ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

THE SOCIO-ECONOMIC AND PSYCHOLOGICAL IMPACTS OF HIV/AIDS ON PLWHA IN BISHOFTU TOWN

SAMUEL TIBEBE

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BY:

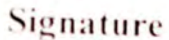
SAMUEL TIBEBE

COLLEGE OF SOCIAL SCIENCES

APPROVED BY BOARD OF EXAMINERS:

Hirut Terefe

Eshetu Gurmu



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Acronyms

AID	Acquired Immuno Dysfunction
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
CHBC	Community and Home Based Care
CSA	Central Statistical Agency
DAC	Department of AIDS Control
EPRDF	Ethiopian People Revolutionary Democratic Front
FDRE	Federal Democratic Republic of Ethiopia
GRID	Gay Related Immune Deficiency
HAPCO	HIV AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
IFRC	International Federation of Red Cross
ILO	International Labor Organization
MDG	Millennium Development Goal
MoH	Ministry of Health
MTCT	Mother to child Transmission
NACP	National AIDS Control Programme
NASC	National AIDS Secretariat Council
NGO	Non Governmental Organization
OPEC	Organization of Petroleum Exporting Countries
OSSA	Organization of Social Services for AIDS
PLWHA	People Living With HIV/AIDS
RCS	Red Crescent Societies
UN	United Nations
UNDP	United Nations Development Programme
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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Abstract

This research has focused mainly on investigating the social, economic and psychological challenges of HIV/AIDS faced by PLWHA in the town of Bishoftu. The methods employed to generate the required data are: unstructured interview and focus group discussions. The life of the victims of HIV/AIDS is greatly traumatized by the consequences of the disease in the town. The study has confirmed that besides the health problems that they face because of the presence of the virus in their blood, PLWHA in the town experience stigma and discrimination in their day-to-day lives. This challenge is not only restricted to the victims in the town. Children are also greatly influenced by and share the burdens of the sero-positive status of their parents. Grandparents are not also untouched by the challenges. The economic and psychological challenges posed by HIV/AIDS on PLWHA are also the outcomes of the society's response to the disease in the study area.

The study revealed that the rejection that PLWHA are facing in the town robbed them of the opportunity to earn their living by securing a job. It also forced them to shift from one rented house to the other for a number of times. It has been revealed in the study that PLWHA, particularly those who are the members of any one of the organizations working on HIV/AIDS and HIV-related issues, are from the lower status of the society, and are leading a hand-to-mouth life.

It has also been investigated that PLWHA have passed through several psychological challenges brought about by the mistreatment they are experiencing from the society. Some of the major psychological challenges revealed by the study are: rejection, loneliness, depression, stress, suicidal attempt, sense of insecurity and fear of disclosing their sero-positive status.

The study has also reveled that the responses of the various governmental and non-governmental organizations in restoring the life of PLWHA in the town are impressive and worth supporting. Besides providing basic necessities to the victims, these organizations are contributing their part in organizing them to put in their potential to lead their life wholly, and take part in the development endeavors of the country.

CHAPTER ONE
INTRODUCTION

1.1 Background

There has not been any other disease in human history than the Black Death which killed more than 25 million people in Europe between 1347 and 1351 that affected the human race in such a large scale in a given time. But, today, the AIDS pandemic is destroying the lives and livelihoods of millions of people around the world. And what makes HIV/AIDS unique in human history is its rapid spread, its extent and the depth of its impacts (UNAIDS, 2004).

Although no part of the world is immune from HIV/AIDS, by far the worst affected region of our planet is Sub-Saharan Africa. The region has just over 10% of the world's population, but is home to close to two-third of all people living with HIV/AIDS. In other words, an estimated 28 million people are currently living with AIDS in the area (World Bank, 2004). In 2005 alone, according to UN report (2006), an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS. It is also reported that the number of people living with HIV has continued to rise from 36.2 million in 2003 to 39.5 million in 2005 in the world. The report further claimed that there were 4.1 million new infections in 2005 (UN, 2006: 14).

Ethiopia, being part of the Sub-Saharan region, is one among those countries that are strongly hit by the disease. An estimated 2.2 million people were living with HIV/AIDS in the country in 2003 (Shitaye, et al, 2004: 75). However, according to the Federal Ministry of Health (2006: 6), the number of people living with HIV/AIDS was reduced to 1, 320, 000 in 2005. But, it is still one of the highest in the continent. The majority of the infections occur

between 15-24 years age group. Since the majority of the victims are in their prime productive years, losing them is not affordable, particularly in connection with sustaining the development of the country.

HIV/AIDS has become a major social, economic and political problem for most countries in the world. In some countries, particularly in Sub-Saharan Africa, the disease has already created an economic and social havoc. Furthermore, since it is a disease that mainly affects the working age group, especially those ranging 15-50 years, the consequence of the epidemic will potentially result in acute shortages of labor, the loss of expensively trained specialists, great number of orphans and severely overloaded health and other forms of service sectors. These all will, in turn, heap a great burden on the development of a nation. According to Barnett and Whiteside (1996: 3), the HIV/AIDS epidemic has already reversed many of the development gains made in central, eastern and southern Africa over the past three decades. They also added that the disease is a major problem for development and must be taken into consideration by anybody working in this field.

Ethiopia's response to the spread of HIV/AIDS was one of the first in Africa. The government took the initiative and developed a national policy on HIV/AIDS. The policy is designed to guide the implementation of successful programmes to prevent the spread of HIV/AIDS, to care for those with AIDS and to reduce the adverse socio-economic consequences of the epidemic. According to Central Statistical Agency (2005: 179), knowledge of AIDS is widespread in the country. Ninety percent of women between the age of 15-49 and 97 percent of men in the same age category have heard of AIDS. Despite this fact, however, the country hosts a large number of People Living with HIV/AIDS (PLWHA) in the global scale (Shitaye et al, 2004: 82). This, in turn, tells us that the epidemic's grip on the society is again one of the highest in the continent.

UNAIDS (2005: 44) reported that the impact of HIV/AIDS range from affecting people's livelihoods to the capacities of nation states. Besides its health problem, the disease has a devastating social, economic and psychological impact on PLWHA. The stigma and discrimination associated with the disease has a great influence on the social, economic as well as psychological well-being of PLWHA. The impacts of the disease can, therefore, affect the relationships of PLWHA with the rest members of the society at all levels. If this relationship develops toward a negative attitude, it may trigger psychological problems, such as anxiety or depression on the part of PLWHA and those associated with them. This may lead them to avenge the society. In light of this pressing issue, therefore, the study investigates the socio-economic and psychological impacts of HIV/AIDS on PLWHA in Bishoftu Town.

1.2 Statement of the Problem

The impact of HIV/AIDS is not only limited to health problems. It greatly affects the different sectors of a country, and then impoverished development. In fact, the spread of HIV/AIDS at the turn of the twenty first century is a sign of maldevelopment- an indicator of the failure to create more equitable and prosperous societies over larger parts of the world. But, the creation of an equitable and prosperous society is not as such an easy task to accomplish. It greatly demands a lot of coordinated efforts. Today, we cannot talk about HIV/AIDS as an independent entity from development. The two are chained together since the former has a great pressure and influence over the latter. The Federal Democratic Republic of Ethiopia (FDRE) government's plan and policies for sustainable development through capacity building also involve the case of HIV/AIDS.

HIV/AIDS affects the social, economic and psychological well-being of individuals and communities. It also conditions national capacities for

economic and political development. However, the most immediate effects of HIV/AIDS are experienced at the individual and household levels. According to Kelly (2001:3), the effects have many facets: illness, physical and psychological pain and suffering, health care and costs, income loss, reduced household productivity, death, funeral costs, mourning and grief; increased poverty, increased vulnerability of women, growth in the number of orphans, the social dislocation of those who survive, and the ultimate disappearance of households.

HIV/AIDS becomes a major research topic for many scholarly works. Although these researches mainly focus on HIV/AIDS, the angle they perceive it, which shapes the theme of their work, is different. For example, the research by Frewoin (2000) was mainly intended to understand and describe the knowledge and attitude of parents towards HIV/AIDS and their efforts in transferring their knowledge to their children. Yonas (2000) also conducted a study on the knowledge, attitude, awareness and belief of people towards HIV/AIDS by taking Awash Melkassa Town as his research site. Alemu's research (2002) also tried to assess the attitude, knowledge, belief and practice of young people towards HIV/AIDS by taking students of Kotebe College of Teacher Education as his research subjects. However, his research is different from the above two in that he also tried to assess the activities of anti-HIV/AIDS clubs around the institution. Solomon (2004) also conducted his research on the knowledge and attitude of Addis Ababa University preparatory origin students towards HIV/AIDS. Generally, therefore, these researches mainly deal with the attitude and knowledge of the various sects of the society towards HIV/AIDS. Thus, they differ from this research, which mainly focus on the social, economic and psychological impacts of HIV/AIDS on PLWHA, not on the disease.

There are also other researches that shifted the angle of their perception from the knowledge and attitude of people towards HIV/AIDS to its impacts on

people living with the virus. However, they restrict themselves to sex or age categories with particular emphasis on women. For example, Jira (2005) wrote his thesis on the consequence of HIV/AIDS on the lives of women in Eastern Wellega Zone. His research work was mainly intended to understand some of the conditions that facilitate the exposure of women to HIV infection and to know its consequences on the day-to-day lives of women in the study area. Habtamu (2004) also wrote his thesis on the socio-economic consequences of HIV/AIDS on women living with the virus and their coping strategies in Addis Ababa. Habtamu's thesis and that of Jira's share similarity in that both tried to explain the disease in terms of its influence on women. Anannia (2000) also produced his thesis on the coping strategies of PLWHA to the challenges of AIDS. He mainly focused on the social challenges of the disease and its influence on women, and the contribution of kinship relations to cope with the problems of the disease. There are also other theses produced on the basis of age category on HIV/AIDS, such as Sebsib's thesis (2000) on young adults in Bahir Dar Town.

In addition to these research papers, there are also several other research works made by different institutions. HIV /AIDS Prevention and Control Office (HAPCO), for example, produced different studies on HIV/AIDS. However, it mainly concentrates on the knowledge and attitude of the people toward HIV/AIDS, Voluntary Counseling and Testing (VCT) for HIV and behavioral survey of HIV/ AIDS infection in different regions of the country. It also produced several literatures which are aimed at educating the society about HIV/AIDS and its prevention mechanisms, and as well as its influence at the national level.

There are also other scholarly works which are published on different journals. For example, The Ethiopian Journal of Health Development, published by the Department of Community Health at Addis Ababa University, in most of its volumes, published several articles about

HIV/AIDS. Most of these articles are about the knowledge and attitude of the society towards HIV/AIDS. And the others described the behavioral changes of the society particularly in line with stigma and discrimination. Many other researches and reports had also been produced by several international organizations. Although these organizations treated the impacts of HIV/AIDS on the society, they mostly concentrate on global or continental level. Thus, it is difficult to take the information down to the level of a particular country.

HIV/AIDS affects all segments of the society. Its catastrophic impact ranges from children to old ages. It does not also respect race, ethnicity, gender, age or economic status. Although this is the case in point, most studies concentrate their analysis either on sex or age category with particular attention to women. It is undeniable that the disease mostly affects girls and women, but it is very difficult to curb the virus and draw national and regional policies as well as render the necessary services to the victims simply by studying the disease on the basis of age and sex differences. Therefore, if we are planning to come up with a general and solid theoretical explanation of the disease on PLWHA, all the victims should be part and parcel of the study.

Therefore, what makes this research different from the previous works is that it has attempted to assess the socio - economic and psychological impacts of HIV/AIDS on PLWHA in a comprehensive manner. In other words, victims of HIV/AIDS: children, youth, women and old ages have been incorporated as subjects of the study. Thus, the research, unlike other researches, is not a sex or age based study.

Generally, therefore, in this research, an attempt has been made to uncover the socio-economic and psychological impacts of HIV/AIDS on PLWHA from anthropological viewpoint in Bishoftu Town. In line with this, an attempt has also been made to integrate the consequences of the disease on individuals and its implication on the future directions of the country.

1.3 Research Questions

The research is undertaken on the basis of the following major research questions:

1. How do PLWHA explain their social and economic status before they acquire HIV/AIDS?
2. What are the social, economic and psychological burdens of HIV/AIDS on PLWHA in the study area?

1.4 Objectives of the Study

1.4.1 General Objective

The overall objective of this research is to investigate the socio-economic and psychological burdens of HIV/AIDS on PLWHA in Bishoftu Town.

