. But, she also claims to have regained her lost hair. Workitu has experienced loss of energy and has skin conditions though she is on the antiretroviral drugs.

All five women have cited housing as their major concern and one of their barriers to disclosing their HIV positive status. They all have fears of being “thrown out” if they fall ill and become bedridden. Problem of housing for PLWHA is also a world wide problem; Schietenge (1993) attributes two reasons to PLWHA’s problem of housing. One reason is the public’s fear of “catching” AIDS which results in eviction of PLWHA and the other is the financial difficulties faced by PLWHA. This is also the case for all five women.

On the positive side, despite their traumatic experiences, all five women have taken proactive measures in their lives; Alemitu is taking embroidery training, Senait and Workitu have taken small business management courses and on their way starting small trade. Beza is pursuing her college education whereas Mulunesh is engaged in dry waste disposal work (*Á[p qhh T"df RW*).

## **5. SUMMARY AND CONCLUSION**

Gender based violence is pervasive and irrespective of their social and economic status, women are at risk of violence. The experiences of the research participants in the interviews, focus group discussions, informal conversations and surveys have clearly indicated that violence against women is widespread even though its magnitude is not fully known in Ethiopia and needs further studies.

Although there are laws affirming the rights of women, in reality, they did not benefit from them because many women are not educated and unaware of their rights. The legal system is not sensitive to women's conditions. Thus crimes committed against women do not get the justice they deserve. There are also social barriers for women to seek legal redress among which are the prevalent thinking that family matters should not be exposed to outsiders, the mediation of elders pressurizing women to comply in spite of the gravity of the crime committed against them by the perpetrator, the thinking that women are to blame for the violence directed at them such as their way of dressing and for triggering the anger of their partners. Therefore, the education of women, even elimination of illiteracy of women raises women's awareness of their rights and entitlement.

In this study, it was also found out that sexual violence contributes to the spread of HIV directly through coercive sex and indirectly through women's inability to negotiate safe sexual behavior including condom use. The use of condoms requires male cooperation and willingness. This clearly indicates the need for promotion of female controlled prevention methods such as the female condom that women can use without fear.

The socialization of women and men also reinforces the unequal power relations where men are encouraged to be sexually active and knowledgeable whereas women are kept

and expected to be ignorant and passive about sexual matters. As a consequence issues related to sexuality are not openly discussed within families, in the community and even in schools which is a barrier in communication on sexual matters. Hence, tailor made education on sexual and reproductive health targeting youth as well as adult community members is instrumental in addressing sexual violence and the norms that sustain it. The active involvement of men is of vital importance in the effective addressing of the issue.

Harmful traditional practices such as early marriage and abduction are prevalent in Ethiopia. These social norms and cultural values encourage men to wield power and to impose their will upon women. In addition, parents give away their daughters in marriage for economic reasons with no regard for their future. Young girls on the other hand are adversely affected by such practices in that their prospect for education and a better future are abruptly halted.

On the other hand, in addition to their ignorance in sexual matters, girls are married at a very young age to much older and sexually experienced men thus they are in no position to negotiate safe sexual behaviors including the use of contraceptives. They are also traumatized by the forced and unwanted sex. This in turn often results in adverse health effects such as fistula and sexually transmitted infection among which is HIV/AIDS. On top of this, the girls also bear children at a very young age with a high risk of maternal mortality.

Since the girls have little or no support in getting out of this relationship, most are forced to run away to cities. This is illustrated by the five women whose cases have been presented in this thesis. Due to poverty also women migrate to urban areas in search of employment and a better life. However, since most are not educated, their options for employment is limited to low paying works of which the readily available ones are as domestic workers and commercial sex workers. This situation in fact exposes the girls to further violence, unintended pregnancy and HIV/AIDS. When these women encounter sexual violence they most often keep silent because of the lack of support and their unawareness of their rights due to their low level of education.

HIV is increasingly affecting women. In fact, statistics is showing there are more young women living with HIV/AIDS than young men. Women due to biological, economic

and socio-cultural reasons are highly vulnerable to HIV. As evidenced in this research, women come to know about their HIV positive status due to persistent illness, during pregnancy and when applying for visas to go abroad. Women, when learning of their HIV positive status, face dilemmas of how to disclose their HIV positive status to others. Disclosure is very important in that it results in improved access to HIV prevention and control programs and treatment and creates opportunities for the regular review of services to meet the special needs of women. It also enables a better understanding of HIV/AIDS. In addition, HIV prevention and control programs should give serious thought to gender dimensions of HIV/AIDS such as women's particular vulnerabilities to HIV instead of focusing on the *ABC strategy*— Abstinence, Being faithful to one partner and Condom use. Women are powerless in sexual relations especially in the case of sexual violence.

The major reason for non-disclosure of HIV positive status is the fear of HIV related stigma. This fear is not without justification. Many HIV positive persons faced difficulty in getting housing, they have fear of isolation, perceived difficulty in social interaction, are victims of insults and taunts, and a prevalent thinking that associates HIV/AIDS with immorality and a “punishment from God” no wonder HIV positive women are reluctant to disclose their HIV positive status. Since these issues as stated above are pervasive, HIV prevention and control should aggressively tackle HIV related stigma.

HIV positive women use a variety of coping mechanisms to deal with their situations such as accessing NGOs, seeking religious redemption by going to churches and taking Tsebel (Tsebel). This signifies the important role of religious leaders in assisting PLWHA and also teaching the faithful on HIV related issues. Religious leaders' knowledge about HIV/AIDS is important in that they can preach the faithful about HIV and also help deconstruct the belief about HIV as being a “punishment from God” In addition, through the use of prayers and counseling they can also provide comfort to HIV positive women.