1.4.2 Specific Objectives

1. To explain the economic burdens PLWHA face in Bishoftu Town.
2. To assess the major psychological impacts that PLWHA face because of their sero-positive status in Bishoftu Town.
3. To explore the effects of HIV/AIDS on the social status of PLWHA in the study area.
4. To examine the efforts of governmental and non-governmental organizations in assisting PLWHA in the study area.

1.5 Research Methods

Although there are various strategies to do researches, this research, however, is basically qualitative. The use of this research paradigm enabled me to draw the necessary information from the field site, and also in the analysis of the collected data. As a qualitative research, therefore, the research has taken place in the natural setting of the participants, and

various methods that are interactive and humanistic had also been implemented. This, in turn, enabled me to develop a level of detail about individuals and to be highly involved in actual experiences of the participants.

Appropriate methods of data collection have been used to gather the relevant information to the study. These methods can be categorized under the broad division of primary and secondary sources of data.

As to the primary sources of data, unstructured interviews and focus group discussions have been used to generate the necessary information. Journals, books, and reports of international and national organizations have also been used to review the previous works in the area as secondary sources.

1.5.1 Unstructured Interview

Face-to-face interviews with PLWHA had been conducted in the study area. These interviews were conducted on the basis of unstructured and generally open-ended questions. Although the identification of informants who were willing to share their life experiences had been the most difficult task to be accomplished, the different organizations that are working on HIV/AIDS in the study area assisted me a lot to get potential interviewees. Since I go through these organizations, it makes it easier and time-saving for me to reach to PLWHA. So, individual victims had been identified and interviewed with the aim of attaining the major objectives of the research. No less than twenty PLWHA were interviewed in such manner. I also selected my case informants from these twenty PLWHA on the basis of their informative power for the study. Interviews were also held with heads of the organizations and medical personnel to investigate their opinions about the lives of their clients.

Interviews with PLWHA, medical personnel from governmental and non governmental institutions, the heads of the various institutions working on

HIV/AIDS and HIV-related issues, and as well as a few elderly people in the town was mainly conducted between March16, 2007 and April14, 2007. I did not face a strong challenge to meet PLWHA for interview on the right time of my schedule. In fact, the research site has been selected on the basis of my earlier contact with the subjects of the study when I, together with other students, conducted a mini-group work research to the course: Research Methods in Social anthropology. This earlier contact made it easier for me to reach to the subjects of the study. However, I was forced to reshape my schedule several times to interview the heads of governmental and non-governmental institutions. This was mainly because they were busy in attending meetings in different areas, particularly in Adama and Addis Ababa. This was particularly true with regard to the heads of HAPCO and Dawn of Hope Ethiopia Debre Zeit branch. Finally, however, I got access to them and obtained valuable information for my study.

1.5.2 Focus Group Discussion

Focus group discussions were also conducted to strengthen and widen the different views and opinions that had been obtained from individual PLWHA. This method enabled to closely check and cross check the responses of individual respondent's vis-à-vis the others. I conducted five focus group discussions through out my fieldwork. I made three round field visits and each was extended for no less than ten days. Since the research includes victims across all age groups, I first organized the discussions on the basis of age and then on the basis of sex. The last focus group discussion, however, included victims from different sex and age categories. This enabled me to see the different views and opinions of PLWHA from different age and sex categories at the same time and their reaction to each other's point of view. Each focus group discussion contained eight PLWHA. I also incorporated non-victims who are strongly influenced by HIV/AIDS in one of the focus group discussions held with those victims above the age of forty to explore

their experiences in relation to PLWHA. I find these people in Dawn of Hope Ethiopia, Debre Zeit branch while I was on the process to secure permission from the organization to start my study. I had an informal chat with them and found their life experience relevant for my study and incorporate them in the focus group discussion.

1.6 Significance of the study

There has never been a time in history when disease did not exist. The history of epidemics dates at least as far back as 1157 B.C to the death of the Egyptian pharaoh, Ramses V, from small pox (Stine, 2002:1). Thus, epidemics are not new to human kind, but the fear they impose on each generation is. In this regard, HIV/AIDS is one of the major threats our globe faces today. If something is feared by this generation, it should be HIV/AIDS.

HIV/AIDS has also succeeded in joining people around the world in a common consciousness about its threats and implications. It is the only disease to have a dedicated United Nations Organization-UNAIDS- charged with the single aim of confronting it. It is also the first epidemic where the long-term implications could be recognized as they happen. In the words of Stein (2002: 1), it is the first plague in the era of globalization. Children are being orphaned. The elderly are left uncared for. Already disgraceful poverty is made worse. So, all these facts greatly attracted my attention to focus on HIV/AIDS and contribute something on the area.

In the global scale, Ethiopia hosts the third largest number of people living with HIV/AIDS, and ranked sixteenth in terms of prevalence (Shitaye, et al, 2004: 82). This means many people in Ethiopia already feel the impacts of the disease. And these impacts need to be studied to help policy makers and those involved in the service provision to PLWHA to incorporate and address them effectively.

HIV is spreading at an alarming speed causing untold suffering and death and creating profound development challenges. Although we are in to the third decade of AIDS, it remains a great challenge to public health, development and national security. Generally, these situations gave me a high degree of interest towards learning more about the problem and see its burdens on PLWHA by taking Bishoftu Town as a research site.

Different researches have been conducted on HIV/AIDS since the discovery of the disease. These studies have focused mainly on the medical aspects of the disease. This research is, however, focused on the social, economic and psychological burdens of the disease on PLWHA. Through the study, therefore, the challenges that PLWHA have been facing are integrated and thoroughly presented. This enabled to closely examine the real life situations of the victims to create the necessary awareness among the society. By presenting the actual life situations of PLWHA, the study is intended to give some information for service providers, both governmental and non-governmental, to reshape their policies and strategies to incorporate and address them effectively. It could also have a paramount importance in helping policy makers to develop appropriate strategies to tackle the challenges that are being faced by PLWHA.

1.7 The Study Area

Bishoftu is located in the Eastern Shewa Zone of the Oromia Administrative Region. The town lays about 50 kilometers South East of Addis Ababa. It has a latitude and longitude of 8⁰ 45' N and 38⁰ 59'E respectively (Kulczyzki, 2001). This geographical area is a land of as many as seven crater lakes: Lake Bishoftu, Hora, Babo Gaya, Cheleklaka, the seasonal Lake Kuriftu, Guda and the new earthen dam, also known as the "Cuban Lake". These beautiful crater lakes entertain thousands of visitors who come to the town almost everyday particularly to enjoy around Lake Hora.

In addition to these crater lakes, the crater topped mount Ziquala that serves a hub of pilgrimage for both Orthodox Christians and "traditional" believers is also a center of interaction for people from different background and coming from almost all corners of Ethiopia (Graham, 2001). Although I did not get authorized and statistically supported information, Ato Afework, the head of HAPCO Bishoftu branch, and Ato Getachew, a social worker at Dawn of Hope Ethiopia, Debre Zeit branch, claimed that the majority of the residents in the town are followers of Orthodox Christianity, followed by Islamic religion. They also stated that Protestantism is now spreading in the town.

The town's close proximity to the capital, its Italian built hotel, and its attractive lakes made it a weekend recreational center for both Ethiopians and foreigners. Today, if the middle classes of Addis Ababa leave for an excursion, most likely their destination is Bishoftu.

Based on figures from the Central Statistical Agency (2005), Bishoftu had an estimated total population of 131,159 (64,642 male, 66,517 female). Unlike the adjacent rural areas, which are dominated by the Oromos, the majority of the inhabitants of the town of Bishoftu are the Amharas. Besides the Amharas, the town is inhabited by a significant number of Oromos, Sebat Bet Gurages, Tigrawi and Silte. Insignificant number of Walayta, Dorze, Gamo and Kullo are also part of the population composition of Bishoftu (Fassika, 1998: 80). The town was formerly divided into fifteen 'kebeles'. But, today, according to the new strategic plan of the town, they are reduced to nine.

Since Bishoftu is a center of commerce, most people in the town are engaged in trading activities. The Addis Ababa-Moyale high way, which is also a major high way linking the capital to the ports in the east and the southern regions, and the Ethio- Djibouti rail way line which run through the town are believed to enhance the trade activity. The town seems always busy and it is not

wonder to see visitors on the streets of Bishoftu everyday. Some come to entertain themselves, others to participate in seminars, while a significant number are merchants. Thus, Bishoftu is a place where one witnesses complex socio-economic interaction.

The market area in Bishoftu is crowded with small local beer houses. According to Fassika (1998: 87), the owners of these houses are largely single. Some are widows or divorcee, others are unmarried young women, or rural migrants who moved to the town due to various social and economic reasons. Since most of Bishoftu's local beer houses are concentrated around the market areas, besides the urban dwellers, farmers are the frequent visitors of these brewers. He further claimed that:

> *The steady visiting of these brewers sometimes leads some farmers to develop special acquaintance with the local beer sellers. Through time, the most regular rural custom can cross the boundary of seller- customer relationship and establish casual courting with the owner. The casual relation, too, can be transformed into permanent and steady sexual relations, locally known as 'wushimenet' (concubine).*

From this, one can say that the income generating activities of some sections of the society in the town can be taken as a favorable ground for the spread of HIV/AIDS. Ato Getachew also claimed that the disease is now spreading to the adjacent rural areas in this way, and nobody is paying attention to it.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 HIV and AIDS: Meaning

The entomology of HIV has passed through several stages until it finally got its present shape. In the initial stage, different groups referred to it in different ways. Some associated it with its initial occurrence in gay men, calling it "gay compromise syndrome". Others called it GRID (Gay-Related Immune Deficiency), AID (Acquired Immune Dysfunction), "gay cancer" or "community acquired immune dysfunction" (Stine, 2002: 2).

According to Granich and Mermin (2001: 5), today, the most widely accepted and workable name for the virus that causes AIDS is HIV. HIV stands for "Human Immune deficiency Virus". "Human" because the virus causes disease only in people, "immune deficiency" because the immune system, which normally protects a person from disease, becomes weak, "virus" because like all viruses, HIV is a small organism that infects living things and uses them to make copies of itself. Smith (2001: 277) also claimed that HIV is a particular type of virus, a retrovirus, and more specifically, a lentivirus, a particular type of retrovirus.

When diagnosed in a person with HIV, these conditions indicate that a person has progressed to AIDS. The full name for AIDS is Acquired Immune Deficiency Syndrome. As the name implies, it is a disease caused by deficiency in the body's immune system. It is a syndrome because there are ranges of different symptoms that are not always found in each case. It is acquired because AIDS is an infectious disease caused by a virus that is spread from person to person through a variety routes (Hubley, 2002: 1). Granich and Mermin (2001: 1) further claimed that AIDS is a group of disease that occurs when a person's immune system is damaged by HIV.

Stine (2002:10) also added that AIDS is primarily defined by severe immune deficiency, and is distinguished from virtually every other disease in history by the fact that it has no constant or specific symptoms. He further claimed that AIDS is the end stage of chronic HIV infection. And it is not transmitted, but the virus is.

Most people with HIV feel healthy for the first few years after getting the virus, but later they become sick with AIDS. However, according to Stine (2002: 25), they do not die of AIDS; they rather die of opportunistic infections, cancers, and organ failures brought on by the results of a failed immune system.

Generally, it is widely accepted throughout the scientific community that infection with HIV is the necessary precondition for the development of AIDS. Although it is clear that HIV has a central role in the development of AIDS, there remain unanswered questions about some of the specific mechanisms by which it damages the immune system.

2.2 Transmission Mechanisms

HIV can be transmitted from infected persons to healthy persons through several ways. However, unlike many diseases, it can only be transmitted through contaminated body fluids. In addition to this, for a person to be infected, the virus has to enter the body in sufficient quantities (Barnett and Whiteside, 2002: 38).

According to Stine (2002: 208), the predominant mode of HIV transmission is through sexual contact. Initially, most cases were discovered among homosexual men. But, today, heterosexual transmission is the major mode of HIV infection in the world. The national HIV/AIDS control programme at the Ministry of Health also reported that an estimates of 88% of all infection in Ethiopia results from heterosexual transmission (UNAIDS Ethiopia, 2003).

Next to sexual transmission, as to Barnett and Whiteside (2002: 40), the most important cause of HIV infection is mother-to-child transmission (MTCT). The child can be infected with HIV prenatally, at the time of delivery, or postnatally through breastfeeding. However, infection at delivery is the most common mode of transmission. The incidence of pregnancy-related HIV infection in infants directly depends on the number of women with HIV/AIDS. As long as the number and proportion of women with HIV keeps increasing, so will the numbers of affected infants (Berer and Ray, 1993: 71).

The use of contaminated blood or blood products is the most effective way of transmitting the virus as it introduces the virus directly into the blood stream. HIV is also frequently spread by sharing needles, syringes or drug use equipment with someone who is infected with the virus (UNAIDS, 2005). But, researches revealed that the transmission of the virus from patient to health care worker or vise versa through accidental sticks with contaminated needles or other medical instruments is rare.

2.3 The Spread of HIV/AIDS: An Overview

The end of 1981 reported the first HIV case. Since then, the problem has been spreading throughout the world like a wildfire. Today, HIV/AIDS has been reported from every inhabited continent and from every country. According to UNAIDS (2006:7), an estimated 39.5 million people are living with HIV/AIDS worldwide, 38.6 million in 2005; with 4.3 million new infections, 4.1 million in 2005, and 3 million deaths, 2.8 million in 2005, in 2006 alone. The same source also claims that there is regional variation in the prevalence of HIV – ranging from the highest in Sub-Saharan Africa – 2% to the lowest in North Africa and the Middle East – 0.2%.

Sub Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world. An estimated 24.5 million people were living with HIV at the end of 2005 and approximately 2.7 million additional people were

infected with HIV during that year (UNAIDS, 2006). With 70% of the worlds' AIDS cases, the region's populations have seen sharp drops in their life expectancies and their overall quality of life due to AIDS (Smith, 2001: XV). Africa in general has 43% of the total deaths in children, 50% of maternal deaths and 30% of AIDS orphans. Barnett and Whiteside (2002:9) also claimed that most, if not all, of the 24.5 million people will have died by the year 2020, in addition to the 13.7 million Africans already claimed by the epidemic. From this, one can infer that the epidemic's grip on the continent is one of the deadliest in the world.

UNAIDS (2006: 23) reported that 8.3 million people were living with HIV in Asia at the end of 2005. From these victims, an estimated 5.2 million people, more than two-third, were living in one country, India. According to Barnett and Whiteside (2002: 9), Asia will overtake Sub-Saharan Africa in absolute numbers before 2010. They further claimed that by 2020, Asia would be HIV/AIDS epicenter. The United Nations (2005: 1) also stressed that countries of Asia and Eastern Europe currently have the fastest growing rates of HIV infection in the world, and the populous countries: China, India and Indonesia are of particular concern.

In the Caribbean region, a total of 330,000 people are living with HIV, where as a total of 1.6 million people, with some 140,000 people newly infected, were living with HIV in Latin America in 2005. Eastern Europe and Central Asia also experienced a twenty-fold increase in the number of people living with HIV in less than a decade by 2005. With 220,000 newly infected, the number reached 1.5 million. By 2005, AIDS also killed 53,000 adults and children in the region. However, the case with West and Central Europe and North America is less severe and AIDS deaths in 2005 were comparatively few because of widespread access to antiretroviral therapy. But, the region is home to 2 million HIV infected people. In 2005, 78,000 people were also

living with HIV in Oceania, including 7,200 people who were newly infected in the same year (UNAIDS, 2006: 32-45).

So, no region is spared to HIV/AIDS. Every regions of our planet, where the human race exists, are not unknown to HIV infection, though the extent and severity vary as it is described above. This, in turn, tells us that peoples of the globe feel the pains of HIV/AIDS in one way or another.

2.4 HIV/AIDS and Africa

The first evidence of the existence of HIV in Africa came from Central Africa. A retrospective analysis suggests that the first plateauing of a regional epidemic occurred in the region of Brazzaville and Kinshasa. Most evidences also suggest that the first expansion of an HIV-1 epidemic in Africa took place in the early 1980s, at about the same time the disease was first recognized in the United States. As the result of this, in the mid-to-late 1980s, Kinshasa was the center of much international attention by researchers and public health officials who were working to better understand and prevent HIV infection (Essex and Mboup, 2002:631).

As it is the case in other parts of the world, the predominant mode of HIV transmission in Africa is heterosexual contact, and it is followed by mother-to child transmission. Over 90% of the 2.4 million children under the age of 15 who are living with HIV in Sub-Saharan Africa acquired infection from their mothers. The high rate of mother-to-child transmission in Sub-Saharan Africa is attributed to a lack of access for women to both HIV care and to ante-and postnatal care, together with the predominance of breast-feeding, and the higher proportion of women in Africa with more advanced HIV disease and malnutrition (Piot and Bartos, 2002: 203).

Twenty five years after the initial report of AIDS and some twenty three years since it was first observed in Africa, the HIV epidemic has spread through out

the continent to devastating effect. Today, AIDS has become the leading cause of death in Sub-Saharan Africa among adults and children. Across Sub-Saharan Africa, the average prevalence of HIV in adult's aged 15 to 49 is 8.8%. However, even with in Sub-Saharan Africa, HIV prevalence is not uniformly distributed. East Africa once had the highest infection rates on the continent but has now been overtaken by the Southern ones (Piot and Bartos, 2002: 200).

In Southern Africa, about 20% of all adults are infected with HIV. Angola has a relatively low prevalence rate of 3% but all the other countries of the region have at least 13% infected. The over all rate of HIV infection in Central Africa, which was the first in the continent to be impacted by HIV, is 6%. The highest prevalence rates are found in the Central African Republic. The population of most countries in West Africa, on the other hand, became exposed to HIV later than those countries in Central and East Africa. The first country in the region to experience very high rates of HIV infection was Cote d'Ivoire, followed by Burkina Faso. However, in all countries of North Africa, rates of HIV infection are among the lowest in the world (Essex and Mboup, 2002: 633-636).

There is growing evidence that older people are increasingly being infected by HIV/AIDS. However, available data does not often include how the pandemic is affecting this population group. For example, in U.S.A., 10% of all reported AIDS cases occur in the population group of 50 years plus. Yet, while 83% of all deaths in the world have occurred in Sub-Saharan Africa, very little is known about the epidemiology of HIV/ AIDS among older people in this region. South Africa's national household HIV survey in 2005 found a prevalence of 10.8% among people aged 50-54, 4.5% among those aged 55-59, and 3.9% among those aged 60 or over (WHO, 2007). UNAIDS (2006) also estimated that around 2.8 million people aged 50 and older were living with HIV in 2005, representing 7% of all cases in the world.

The socio-economic impact of HIV/AIDS is devastating and affects individuals, families, communities, institutions and governments. One of the worst impacts of AIDS deaths to young adults is an increase in the number of orphans. Of all HIV infected children worldwide, 87% are estimated to live in Africa (WHO, 2007). USAIDS (2001) also estimated that 44 million children under 15, in 34 developing countries, would have lost one or both parents by 2010, mostly to AIDS. Guest (2001: ix) also claimed that deadlier than war, tyranny and even than malaria, AIDS is silently tearing Africa apart. She added that the epidemic is throwing millions of households into turmoil. She further stressed that often the middle generation is wiped out, and children and elderly are left to fend for themselves. In line with this, the former UN General Secretary, Kofi Annan, once said:

> *The devastation wrought by HIV/AIDS on the continent is so acute that it has become one of the main obstacles to development itself. AIDS threatens to unravel whole societies, communities and economies. In this way, AIDS is not only taking away Africa's present- it is taking away Africa's future (Essex, et al, 2002: 1).*

Generally, therefore, it is clear that the HIV/AIDS epidemic could be as catastrophic for Africa as the Black Death was for medieval Europe. In fact, it could be worse.

2.5 HIV/AIDS Prevalence and Response in Ethiopia

The first cases of HIV and AIDS were reported in Ethiopia in the early 1980s. The first evidence of HIV infection was found in 1984, while the first AIDS cases were reported in hospitals in Addis Ababa in 1986 (Mesfin et al, 2004: 75). Although HIV prevalence was very slow in Ethiopia during the early 1980s, it has been increasing rapidly since the early 1990s (MoH, 2000: 18). HIV/AIDS was prevalent in the urban areas at the beginning. The spread of the epidemic in the rural areas, however, began in the early 1990s (Vaillancourt et al, 2005: 11).

The report of IFRC and RCS (2003: 10) revealed that there were 220,000 AIDS patients and 2.2 Million HIV infected persons living in Ethiopia in 2003. But, according to the Federal Ministry of Health (2006: 6), the number of people living with HIV/AIDS was reduced to 1, 320, 000 in 2005. Of the total number, 634, 000 were living in rural areas and 686,000 in urban areas. The same source also estimated that in 2005, a total of 137, 500 new AIDS cases, 128, 900 new HIV infection (353 a day), 30, 300 HIV positive births (including 20, 190 in Children under 15) occurred. It also further claimed that the cumulative number of AIDS deaths reached 1,267,000 by 2005 and it projected to reach 1.9 million by 2010 if present trend continues. Of the estimated 1.32 million PLWHA in 2005, 730,000 (55%) were females. Females also accounted for 54.5% of AIDS deaths and 53.2% of new infections in the same year.

Although Ethiopia constitutes only 1% of the world's population, it claims seven percent of the world's HIV/AIDS cases. In terms of the number of infected persons, Ethiopia ranks fifth after South Africa, Nigeria, Kenya, and Zimbabwe in Sub Saharan Africa. The country also ranks second to Nigeria in terms of the number of orphans who are 14 years of age or younger (World Bank, 2005: 29).

In 2005, according to the Federal Ministry of Health (2006: 25), there were an estimated total of 4,885,337 orphans aged 0-17 years in the country. Of these, 744,100 were AIDS orphans. From these AIDS orphans, 529,777 were maternal, 464,506 paternal, and 250,195 dual orphans.

The modeled and adjusted national HIV prevalence in 2005 was 3.5% (3% among males and 4% among females). The estimated prevalence in urban areas was 10.5% (9.1% among males and 11.5% among females), 1.9% in rural areas (1.7% among males and 2.2% among females). But there is regional variation in the prevalence of the epidemic. According to the report of Central Statistical Agency (2006: XXVI), the prevalence levels are highest

in Gambella- 6.1% followed by Addis Ababa - 5%. The report also indicates that young women are particularly vulnerable to HIV infection compared with young men. Among women age 15-19, 0.7% are HIV infected, compared with 0.1% of men in the same age category. HIV prevalence among women 20-24 is over three times that of men in the same age group- 1.7% and 0.4% respectively. It is also reported that heterosexual transmission is the major mode of HIV infection in the country.

Following the diagnosis of the first two AIDS cases in 1986, a Department of AIDS Control (DAC) was established in 1987 under the Ministry of Health to report new HIV cases and carryout preventive activities nation wide. During the initial period, national activities were coordinated by the National AIDS Control Programme (NACP) (IFRC and RCS, 2003: 10). This initial response was launched under the Derg government when bilateral donor assistance of AIDS was limited, as many but not all bilateral donors withdrew support to the Marxist regime (Vaillancourt, 2005: 11).

Since 1993, under the new Ethiopia Federal Government, HIV/AIDS activities have been decentralized. The Ministry of Health, well aware of the constraints of providing care for chronically ill people and for people living with HIV/AIDS, developed a guideline for Community and Home Based Care (CHBC) in 1996. The introduction of CHBC as a strategy has been given recognition in the HIV/AIDS policy document that was endorsed by the government in 1998 (IFRC and RCS, 2003: 11).

The government also formed a National AIDS Council Secretariat (NASC) body under the Prime Ministry Office and it coordinates and facilitates the day-to-day implementation of the national HIV/AIDS programme (FMoH, 2006: 8; IFRC and RCS, 2003: 10-11; Vaillancourt, 2005: 12). However, according to Damen and Kloos (2000: 24), protection of human rights, particularly protection against discrimination, is the core principle in the prevention of HIV/AIDS. They further claimed that stigma, denial, and fear of

disclosure due to discrimination among HIV/AIDS-affected persons continue to fuel the epidemic and remain a serious impediment to any control efforts in Ethiopia and other African countries.

The efforts of the government have got support from different international and national organizations. NGOs have prepared and launched projects; many of them focused on information, education and communication activities. However, all these efforts are not strong enough to bring about a radical change in the country, though not totally a failure. Vaillancourt and et al (2005: 18) believes that Ethiopia's political, social and cultural context have shaped both the evolution of the HIV/AIDS epidemic and the responses to it, including support provided by the country's partners.

2.6 Impacts of HIV/AIDS

2.6.1 Socio-Economic Impacts

The impacts of HIV/AIDS extend beyond those living with the virus, as each infection produces consequences which affect the lives of the family, friends and communities surrounding an infected person. The overall impact of the epidemic encompasses effects on the lives of multiples of the millions of people living with HIV/AIDS.