As being observed in the research, HIV positive women gain from the interactions with other women in the same situation as it enables them to exchange ideas share experiences, eliminate feelings of isolation as well as giving them collective voice. For

that reason, the creation of environment conducive for the creation of PLWHA self help groups plays a big role.

Another factor in the disempowerment of women is poverty. Poverty predisposes women to sexual violence and HIV. They have limited access to and control of resources such as land, credit and education. Women, when faced with violence and HIV have few resources to deal with the adverse effects of the virus. That is why many women access non-governmental organizations that give care and support to PLWHA. However, to ensure the sustainability of the support given to these women should enable them to be self sufficient. With respect to this, giving them training and involving them in credit and income generating schemes would ensure their self reliance.

As a result of death of parents, there are a significant number of HIV/AIDS orphans. Consequently, many are forced to become street children as there are insufficient social services for orphans and this add up to the already existing social problems and affects the younger segment of the Ethiopian population which accounts for nearly half of the population. This clearly indicates the need for stepping up social welfare services, including health care, school fee subsidies, and shelter for orphans.

Finally, the removal of legal and cultural constraints on women's access to and control over productive resources is of paramount importance to the economic and social empowerment of women.

## **6. RECOMMENDATIONS**

Based on the findings of this research on sexual violence and HIV/AIDS, the following recommendations are forwarded. Sexual violence and HIV/AIDS in women as this research indicates are multidimensional; addressing sexual violence and HIV/AIDS is not an easy task as it involves multiple actors. In any case, the following major recommendations are addressed to the relevant authorities.

### **a) Ministry of Women:-**

- Create awareness the general public about violence against women using all means possible and amplify access to information about violence against women and HIV/AIDS for women. Massively disseminate information about women.
- Strengthen women's affairs offices at all levels. Ensuring they have adequate budget and trained human resources. Establish women's affairs office in educational institutions especially in higher education institutions.
- Campaign for involvement of women at all levels of decision making and ensure women are represented in decision making bodies.
- Conduct, encourage and finance researches on violence against women and HIV/AIDS in women.
- Promote legal literacy among women in collaboration with legal authorities and women's groups. Pressure relevant authorities to act swiftly on perpetrators of crimes of violence against women and young girls
- Give women skill training and involve them in income generation schemes. Collaborate with other organizations in engaging women living with HIV in productive activities so that they will be able to support themselves and their families.
- Increase social support for women victims of violence and women living with HIV by facilitating their opportunity to meet in groups and create fora which will allow them to draw strengths, learn and acquire practical solutions from one another.

### **b) Ministry of Education:-**

- Give priority to girl's education giving emphasis on their retention.
- Find ways of incorporating sexuality, reproductive health, HIV/AIDS, relationship and violence into school curricula.

- Teach students, especially girls life skills including how to avoid risky or threatening situations related to sex, violence and how to negotiate safe sexual behaviors.
- Give gender awareness training to teachers, both female and male.

**c) Legal Bodies**

- Critically examine existing laws especially those related to women and evaluate their implementation. Strong enforcement of existing laws.
- Encourage recruitment of female police officers to the extent of using affirmative action.
- Special placement of female police officers for crimes of violence against women.
- Proper recording of crimes against women in a gender sensitive manner.
- Promote legal literacy for women.

**d) HAPCO:-**

- Give serious consideration to the gender dimension of HIV/AIDS which make women vulnerable to HIV such as sexual violence. Serious consideration should be given to promoting and availing female controlled prevention methods such as female condom.
- Compile data on HIV. Avail information on HIV. Give accurate information on HIV its transmission and effects on women and aggressively work on tackling AIDS related stigma.
- Involve and work with women living with HIV in HIV/AIDS prevention and control activities
- Facilitate creation of association of women living with HIV.
- Find ways of engaging women living with HIV in productive activities so that they are able to support themselves and their families.
- Closely work with and educate religious leaders and leaders of community based organizations about HIV/AIDS in a sustained manner.
- Conduct and fund research on gender dimensions of HIV/AIDS.
- Reinforce HIV desks especially at Kebele level with the necessary human and material resources.

**e) Regional States:-**

- Give due support to and work closely with women's affairs offices.
- Address issues that act as push factors for women to migrate to cities.

- Increase women's access to resources such as education and training, land, and credit.
- Encourage and involve women in decision making at all levels.
- Promote HIV awareness and education.

**f) Ministry of Health:-**

- Initiate and provide counseling services for sexually violated women and girls.
- Prepare guidelines for media and others involved with educating and reporting about HIV in a gender sensitive and non stigmatizing manner.
- Promote the use of antiretroviral medications by giving information on the benefits and free availability of the medications. Work with religious leaders in promoting the uninterrupted use of these medications.
- Widely disseminate information on the prevention of transmission of HIV from mother-to-child.

**g) Ministry of Culture/ Ministry of Information/ Ministry of Labor and Social Affairs/ Non-governmental Organizations :-**

- Step up services to HIV orphans
- Strongly involve community based organizations and the community in promoting positive traditional practices and addressing harmful traditional practices.
- Promote positive images of HIV positive women and women in general through the mass media, plays and dramas and various other means.

**h) Further research on the gender based violence and gender dimensions of HIV.**



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