HIV/AIDS has the potential of devastating the economy of a nation in a number ways. In the first place, the disease removes the productive members of nation farmers, doctors and service providers among others, and thus burdening the economic and societal fabrics of the country (UNAIDS, 2004: 14). In other words, since it primarily strikes the working-age population, the disease greatly threatens economic security and development.

The economic recovery made by most developing countries, particularly those in Sub- Saharan Africa, is now reversed to where it started because of HIV/AIDS epidemic. The epidemic erodes economic growth though its impact

on labor supply and productivity, saving rates and the delivery of essential services (UNAIDS, 2004: 55). In Ethiopia, where the prevalence rate of the disease is one of the highest in Africa, the economic burden of the disease is felt in a number of ways. The loss of young adults in their most productive years of life will certainly affect the overall economic output of the country (MOH, 2000: 32).

Although HIV/AIDS has a devastating impact on communities and societies at large, its socio-economic burden is first experienced by individual victims and his/her families. As it is indicated in the report of the World Bank (2002: 6), household providers infected with HIV become dependents as their health steadily deteriorates and scarce resources are used for their care and eventual burial. UNAIDS (2004: 58) also reported that in families where the breadwinner developed AIDS, in urban areas in Cote d'Ivoire, the outlay on school education was halved, food consumption went down 41% per capital, and expenditure on health care more than quadrupled.

So far, the AIDS epidemic has left behind 13.2 million orphans- children who, before the age of 15, lost either their mother or both parents to AIDS. Many of these children have died, but many more survive, not only in Africa, where 95% currently live, but also in countries throughout Asia and the Americans (Barnett and Whiteside, 2002: 201). The same source also claimed that children born to infected women may have only a 30% chance of being infected but they have close to a 100% chance of being orphaned. And orphans are less likely to have proper schooling. The household may be less able to pay for schooling.

UNAIDS (2005: 31) also reported that the death of parents by HIV/AIDS has left behind a generation of children to be raised by their grandparents or left on their own in child-headed household. Although grandparents normally expect support form their children, the AIDS epidemic makes the reverse a reality. Having a great deal of orphans in a country also demands a huge

investment that will, in turn, create its own impact on the future directions of a nation.

Disclosure of sero-positive status might be followed by expulsion from job, which, in turn, affects the victim's economic and as well as his/her social position. PLWHA might decide not to disclose their diagnosis to other people because they anticipate rejection. According to Gray (1999), people with HIV/AIDS are exposed to the prejudice of others and are confronted with the negative feelings others might have towards their own behavior. In this situation, he further claimed, disclosing to others is risky since it might strain family relationships and friendships, and may lead to the restriction of career opportunities and loss of employment.

Like AIDS itself, the AIDS stigma is a global problem. It is manifested around the world through ostracism of people with AIDS, discrimination against them, and in a few countries, quarantines (Smith, 2001: 627). UNAIDS (2006: 86) reported that stigma and discrimination are not only obstacles to HIV prevention, care and treatment for people living with HIV, but are among the epidemic worst consequences. It further added that HIV-related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by AIDS by association such as orphans or the children and families of people living with HIV.

In addition to the physical aspect of the disease, PLWHA must cope with its social definitions. According to Morse, et al (1998: 555), the stigma associated with HIV and AIDS makes patients socially isolated, because infected individuals are frequently outcast from their immediate communities. Such isolation is devastating to patients, particularly those who live previously surrounded by friends, families, co-workers, and who were dependent on these people for social and emotional support. Anannia (2000: 85) also stated that the stigma attached to HIV/AIDS has created an environment characterized by fear, distrust, and discrimination that hinder

people's motivation to protect themselves and others from infection, and to seek out care and support. He added that the rejection, discrimination, and shame associated with AIDS indirectly fuel the spread of HIV.

De Bruyn (1999) identified five reasons as contributing to HIV/AIDS-related stigma and discrimination. According to him, these are: the fact that HIV/AIDS is a life threatening disease; the fact that people are afraid of contracting HIV; the disease's association with behaviors such as sex between men and injecting drug use that are already stigmatized in many societies; the fact that PLWHA are often thought of as being responsible for having contracted the disease; religious or moral beliefs that lead some people to conclude that having HIV/AIDS is the result of a moral fault such as promiscuity, or "deviant" sex that deserves punishment.

2.6.2 Psychological Impacts

All persons with HIV are at risk not only to developing AIDS but also of experiencing social and psychological hazards associated with AIDS. This is what Brandt (1999) has called "the double jeopardy of lethal disease and social oppression". The psychological impact on the person with HIV infection is as pervasive and profound as the physiological effects of this chronic and terminal illness. After HIV diagnosis, the individual has to cope not only with the illness itself but also with the increased stress arising from family, friends, and society.

According to Munjas, et al (1998: 418), the psychological responses that people with HIV infection experiences include fear, anxiety, grief, loss, depression mania, psychosis, and suicide. He further claimed that anxiety, grief, and depression are the most frequent responses. Brandt (1999) also outlined the psychological problems that PLWHA experience in their life. He included anxiety, anger, depression, poor self-esteem, isolation, loneliness,

guilt, shame, suicidal thoughts and attempts, stigma and social rejection in his list.

Different psychological issues creating anxiety emerge over the course of the HIV illness. The experience of anxiety in the earlier stages of the disease occurs as the result of uncertainty about the disease process, clinical course, treatment and outcomes. It is also experienced as a result of rejection and social isolation. On the other hand, grief and loss associated with HIV infection extend from the moment an individual contemplates testing until death. However, according to Morse, et al (1998: 556), depression is the most frequently diagnosed psychiatric disorder in persons with HIV infection. It goes beyond grief in duration and intensity, and is increasingly incapacitating in all aspects of the person's life.

In a study by Gray (1999) on 80 HIV positive women, who described the most difficult aspects of living with HIV/AIDS, fear related to disclosure was more frequently described than fear of dying. HIV positive people might blame themselves for their experiences with stigma feeling that they deserve mistreatment. In this way, fear deprives PLWHA from experiencing the most basic of their human rights.

Stigma and discrimination create a great psychological burden on PLWHA. In a community where PLWHA only got blame and discrimination, their courage to live positively with the virus will be eroded, and in its place they will be filled with anxiety or depression, which, in turn, provoke them to avenge the society.

Although any disease has psychological impact on the patients, it is totally incomparable with the case of HIV/AIDS. This is mainly because the psychological burdens of HIV/AIDS exceed the victim and influence all around him/ her. Those most affected by this situation are children.

The illness or death of parents or guardians because of HIV/AIDS can rob a child of the emotional and physical support that defines and sustains childhood. It leaves a void where parents and guardians once provided love, protection, care and support (Lyons: UNDP, issues No.30). The loss of all these things, in turn, creates a great psychological burden on children. In Africa alone, more than 12 million children have lost their parents to the pandemic. Let alone other social and economic influences, the loss of parents by itself have massive emotional, behavioral and psychological impacts on children.

According to UNAIDS (2005: 31), after the death of their parents, surviving children may be fostered by grandparents, other older female relatives, or sent to live with another part of the extended family. These children are less likely to attend school and are more likely to be working more than 40 hours a week than children with both parents, especially if they are fostered by distant relatives or unrelated people. Some children end up on the street, where they are particularly vulnerable to extreme poverty and exploitation. From this, one can easily imagine the extent of psychological frustrations children face in all these processes. Those who believed to have the potential to be active and productive member of their community, but end up on the street because of HIV/AIDS, will face a sever frustration in their future plans and directions.

2.7 HIV/AIDS and Development

Development is about hope for the future and changing social and economic trajectories for the better. It implies either tangible improvement in individual or national circumstances, or belief in change for the better. People need to be able to look to the future and have something to aim for some goal, some promise. Individuals, communities, societies and nations set goals and have

projects. However, having a view of the future depends on individual health, well-being and capabilities.

Across the globe, issues of health and disease are viewed as falling within the domain of the health care sector. The approach to the HIV/AIDS epidemic was not different. Until recently, latest threat to human health was considered a severe health crisis that needed to be handled solely by the health authorities. However, during the 1990s, the devastating impact of this epidemic on social, economic and environmental development became apparent and resulted in the epidemic being increasingly recognized as a development crisis. Indeed, the impacts of HIV/AIDS are so serious that in 2000 the United Nations took the unprecedented step of labeling the epidemic a threat to global security (World Bank, 2004: 5).

Eyassu (2000: 4), described health as a major issue in development studies. He also claimed that the indicator for health is one way of measuring a nation's economic development. Therefore, the health of a nation and individual's health is inextricably linked with economic development. However, since AIDS causes premature death, international, national and personal development goals and aspirations are not achievable. Barnett and Whiteside (2002: 21) also claimed that in the absence of effective and available vaccines or economically feasible and effective treatments, AIDS will be expected to wipeout half a century of development gains as measured by life expectancy at birth.

It has almost become a truism that HIV/AIDS is unraveling hard-won development gains and exerts a crippling effect on future development prospects. The repercussions of the epidemic are such that the worst affected countries are already experiencing major development reversals (Kelly, 2001: 2). UNAIDS (2004: 14) report also shows that the impacts of AIDS on the development capacity of poor countries will significantly undermine their ability to make substantive progress towards the Millennium Development

Goals (MDGs), particularly with regard to poverty reduction, education and health targets and the care of orphans.

The epidemic has placed multiple challenges before the international community, cutting across every sector. The United Nations (2006: 14) reported that the attainment of the MDGs would be in question if the disease continued to spread in its present day rate. In other words, the achievements of sustainable development goals are put in doubt because of HIV/AIDS. Together with its spread, therefore, life becomes too difficult to most people in the world, particularly for those in Sub-Saharan region, where the disease is in prevalence.

In connection with this, ILO Director - General Jvan Somavia says:

> *HIV/AIDS is not only a human crisis, it is a threat to sustainable globe, social and economic development. The loss of life and the debilitating effects of the illness will lead not only to a reduced capacity to sustain production and employment, reduce poverty and promote development, but will be a burden borne by all societies - rich and poor alike (ILO, 2004: 14).*

2.8 Poverty and HIV/AIDS

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

AIDS has had a devastating effect on individuals, families and communities everywhere the disease has spread. However, it is the developing nations of

the Caribbean, Latin America, Asia and Sub-Saharan Africa where the situation is most worrying, and the AIDS epidemic has a major impact on their already severe problems. Today, about 95% of people with HIV infection live in the developing world. However, with the world's highest levels of HIV/AIDS, it is Sub-Saharan Africa where the social and economic impacts are the greatest (Hubley, 2002: 10).

According to Cohen (2006), poverty is associated with weak endowments of human and financial resources, such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status and low productivity as a result. He further claimed that in these circumstances, it is not at all surprising that the poor adopt behaviors that expose them to HIV infection. Given the reality of their lives, therefore, the messages about HIV/AIDS are often irrelevant and inoperable to them. Even if the poor understood what they are being urged to do, it is rarely the case that they have either the incentive or the resources to adopt the recommended behaviors. In this regard, Bob Kennedy, the Senator of Dallas, once said, "*When people are hungry and must provide for themselves and their families, even education will not stop the behaviours which lead to infection.*" The United Nations report (2005: 3) also claimed that poverty is a key factor leading to behaviours that expose people to rise of HIV infection, and it exacerbates the impact of HIV/AIDS. Cohen (2006) further stressed that for the poor it is the here and now that matters, and policies and programmes that recommend deferral of gratification will, and do, fall on deaf ears.

According to the report of the United Nations (2005: 1-2), although the highest HIV prevalence rates are found in poor countries, within regions such as Africa, it is not necessarily the poorest countries that have the highest prevalence rates. Nevertheless, poverty increases vulnerability to HIV/AIDS and exacerbates the devastation of the epidemic. The report further claimed that poverty deprives individuals of the means to cope with HIV/AIDS. The

poor often lack the knowledge and awareness that would enable them to protect themselves from the virus, and once infected, they are less able to gain access to care and life-prolonging treatment.

HIV/AIDS is acknowledged for its collocation with poverty and in most cases, poverty-stricken regions are the most severely affected ones. Different sources relate HIV/AIDS to chronic food shortages, malnutrition, and social instability. The area most famous for these features is the Sub-Saharan Africa, where 24% of the world's undernourished people live (UNAIDS, 2004).

In this part of the world, the largest percentage of HIV prevalence is always registered as a result of the continuously deteriorating living conditions of the general population. According to Hubley (2002: 11), poverty and HIV/AIDS can create a vicious circle. He further claimed that poverty and social upheaval are underlying factors in the spread of HIV, and the resulting AIDS epidemic is causing further social and economic distress at all levels of the society.

Kloos and Damen (2000: 14) believed that, as else where in Sub-Saharan Africa, the HIV/AIDS problem in Ethiopia has its roots in poverty, deeply entrenched attitudes and behaviours, and weak administrative capacity and infrastructure. Therefore, they strongly claimed that poverty alleviation holds considerable promise in HIV/AIDS prevention, as it may not only reduce high-risk behaviour of commercial sex workers through alternative employment but also enable many women and children to obtain a better education and life skills closely linked with female empowerment and socio-economic progress at the societal level.

The data that has been collected from the field is, therefore, analyzed on the basis of the existing literature. As it has been pointed out in this chapter, poverty is a major cause of HIV infection and a factor for the spread of the virus. This is because it increases vulnerability to HIV/AIDS and exacerbates

the devastation of the epidemic. In addition to this, it drives individuals of the means to cope with the challenges of the disease. Although there are various thoughts that have been used in HIV/AIDS researches conducted since the early 1980's, the structural approach, which emphasized that political and economic factors have played a key role in determining the shape and spread of the epidemic and also emphasized that these factors have been responsible for many of the most complex barriers to effective AIDS prevention program, has become widely used since 1990's (Singer, 1998).

It also emphasize on addressing systems in which diverse political and economic processes and policies (whether related to economic development, housing, migration or immigration, labor employment or unemployment, health, water, and welfare) that create the dynamics of the epidemic in order to have any hope of reducing the spread of HIV/AIDS (Parker, 2001). In general, the potential implication of understanding these factors and their relationships with the spread of the pandemic for prevention and strategies are far reaching.

Perhaps most important of these research and the current studies is its focus on the extent to which HIV/AIDS prevention must be understood as part of the broader process of social transformation aimed not merely at the reduction of the risk but at the redress of the social and economic inequalities and injustice that has almost universally been found linked to increased vulnerability in the face of HIV and AIDS (Parker, 1991: 173). Therefore, this approach, which is used as a base for the study at hand, argues that the social and economic challenges of HIV/AIDS can be redressed through a broader process of social transformation.

CHAPTER THREE

THE ROLE OF INSTITUTIONS IN THE BATTLE AGAINST HIV/AIDS AND IN ASSISTING PLWHA

HIV/AIDS has been the most important health problem in Ethiopia, and a threat to the social and economic fabric of the nation. The impacts of HIV/AIDS are not only limited to health problems. It greatly affects the different sectors of one's country, and then it impeded the country's development. Therefore, the government accredited this, and developed a national policy on HIV/AIDS. The government is, therefore, using the different institutions under its control to implement these policies. However, the efforts of the government alone cannot address every socio-economic problems of the country in general, and the problems associated with HIV/AIDS in particular. Thus, there should be an ally to this effect. In line with this, Ms. Ann Veneman, former director of Organization of Petroleum Exporting Countries (OPEC), strongly suggested that partnerships are critical in the battle against HIV/AIDS. She further claimed:

> *The problems are so many and so varied that we need to address them in a systematic, coordinated fashion, and this means working with all partners, be they donor governments, NGOs, other UN agencies, and of course, host governments (OPEC FUND NEWSLETTER, 2005).*

Generally, therefore, the government needs the intervention of other agencies, like indigenous and international organizations. These organizations are the key tools to improve the living standard of disadvantaged segment of the population in general and PLWHA in particular, which is the major concern of this chapter. The chapter also serves as a background literature to the coming chapter.

3.1 Governmental Institutions

3.1.1 Bishoftu Hospital

Bishoftu hospital is the only governmental hospital in the town of Debre Zeit that gives medical treatment for the general public coming from all walks of life in and around the town. One of the services that the hospital provides is associated with HIV/AIDS. The hospital began to provide well-organized HIV/AIDS services since 2005. The major services of the hospital in this regard are:

- Counseling, both to HIV positive and negative people.
- Antiretroviral drugs (ART) therapy
- Giving lecture when invited in schools, conferences, seminars and any other public gatherings.
- Provision of confirmation letter to HIV positive people to get support from NGOs working in the town through HAPCO.

There are almost 1,910 PLWHA who are currently receiving counseling service from the hospital. There are also 747 people who are following ART. However, the hospital does not have enough personnel to provide the services in an efficient and effective manner. There are seven counselors in the hospital. But, only two of them are regularly engaged in the unit. The remaining five nurses are simultaneously doing the work with their other major tasks. And a doctor is also assigned to the service. According to my informants, a senior nurse, Almaz, and a statistician working in the HIV unit, Daniel, the staff is not well organized and at the same time lacked the necessary training. As one of the nurses said, the service seekers are too many so they couldn't handle the job with the present staff members. Nevertheless, she added that the hospital is performing to its full potential to assist the needy.

Bishoftu hospital is providing service not only to the residents of the town but also to people coming from the surrounding rural areas. People also come form Adama to get HIV test since they fear stigma and discrimination in their own town in case they acquire the virus. This, by itself, created its own work burden on the services of the hospital. The hospital also gives confirmation letter to HIV positive people, and sends them to HAPCO. This service is, however, rendered only for those people who are the resident of the town of Bishoftu. This is because HAPCO, Bishoftu branch provide its support only for the residents of the town.

The hospital is currently working in close cooperation with Columbia University on the issue of HIV/AIDS. The University has been providing technical, material and financial support to the hospital. It also organizes training for the nurses who are working on HIV/AIDS. Today, the University is constructing ART unit in the hospital's compound. It also promised to employ trained medical personnel to the service when the unit began its full performance.

Bishoftu hospital also teaches people who come to the hospital to receive other medical treatments. They advice these people to give their blood for a test. There are also peer educators who teach people who wait for their turn. Thus, one can say that the activities of the hospital are limited within its own yard. Their activities to bring about the intended behavioral change by going down to the society in their own effort are very minimal and restricted.

3.1.2 Debre Zeit Health Center

Debre Zeit Health Center began to provide services in connection with HIV/AIDS in an organized way in June 2005. The major services in the health center are: counseling, testing and referring HIV positive people to Bishoftu hospital.

The heath center has been giving HIV blood test service only to people above the age of eighteen. It also gives free medical treatment for HIV positive people to check opportunist infections. The center referred HIV positive people to Bishoftu hospital to know the number of their CD4. It also sends them to the same hospital to help them receive ART service, which is not rendered in the health center.

The health center also gives health education to all people who come to the center seeking for other medical treatments. The staff has also been engaged in providing lectures in schools when invited. However, the contribution of the health center in preventing the further spread of the virus is minimal. It did not go down to the community to teach or organize them in the fight against HIV/AIDS. The center describes its success simply on the basis of the number of people who come to receive counseling and testing.

The Health center is not also well staffed. There are no medical personnel who are specially trained and assigned for HIV/AIDS. However, there are two nurses who are giving counseling. These two nurses are also expected to perform other activities in other units. According to my informant, sister Aster, there were times when both of them were engaged in other tasks, and the service seekers wait for long. This problem has been presented to the health coordinating bureau of Bishoftu in different meetings. However, the problem still persists.

3.1.3 HIV/AIDS Prevention and Control Office (HAPCO) Debre Zeit Branch

HAPCO is one of the major government organizations working on prevention and control of HIV/AIDS in Bishoftu. It has been almost three years since the organization began its services in the town. Formerly, the organization was functioning independent of the Health Control Bureau of Bishoftu. The Oromia Health Bureau also directly allocated its budget. However, today,

according to the new strategy of Oromia Health Bureau, HAPCO is placed under the direct control and supervision of the Health Control Bureau of Bishoftu.

The major task of the organization is the coordination of the various institutions that are working in the town on HIV/AIDS. It works in close relation with NGOs, and Anti- AIDS clubs. It also held seminars and lectures at different times to bring about the intended behavioral change among the society only in Bishoftu town. HAPCO does not directly give support to PLWHA. However, it works with the various service providers, particularly with NGOs, to help PLWHA in every aspect of their life.

Those people who are identified as HIV positive have been sent to HAPCO particularly from Bishoftu and Air Force hospitals. Then HAPCO assign them to the various service providers in the town. In addition to this, the organization also provides counseling service for the needy after they have known their sero-positive status. There are now 729 PLWHA under the organization. These people monthly receive food support form NGOs through HAPCO.

HAPCO also organizes 'Bunna Tetu' (Let's drink coffee) program once in a month to discuss matters associated with the life of HIV positive people in the town. The theme of the discussion in the program is sharing of experiences on how to live positively with HIV/AIDS. The other major agendas of the discussion are: the health, social and financial problems that they are facing, how to use ART effectively, and how to protect HIV negative people from the virus. According to the head of HAPCO, Ato Afework, these discussions enabled most HIV positive people to live positively with the virus by contributing their part in the combat against HIV/AIDS in the community. He further stated that the discussions also encouraged and strengthened newly infected people that they can fully live and achieve their goals.

The other major assignment of HAPCO is to assist those PLWHA who faced complicated situations to rent a house because of the stigma and discrimination the experience in the town. Therefore, in order to solve the matter, the organization held several discussions with 'kebele' leaders, and obtained their full support. Thus, PLWHA are now served first in the available 'kebele' houses in the town. Together with this, the organization also encourages those institutions that are covering house fees for PLWHA. Visiting associations and directing them to receive assistance from NGOs is also the other function of HAPCO.

According to Ato Afework, the number of people who give their blood for a test in Bishoftu and Air force hospital has been dramatically increasing. There were only 2,693 people who gave their blood for a test in 2005. However, in 2006, 5,240 people were tested only with the past eight months. The number of people living with the virus also decreases in the town. In 2004 there were 20.7% of HIV positive cases, and the figure dropped to 19.9% in 2005. But today, only within the past nine months, it reached 11.9%. However, Ato Afework stated that these are of rough data that represent only the reports of Bishoftu hospital. He further said that people from the town went to the neighboring regions to get their blood tested and returned to the town. Therefore, there is no solid figure that shows the number of HIV victims in the town of Bishoftu.

HAPCO is working in close collaboration with the society, particularly as of 2005. This was mainly the result of the shift in government's strategy to combat HIV/AIDS. In 2005, the government announced that the community should have to take the lead and actively participate in the fight against HIV/AIDS. Thus, in order to implement the program, HAPCO started to work in close collaboration with the various religious institutions and 'Idirs' in Debre Zeit, besides with other NGOs.

There are two government health centers and eight NGOs that are recognized and working in coordination with HAPCO. These institutions are expected to submit their annual report to HAPCO. The two government institutions are: Bishoftu hospital and Debre Zeit health center; where as, the eight NGOs are:

1. LENI Derash
2. Mulu Wongel Church
3. Organization of Social Services for AIDS (OSSA)
4. The Ethiopian Family Guidance Association
5. The American Children Aid Organization
6. RATSON: Women, Youth and Children Development Program
7. Jerusalem Children and Community Development Organization: Debre Zeit Community Program Office
8. The Ethiopia Genet Church Development and Welfare Association: Stop AIDS in Debre Zeit (SAID)

Besides these organizations, Kale Hiwot Church also designed a major project to help PLWHA, and it is in the process implementing it. Moreover, there are various associations that are working on HIV/AIDS in the town.

However, HAPCO is staffed only with a single individual to accomplish all these activities. Since there are a lot to be performed through the organization as discussed above, it is very hard to believe that only a single individual can properly manage it. Ato Afework, the only staff in HAPCO, strongly stressed that he couldn't do the entire job by himself. When he is out to attend seminars, panel discussions and conferences in other regions, he usually locked his office and goes there, and the work awaits him. This, according to him, creates a great burden on him, and service seekers are also mistreated in the process, let alone its impact on the effectiveness and efficiency of the services rendered. Nevertheless, he expressed his hope that the Oromia Health Bureau would solve the problem with in a short period.

3.2 Non Governmental Organizations

3.2.1 Dawn of Hope Ethiopia Debre Zeit Branch

Dawn of Hope Ethiopia is a non-profit making, non-religious indigenous organization. The association was first established in June 1998 by eleven HIV-positive people in Addis Ababa. Seven HIV-positive people who were living in and around the town opened its branch in the town of Bishoftu in 2002.

The mission of Dawn of Hope Ethiopia Debre Zeit Branch is to see AIDS-free generation in Ethiopia in general and Bishoftu in particular. When they established it, the seven HIV-positive people promised themselves to work hard for that end. Decreasing the number of orphans in the town through organizing and giving them support, and the protection of the human rights of PLWHA are also the other major vexations that the organization puts great effort. In connection with the protection of the human rights of PLWHA, the head of the organization mentioned that the organization cannot by itself solve all human right problems associated with HIV/AIDS. He further stated that the violations of human rights are not only the problems of HIV-positive people. Thus, he said, the government should have to take the issue very seriously as its own major agenda and is expected to contribute its own part to solve it.

The other services rendered by the organization are: counseling (including house-to-house), organizing home based care providers, care and support, which in extended to include both orphans and PLWHA and organizing PLWHA in income generating activities. The organization covers the school fees, the expenses of uniform, and other necessary educational materials for the orphans (see plate 7).

The organization strongly believes that PLWHA can contribute their part to the development of the country. Therefore, to become part of the development Programmes of the country, the organization provides money to the victims who were organized and ready, both mentally and physically, to work. It is also working hard to curb the sprit of expecting the hands of others from its members. Today, PLWHA are attending different trainings from the organizations, which has greater links with various other institutions that are ready to assist them. In this regard, PLWHA are receiving training to be a tailoring and needlework. There are also PLWHA who organized themselves and engaged in poultry (see plate 6). Currently, the organization is preparing itself to set up metalwork training center. To this end, the municipality of the town provided them space for the activity.

Today, the members of Dawn of Hope Ethiopia Debre Zeit Branch reached 700. All are living with the virus. In fact, one of the major criteria to be the member of the association is to be tested and proved HIV-positive from known health institute. Besides this, members are expected to know the missions of the association and give their full backing to that end. According to the 2006 statistic of the organization, there were 290 men and 380 women in the organization. The remaining 30, became member of the association in this year, and most, according to the head, are women. In addition to PLWHA, there are also 1,886 orphans registered in the organization. All live with their respective parents, or care givers, or foster parent's house, and receive the different provisions of the association from there. Out of the 1,886 orphans, 230 of them are HIV-positive.

Youths are the most dominant members of the association, followed by children, which reached 230 in 2007. This might not be taken as a surprise since the disease mainly attacks the young members of any community. Children acquired the virus from their mother either in the prenatal or

postnatal stage. There are also quite a large number of old ages (above 50) registered in the organization.

In the earlier days, after its establishment in Bishoftu town, the organization received support from the various institutions, government and non-government, working in the town. According to some of the founding members I interviewed, there were organizations that covered the whole expenses of the association particularly by covering the yearly telephone bill, and by supplying different office materials.

Currently the organization has completed the proposal of a major project called Association of Handicapped HIV- Positive People. The organization is planning to do advocacy work and support handicapped HIV-positive people technically and financially. The municipality has already accepted the proposal.

The members strongly believe that the association makes a huge difference in their life. They were also the first to receive ART service in the country, even before the government imported the drugs. The drugs were supplied by RATSON, one of the major NGOs working in Bishoftu. The association also has a strong link with the other government and non-government organizations, which makes its activities a lot easier.

3.2.2 RATSON: Women, Youth and Children Development Program

RATSON envisions a self-reliant community free from any psychosocial and economic burden and a community that enjoys the basic human needs and human rights. Its mission is to improve the deep rooted development problems to target communities living in the country, especially women, youth and children by promoting genuine participation of the target constituent and all stakeholders through community based rural and urban development programs.

RATSON began to implement programs associated with HIV/AIDS in 2005. It works in close collaboration with Bishoftu and Air Force hospitals. The organization is the first NGO in the country to import ART from Canada. However, it did not directly distribute the drug to HIV-positive people, but to Bishoftu and Air Force hospitals that took the responsibility of distributing the drug to the necessitous.

There are 500 children who are sponsored by foreigners in the organization. From this figure, 150 of them are orphans. There are also 400 HIV-positive households who are receiving the assistances of the organization. These people were not directly chosen by the organization. Those people who become HIV-positive and badly need care and support will be referred to HAPCO from Bishoftu hospital. Then, HAPCO send them to the various service providers in the town. And this is how RATSON received those people under its care. Besides the importation of ART, the major provisions of the organization include the distribution of cooking oil. In addition to this, the organization provides training for the home-based care providers. Both HIV-positive and negative people are included in the training. According to the program coordinator, these people are doing a very great work, and that victims who were once bedridden are now engaged in the same activity after attending the required training. These people are given food supply in return for their services.

RATSON works with Anti-AIDS clubs to prevent the further spread of HIV/AIDS. It gives training for members of the Anti-AIDS clubs and as well as to peer educators to get in touch with the community. The focus of the organization in the area of prevention is advocating abstinence and faithfulness. It also provides training for the trainees of peer educators. The selected Anti-AIDS clubs and the peer educators had also received material assistance from the organization. RATSON also pays the fees of rented houses for those who are not in a position to pay by themselves. It also

creates job opportunity for PLWHA by building a market center and by distributing micro-shopping at different sites of the town.

The project coordinator stated that the organization is now working in full potential, and has no staff problem. The chief aim of the organization, which is believed to be achieved in 2008, is to see those people on its list sustain their life without its support. According to the project coordinator, they are approaching to that target.

3.2.3 Jerusalem Children and Community Development Organization: Debre Zeit Community Program Office

This organization has been involved in community children care services since 2001. Together with this, it started to render services in connection with HIV/AIDS. The major activities of the organization in relation to HIV/AIDS are: awareness raising, counselors training, care and support program, home based care-ART and TB volunteers follow-up (see plate 1 and 2) and financial support to bedridden PLWHA.

The organization is also supporting the biggest Anti-AIDS club in the town. The club has 60 members. All the members receive training from the organization. The organization also provides material and financial support to this anti-AIDS club. It uses this club in the awareness raising programs in schools and on public gatherings. In schools, they teach about abstinence. On the other hand, the organization selected and organizes a health committee from among the community who are engaged in condom distribution.

Three hundred and sixty orphans are currently receiving support form the organization. Each orphan has an account number in a bank. The organization saves money in the name of each one of them. The foster parents of the orphans are also allowed to participate in income generating

activities of the organization. This service is not only provided for PLWHA. HIV- negative people are also included in self-help associations, which are financially supported by the organization. The organization also provides tutorial classes for the orphans and other poor members of the community up to grade six. Currently, the number of children attending the program reaches 500.

Jerusalem children and community development organization has been working in 'kebele' 11 in the town of Bishoftu. Today, it opened a new office in 'kebele' 07. However, its activities in 'kebele' 11 are not phased out. According to the health coordinator of the origination, it was their success in 'kebele' 11 that enabled them to open another branch in 'kebele' 07. Besides the opening of new office, the organization has also started to run a new program. This program is planned only for PLWHA. The program is intended to involve PLWHA in urban agriculture. Thus, PLWHA have been given the seeds of different vegetables, which they sow it on the land that the organization has received from the municipality of the town. It is also anticipated to help PLWHA to obtain balanced diet, and also enable them bring their products to the market and financially support themselves. Although the program is in its minimal stage, it is very promising.

Foreign donors financially sponsor the organization to undertake its activities. As a result, the organization faces no financial constraints to run its programs effectively. It has also enough staff members in every unit. However, the major challenge of the organization is that since it mainly focused on children and women, it neglected the elders. This, in turn, puts its own impact on the performance of the organization, which largely aimed at community empowerment.

3.2.4 Ethiopian Genet Church Development and Welfare Organization (EGC/DWO): Stop AIDS in Debre Zeit (SAID) Project

Although EGC is a religious institution, since one of its major objectives is giving all-encompassing services to all people, it began to run a project called Stop AIDS in Debre Zeit (SAID). This program began its full service in 2004. The church received financial and material assistance from donor agencies particularly from Finland to undertake its activities.

The organization has four major strategies to stop AIDS in Bishoftu. These are:

1. ***Care and support:-*** this service is provided only for HIV-positive people who were sent to the organization from HAPCO, and orphans.
2. ***Advocacy:-*** this includes giving training for home based care providers and peer educators. Seventy nine HIV-negative and positive people have been trained for the home based care service. But, only 50 of them are currently engaged in the service. Out of this, only four are HIV-positive. These people are given 35 birr per month, for transportation.
3. ***Prevention:-*** this includes awareness creation, particularly among youths and women who are working in bars and hotels in the town. It also includes organizing these people to change their life through alternative means. In this regard, twenty women, who were working as bar ladies, were organized and given financial and material assistance to engage in a different task.
4. ***Capacity building:-*** this is extended only for HIV positive people. It includes income-generating activities. For example, there are fourteen HIV-positive people who are organized and receiving financial aid from the organization, and engaged in poultry production.

There were 35 HIV-positive people who were receiving 200 birr per month in 2006 form the organization. However, after their health status has been

restored, and become ready, both physically and psychologically, to engage in income generating activities, the monthly support stopped. Currently, there are only ten bedridden HIV-positive women who are receiving the support. The orphans, on the other hand, received all the necessary materials for their education such as exercise books, pen, pencil, school uniform, school fee and the like.

The peer educators who received the training engaged in awareness creation in the community. They teach on 'Idirs', in school and in different public gatherings. They have a drama group which is very famous in teaching about HIV/AIDS especially in schools. The organization is obtaining positive feed backs from different members of the society in this regard.

The organization has only three people in the program: two nurses and one environmental health worker. These staff members agree that they are facing work burdens. However, they stressed that they are doing the work with great interest and courage.

The challenges of HIV/AIDS are so many that they greatly need the coordinated assistance of the various institutions to address them effectively. PLWHA have passed through several challenges in their life. However, it would be difficult to come out of these challenges with out the support of governmental and non-governmental organizations. Had it not been the assistance of the various institutions working on the issue in the town, the burdens that PLWHA faced would threaten their own existence.

Since most PLWHA in the town came from the bottom strata of the society, they require great assistance in every aspects of their life. The government put its efforts to assist these people through HAPCO, besides health centers. HAPCO is performing its tasks in a good manner by addressing the various issues of PLWHA in Bishoftu. The huge magnitudes of problems that PLWHA have, however, cannot only be addressed by the efforts of the government. Thus, various NGOs are participating in the endeavors of the government to

assist PLWHA. These NGOs integrated HIV/AIDS prevention and control programme in their services. This has mainly emanated from the great threat that the disease poses to the country's development. So, for most of these NGOs, striving to bring about sustainable development without curbing the alarming spread of HIV/AIDS in the country, and supporting those already infected by the virus are daydreaming.

However, these NGOs follow different approaches to address these major and all encompassing problems in the town. Some of them have focused on the direct provision of basic necessities like food, health and relief while others have designed strategies where by PLWHA organize themselves and make use of their own resources with little external assistance. The efforts of some of the NGOs in participating PLWHA in different income generating activities is important because it will enable them to realize their potential and energy, and as well as their contribution in the country's effort to bring about sustainable development through capacity building.

The works of NGOs in supporting orphans cannot also be down played. Orphans would have been the menace of development in the country in general and in Bishoftu in particular had it not been the support they got from the various NGOs. They are also teaching and organizing youths in the fight against HIV/AIDS. Therefore, besides covering the school expenses of orphans, NGOs are also throwing their part in preparing the way for the coming of able and productive generation.

PLWHA in the town were strengthened and began to lead a courageous life after they became member of an organization. This is mainly because, besides the assistance they receive, it gives them the opportunity to talk about their experiences and learn from it. The counseling that is available both in governmental and NGOs is also a great help in instigating hope and dream in the life of PLWHA. Generally, therefore, although much is expected to be performed, what governmental and NGOs are doing to assist the life of PLWHA in every aspect of their life is worth encouraging and supporting.

CHAPTER FOUR

MAJOR FINDINGS OF THE STUDY

This chapter contains the presentation and analysis of the data collected from the field through in-depth interview, focus group discussions and systematic observation. The chapter gives a detailed ethnographic account of the subject of the study. This section of the study is also believed to furnish the reader with a sense of the variety of PLWHA's experiences. In this regard, therefore, of the overall cases which were covered by this study during the field research, I have selected cases of some of my informants, which, I believe, would give the reader a picture about the challenges being faced by PLWHA and persons who are living with them. They are selected in such a way that they would represent the different categories of PLWHA. However, because of the sensitivity of the subject of the study, the names of all the persons presented as cases in this chapter are pseudonyms.

The chapter is divided into three major sections. These are: the social burdens of HIV/AIDS on PLWHA, the economic hardships of PLWHA, and the psychological burdens that PLWHA have faced. Each section is also divided into several subsections. Thus, we will be looking into issues of stigma and discrimination, housing problem, rejection, loss of job, depression, loneliness and the social, economic and psychological challenges of HIV/AIDS on the children and parents of PLWHA. The discussion will begin from the social burdens of HIV/AIDS on PLWHA.

4.1 Social burdens of HIV/AIDS on PLWHA

No less than the etiology of HIV/AIDS, the societal reactions to the AIDS epidemic pose important social problems that are as vexing as are the medical aspects of the disease. The immediate cause of any infectious disease is a microorganism. However, social factors influence person to

person transmission and may explain why the prevalence of a disease varies between populations. Thus, HIV is the biological cause of AIDS, but social factors determine the behavior that is crucial in most transmissions of HIV and explain why some groups and populations have higher rates than other groups and populations.

The principle that behavioral differences are related to social conditions is the central principle in the analysis of the social etiology of a disease. It applies to HIV/AIDS no less than to other diseases.

> *Societal reactions to HIV/AIDS especially during the 1980s are as significant as the social etiology of the disease. Persons with HIV/AIDS, particularly gays, have been deserted, denied proper medical care, and physically brutalized. Children with HIV/AIDS have been prohibited from attending school and church, and children with hemophilia who have contracted HIV have been stigmatized and treated as outcasts. Too many people, person's with HIV/AIDS are morally impaired (Rushing, 1995:5).*

History records similar reactions to past epidemics. As in the past, people respond to the social meaning of a disease, not to its biological features and medical definition. Hence the social meaning of a disease is determined by the social conditions under which that disease occurs.

4.1.1 Stigma and Discrimination

Stigma is a broad and multidimensional concept whose essence centers on the issue of distance. Birenbaum and Sagarin (1976:33) saw stigmatized people as: *"the entire field of people who are regarded negatively, for having violated rules, others for being the sort of people they are or having traits that are highly valued."*

In general, there is consensus in the stigma literature that stigma represents a construction of deviation from the ideal or expected form of behavior. Goffman (1963) viewed 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. It is also stated in the literature review section from UNAIDS (2006) report that HIV-related stigma consists of negative attitudes towards those infected or suspected of being infected with HIV and those affected by AIDS by association such as orphans or the children and families of people living with HIV.

Although it showed a slight improvement from earlier days, stigma and discrimination is still one of the major challenges that PLWHA are facing in Bishoftu Town. PLWHA are facing stigma and discrimination from different groups. This can be explained in terms of rejection beginning from ones own family members. They also experience it in their neighborhood, at work place and from their close friends.

The following is the story of a person who has been diagnosed to have the HIV virus in her body, but rejected by her neighborhood and her parents and/or blood relatives when they came to be cognizant of the fact that she is living with the virus. This is one of the cases that have been selected to demonstrate the experience of some PLWHA who are faced with the challenges of stigma.

Case One: A House Wife (Largoni)

> *I was born in Bishoftu in 1970, and learnt there up to grade six. Then I left Bishoftu to Haromaya. But, I didn't continue my education there. I did not have a job as well. So, I used to spend most of my time in the house.*
>
> *I gave my blood for a test when my daughter died after a long suffering. I came to know my sero-positive status in 1997. I had no knowledge and understanding about HIV/AIDS before I acquired the virus. In fact, I did not even have the courage to hear or read about HIV/AIDS. After I knew my sero-positive status, I promised myself not to disclose my situation to anyone, and months passed before I disclosed my sero-positive status.*

However, my closed sero-positive status did not give me peace and rest. Thus, I decided to disclose my status, and teach the society. Nevertheless, I did not properly attained counseling services that can give me courage and strength, and alternative means to live positively with the virus.

I had been living in harmony with the community before I disclosed my sero-positive status. However, things began to change around me the moment I disclosed myself as HIV patient. The next chapter of my life started after this time. I was only teaching the community to protect themselves from HIV/AIDS. I did not tell them to obliterate themselves, but to save their life and achieve their goals. However, the moment I did that, I found myself as a stranger in my own community. First, I didn't recognize that those strange feelings I sensed were the results of my disclosed sero-positive status. But, when I recognized that I feel like outcast and useless in the community I was brought up. Now, I know that these feelings get into me because I didn't receive proper counseling to handle the situation.

She continued...... *The community I was brought up harshly treated me. Although the first challenge came from my neighborhood, what really hurt my feeling was the mistreatment and later the rejection I faced from my own blood relatives. I faced several social challenges that even urged me to question my own existence. You know what? All of a sudden people began to run and hide when they saw me. These people used to give me a hug when they got me. Everybody gave me their back. They stopped borrowing me washing equipments like a tub. They even stopped to use the rope I used to spread out my clothes. Even my own blood relatives planned to kill me on the ground that I disgraced their honor. It was on this point that I began to think that I made a fool of myself by disclosing my sero-positive status.*

People feared and rejected me as if I was some kind of monster. People did not even sit on the chair that I sit, even on the taxi. I also remembered a person who rubbed his hand after he shake with me. My response to all these challenges was to lock my door and cry. When the stigma and discrimination become too intense, I began to fear for my own life. Thus, I married a policeman, who was also HIV-positive. I got a daughter from him. My daughter is now nine years of age, and a grade three student.

I asked her whether the stigma and discrimination she has faced extended to her family. She said:

Of course. Children were not allowed to play with my daughter in my neighborhood. There was also a time that my daughter was given a separate plate while the other children were eating together. This created a great depression and loneliness on my daughter. This was a pain for me. I could not handle the whole situation by myself particularly after the death of my husband. Thus, there were times that I decided to give my daughter to any organization working on children and commit suicide. But, I did not do that, all have passed now, I am still alive. Now, I believe that I have the courage and knowledge to contribute my part in the battle against HIV/AIDS.

Today, Largoni is teaching the society to bring about behavioral changes. She teaches in schools and on any other public gatherings. She said that those people who looked at her as a "monster" are changed, and treat her well. While she was taking me to her house, I also observed that people are greeting and taking to her normally. However, she added that a great deal of work is required to bring about a long lasting behavioral change and understanding in the society. Largoni is currently working as a counselor in Dawn of Hope Ethiopia, Debre Zeit Branch.

The harmony and the smooth relationships a person has with his/her community might be impaired when he/she is disclosed as HIV patient, which is depicted in Largoni's case. The efforts of PLWHA to teach the society about HIV/AIDS on the basis of their own experience is observed to backfire on them instead of granting them the support and encouragement they undoubtedly need. This might be the result of the lack of the necessary knowledge and understanding about HIV/AIDS on the part of the society. The way we react to a certain thing is greatly influenced and challenged by our level of understanding to that particular thing. In this regard, a person's knowledge and understanding about HIV/AIDS determines the way he/she responds to it and to those infected by it.

The widespread stigma and discrimination in the town enormously undermined the benefits that the society would get through supporting and encouraging those people living with the virus. The society is robbing the

courage of PLWHA to live positively with the virus by sharing their life experiences to their community through mistreatment. The pain of this mistreatment, however, becomes high when it comes from one's own parents and/or blood relatives. In this regard, the focus of structural approach, HIV/AIDS prevention must be understood as part of the broader process of social transformation aimed not merely at the reduction of the risk but at the redress of the social and economic inequalities and injustices, should be advocated by the concerned bodies to bring about the intended change in the society.

If a person is treated like some kind of creature other than a human being in his/her own community, he/she will feel different and becomes hopeless. This, in turn, robs him/her the courage to live. By doing so, the society is losing the life experiences of PLWHA which have a great contribution in the battle against HIV/AIDS if used appropriately.

A person who had an experience that even a mother rejected her own son best narrates this situation in one of the focus group discussions which was held with male informants. He described the situation as follows:

> *There was a person who was infected with HIV some years back. The person was greatly weakened by the virus so he was bedridden. However, although he was living with his parents, there was no one by his side to give him the proper care and support. The whole family rejected him, even his mother. When he died, his family called members of Dawn of Hope Ethiopia to burry him. They were not even present in his funeral.*

From this one can infer that if a mother develops a great hatred towards her own HIV- positive son, it might be very difficult to expect the rest members of the society to give the necessary care and support to other PLWHA. Although love and support to PLWHA should have to come first from their own parents and blood relatives, sometimes they get their first experience of rejection from them. In this regard, the case with Largoni is a good example.

In what follows, I present the case of two individuals whose sero status is positive. These cases are presented to show the challenges of stigma and discrimination that PLWHA are experiencing from their spouses and close friends. In the first case, we will see the challenges that a former barmaid (Welaros) experienced the moment she disclose her sero-positive status to her husband. The second case (the case of a pensioned –soldier: Balermo) shows the rejection that the person faced because of his disclosed sero-positive status from his close friends and colleagues.

Case Two: A Former Barmaid (Welaros)

> *I was born in Wollo in 1975. I only attend elementary education. I came to Addis Ababa in 1987 and lived in the capital until 1993 before I moved to Bishoftu. I had a family. I conceived my first daughter when I was fifteen years of age. Today, I have two HIV–negative daughters.*
>
> *I gave my blood for a test in 2003. The result of the test indicated the presence of HIV virus in my blood. I immediately told the result to my younger sister who was a third year student at Bahir Dar University. I received the first counseling from my own sister. However, I did not disclose my sero-positive status to my husband, who was a 'Shaleqa' (Lieutenant) in the defense force, for about four months since my pregnancy. But, we were living under the same roof.*
>
> *However, I lost all my hope and peace after I disclosed my status to my husband. My husband made my life miserable. He treated me as a useless person, and he always told me that death was at my doorsteps. He totally denied the honor and respect a husband should show to his wife. Moreover, when his parents came to visit us, I was not allowed to sit and play with them, or involved in any of the discussion, which even included my own household. I used to spend the time sitting in my bedroom. The mistreatment of my husband, who claimed to be HIV- positive without testing, added to my sero-positive status, created a great psychological pain on me.*
>
> *By using his position in the defense force, my husband also ordered some police men to take my 'kebele' Identify Card. This was intended to block me from becoming a member of HIV/AIDS organization. Moreover, after a while, he expelled me from the*

house. This was the difficult moment for me. I spent so many nights on the gate of the police force seeking for justice. I even spend a night in a house prepared for a dog. I lived for days eating only bread per day. However, what I claimed fall on the deaf ears of the 'kebele' leaders. All these challenges finally drove me to madness. And I did not remember what happened in my life for a month or so after that. However, after my health status was restored being assisted by an organization, I presented all the problems I had been through in one of the programmes broadcasted by Radio Fana. After this, things began to change around me. The first to respond to my claim on the Radio was the 'kebele' leaders- by returning my Identification Card. Then I filed charges on my husband, and got success.

My daughters had also felt the impacts of the disclosure of my sero-positive status. They were not allowed to play with their age groups. They were cast aside from any contact with the other children, even if they were HIV- negative. This once forced me to change place of residence.

I become a member of Dawn of Hope Ethiopia in 2006. Now, I am attending needlework training given by the organization in collaboration with other institutions. However, I am not as strong as before, but I am still working and making a living for myself and my daughters. It was the counseling that I received enabled me to walk again in full confidence. Although, the challenges of HIV/AIDS are still there in one way or another, changes have been observed in the town than earlier days. I finally want to say that the efforts of the various organizations in assisting the life of PLWHA have to be strengthened and encouraged, and should get the backing of the society.

As can be seen from this case, PLWHA can face serious challenges from their spouses. The hardships that Welaros have passed through can be taken as an exemplary case for most PLWHA. Spouses are supposed to help each other, in what ever circumstances, and respect one another in all aspects of their life situations. However, sometimes, they might quarrel because of a number of reasons, and unable to solve the situation by themselves, and settle the issue through divorce. In the same sense, HIV/AIDS can lead to the breakdown of healthy relations between the husband and the wife. This, in turn, makes separation of spouses inevitable. Most of the time, children are the victims of such circumstances.

The second point that could be made in relation to this case could be the challenges that PLWHA have been facing from people who holds administrative positions. Those people in the administration position are given greater responsibilities to treat all the people they administer equally, and to provide justice whenever it is demanded in the proper way. But, sometimes, they might neglect their responsibilities and misuse their power and authority. These people are also accountable to all decisions they make by using their authority. And at the same time, they are expected to have at least a better understanding about major societal issues. However, when they abuse their power, the people they administer will feel hopelessness, particularly those who have no one to turn to. When this becomes too intense, it can lead a person to madness. This was what happened in the life of Welaros. The structural approach which claims that political factors have been responsible for the most complex barrier to effective AIDS prevention programme best fits in the situation of Welaros.

Every healthy person needs to feel secure in the community he/she is living. However, PLWHA feel insecure in their own community because of the mistreatment and subsequent rejection they encounter in their daily life. This becomes worse when it comes from those people who are supposed to administer the community in peace and harmony, and worst when it comes from ones spouse.

Case There: A Pensioned Soldier (Balermo)

> *I was born in Wollo in 1957. I learned up to grade eleven in W/ro Sihen School. Then I moved to Bishoftu and completed my education up to grade twelve. Since I did not get a passing grade to join higher education, I enrolled myself into the army. However, I did not give up my education. So I continued learning for diploma in a college. Nevertheless, I was transferred from Bishoftu to another area. Therefore, I failed to complete what I had started. Thus, the level of my education remained 12 +1 in Accounting.*

I had almost no knowledge and understanding about HIV/AIDS. I even thought that the disease is communicable through breathing. I did not participate in any public discussions, seminars and conferences about HIV/AIDS, particularly after I became a soldier. I did not use any protection when I had sex. And I had sex with different women in different areas with out any protection. This was mainly because I had a wild belief that I would die at any battle or on any duty; thus, I was using everything that can give me satisfaction, including regularly visiting commercial sex workers. In general, I was too careless about my life, and I did not have a major goal to achieve in my life.

I got married in 1991. My wife was a former commercial sex worker. I knew about her work before I married her. However, we did not give our blood for HIV test when we got married. Worse than this, I was not loyal to my marriage. I had sex with different women even after I got married. Thus, our marriage did not last a decade, and we divorced in 1999. I married another woman on the same year, but again without blood test. I got two daughters from my second marriage. The first-born girl is HIV- negative, whereas the second one is HIV-positive. I gave my first daughter in 'Gudifecha' (adoption). Even, my second marriage did not work out properly. My wife did not treat me like a husband, and had no peace in the house. Thus, the only way to restore my peace was to get a divorce, which I had it in 2003.

I gave my blood for a test when I felt sick frequently, and when my strength showed a dramatic decline. Together with these, I also faced a gradual loss of weight. Then I went to Bishoftu hospital for a test. And the result indicated the presence of the virus in my blood. This was in 2006. The result was not what I expected. I was really shocked. Then, I immediately took my daughters to the hospital for a test. After the test, the nurse told me that my first-born is HIV- negative. I became greatly relaxed and happy. But my happiness was overshadowed when the same nurse gave me the result of my second daughter: HIV- positive. I felt like I murdered an innocent child. I couldn't stand the pain for weeks, which gradually improved with the counseling I followed at RATSON. •

I first disclosed my sero-positive status to my close friend. But, when I told him, he was shocked and run away. It was after this incident that I began to face discrimination. My colleagues began to give me their backs. Before I disclosed my sero-positive status, people used to gather around me since I create jokes. However, all that was eroded when my sero-status was disclosed. What was

worse for me was that even my close friends who used to spend most of their free time with me stopped coming to my house. This created a sense of loneliness and rejection. There was also a time that I considered myself as a useless person and as a person who commits a huge crime that deserves a death penalty. I really missed the fun I used to have with my friends. We were too close. I didn't think for a minute that something will interrupt our friendship. I tried to approach them so as to restore our friendship. But, I failed to create the atmosphere I was accustomed to.

After this, I became a member of RATSON in January 2006. And I was pensioned in March 2006. But this had nothing to do with my disclosed sero- positive status. I am now receiving assistance form NGOs through RATSON. I receive forty five kilo wheat, three liters of cooking oil, and seven kilo beans a month.

Balermo regards HIV/AIDS as God's punishment for misbehavior and immoral practices. He said:

I was infected with HIV/AIDS because I denied God. I did things that were not favored by God. For example, I chewed 'chat', smoke cigarettes, drunk a lot, and commit adultery. But now, I returned to God. I even received the Holy Communion. However, I am still HIV-positive, which means my faith in Him is still minimal. But, to your surprise, I don't want to get cured now because the virus enabled me to give up all the bad habits.

As can be seen from this case, if a person fails to see his/her future directions in a very settled and normal way, he/she is more likely to be trapped by matters that are at hand, which have little to do with building ones career. In other words, a person with no major goal and/ or vision in his/her life is less likely to care for himself/herself, let alone for the society. It was the lack of ultimate goals in his life in general and too much carelessness about his own life in particular that exposed Balermo to HIV infection.

In addition to the frustration he faced when he came to know his sero-positive status, the rejection Balermo experienced from his colleagues and close friends greatly hurt his feelings. PLWHA, who were surrounded by so many people before their disclosed sero-positive status, and experience

rejection as the result of their disclosed blood status, would feel lonely and isolated from the community. This might robe them the strength to live positively with the virus. The rejection that comes from colleagues and close friends has a strong influence on the life of PLWHA. PLWHA would have lead a normal and fruitful life if they receive love and support from their close friends instead of rejection, which will drove them to feel guilty for what they did. This has no good in bringing the experiences of these people to teach the community.

4.1.2 PLWHA and their Children

The social impact of HIV/AIDS is not only restricted to PLWHA. It also influences people around them, particularly their children. Although they are HIV-negative, children of HIV victim parents experience discrimination. As it is presented with the cases of Welaros' and Largoni's daughters, they were not allowed to play and eat with the other children in the neighborhood. Therefore, they spend most of their time in the house playing with their siblings. There are also cases that children's of HIV - positive parents sit alone in school because nobody is willing to sit and share educational materials with them. In this regard, a woman in one of the focus group discussions that includes both male and female stated that her daughter faced a great discrimination in school. She further stated that:

> *My daughter is HIV-negative. But, she had no friend in the neighborhood and in the school. She always went to school alone. What was worse than this was that nobody was wiling to talk to her and discuss subject matter issues with her in the classroom. I was also forced to buy the necessary educational materials like text books since there was no one to share it with her. She used to think her situation than her education. There was also a time that she decided not to go to school. However, the situation is now somehow changed.*

There are also times when PLWHA had no alternatives but to give their children to a stranger in 'Gudifecha', as in the case of Balermo. He explained the situation as follows:

> *My first born daughter is HIV-negative. Where as, my second born is HIV-positive. Thus, I decided to give my first born to foster parents in 'Gudifecha' since I feared that she might be infected by the virus with an accident if she keeps living with us. I remember her face when they came and took her. She did not know where they were taking her. She was crying and looked desperate. Her foster parents are living in Addis Ababa. They allowed me to visit her whenever I want. But, I did not have the courage to visit her. I also believed it is good for her to forget us and get along with her new parents. Almost seven months have passed now. I once called to her foster parents and checked that she is in a good condition.*

In this situation, children will loss the love and care they used to entertain from their parents. It is not also hard to know the feelings of these children when they are given to completely strange people. They will be depressed and feel loneliness; they might even consider it as a rejection by their own parents. Sometimes people do things that they shouldn't do in their life. When it happens, they remain only with the pain. It is not easy to give up one's own child to foster parents. But, sometimes situations force parents to do that. The case with HIV victims is not an exception.

All these discriminatory acts will create a great social disaster on these children when they grow up. If a person is always looked down and told that he/she is different, he/she will feel rejected, and will start to look for mechanisms to avoid that. This might include the development of hatred to all members of the society. This will, in turn, affect the life of the person and will disturb the co-existence of the society in the long run.

4.2 Economic Hardships of HIV/AIDS on PLWHA

Besides the social challenges, PLWHA also face several economic challenges which are mainly the results of their disclosed sero-positive status. The social and economic challenges of HIV/AIDS on PLWHA can not be treated separately since the social challenges are quite connected with the economic hardships that these people are dealing with, particularly in the study area. For example, stigma and discrimination, which is heightened as a major social challenge to PLWHA, greatly influenced the economic wellbeing of the victims in the town. Those people living with the virus who are in a position to work and make their own life through different activities are greatly discouraged by the society through rejection. This forced some PLWHA to fold their hand and sit, and expect only the assistance of government and non-government organizations.

Their disclosed sero-positive status also forced some PLWHA to loss their job, and forced them to pass through greater challenges to secure a job in the town. PLWHA in the town of Bishoftu mainly came from the lower member of the society. Most of them were leading a hand to mouth existence before they acquire the virus, which, in turn, make their life even worse. This is highly observed on those people who were working as daily laborer and on those who were engaged in selling different food items in 'Gullet' (open air market). These sections of the society have to reveal their sero-positive status to the various organizations in order to start their medication, and as well as to obtain the different provisions of organizations, particularly food items.

In this sub-section, an attempt has been made to clearly present the economic challenges of HIV/AIDS on PLWHA in the study area. Loss of ones job, problem of securing a job, frequent shift of rented houses and problems associated with access to food are the major economic challenges that are faced by PLWHA. The following case is presented to show the challenges

Aligora has faced to secure a job and to rent a house. This case is selected on the ground that it can serve as a good example for the circumstances of most PLWHA in the study area.

Case Four: A Man with Bad habits (Aligora)

> *I had several bad habits, which I considered as the cause for my infection with HIV/AIDS. I chewed 'chat', smoked cigarettes, drunk too much, and went out with several women. I did not have a good understanding of the virus before I acquired it.*

I asked him how he came to know his sero- positive status. He said:

> *I was in the battle field in the war against 'Shabiya' (the Eritrean Government). I was greatly wounded in one of the battles. Then, since the doctors could not help me more in the war front, they transferred me to the Air force hospital in Bishoftu. It was in this hospital that I knew my sero-positive status. After a short counseling, the nurse told me that I am HIV positive. I thought I would die immediately. This happened in July 2003.*
>
> *I did not disclose my sero-status to anyone for long. I was not married when I came to know my sero-positive status. I had no one nearby to share my feelings. I do not even remember the person to whom I first disclosed my sero-status. Though I did not receive a strong counseling, I developed my knowledge about HIV/AIDS through reading. However, it took me two years to disclose my sero-positive status and become a member of an organization with other PLWHA. Now, I have a wife, who is HIV-positive, but no children.*
>
> *Life was not easy for me after I was excluded from the army since I was badly wounded. Living out of the house of the government after I had accustomed to it for long was not easy for me. In the first place, I had to look for a house to rent. I didn't face challenges to find a house to rent before I disclose my sero-positive status. But, the problem began the moment my name was registered as one of the members of Dawn of Hope Ethiopia, Debre Zeit branch. After this, I moved in and out from at least six rented houses. There was also a time that I moved out of my rented house even before a month passed. However, above all, what troubled me was securing a job. In connection with this, I had a surprising experience.*

Securing a job was not a plain sailing for me after I disclosed my sero-positive status. One day I read a vacant position in an organization and went there for a test. There were forty six applicants besides me. But, I stood first in the test. I became happy since I suffered a lot to get a job. Then I told the manager that I am living with HIV virus. He immediately called the person who stood second and hired him, and rejected me. The manager said that his organization is a profit making organization so he told me that he couldn't rely on my strength to do the job properly. He also told me that he doesn't want to lose profit by hiring unfit person for the job. Remember! I stood first in the test, but he addressed me as "unfit". I tried to convince him but he wouldn't listen.

When I walked out of the organization's compound, I was thinking of revenge. I began to think of myself as a useless person. I had spent weeks thinking about this. Then, I started to take actions to make my remaining life better and pleasant. The first thing I decided was convincing myself not to see the hands of others, but to prove myself that I can work and change. Today, I am preparing myself to continue my education in a college. I strongly believe that the only way to see the intended behavioral change in the society is to educate them in general and to involve them as a major force in the fight against HIV/AIDS in particular.

4.2.1 Problem of securing a job

Securing a job is one of the major problems PLWHA are experiencing in the study area as one can learn from the case of Aligora. Let alone having a family, it is very difficult to lead one's own life without any sort of income. If a person has no job, which means no regular income, anybody can imagine the economic burdens that he/she will suffer. It might put individuals in a difficult position even to get their daily bread let alone to cover other expenses.

PLWHA are also forced to leave the job they secured because of their disclosed sero-positive status. This has been one of the major issues I have raised for the participants of the focus group discussions for both the female and male groups. One of the participants of the focus group discussion

which was held with the male group was working in the air force before he was fired. He explained the situation he had passed through as follows:

> *I disclosed my sero- positive status to the army members and began to teach and discuss about the virus with them. But, this didn't impress the higher military officials. Moreover, I began to face challenges from the administration posts. Finally, I received a letter that indicates my dismissal from the army from the board that administers the air force. I know that it was not my poor qualification that forced me to loss my job, but my sero-positive status. However, this was only the beginning of the discrimination which is widespread in the town.*

However, this does not mean that all PLWHA have passed through the same experiences with the above case. There are PLWHA who disclosed their blood status but maintained their job. In this case, I found a lady who works as a secretary in a private institution in my focus group discussion with the females. She said that she received a warm support from her colleagues and faced no challenge that can put her work at risk.

In the focus group discussion I held with females I also came to learn that there are people with at least the basic knowledge and understanding of the transmission mechanisms of HIV/AIDS, but performed sexual intercourses with different people and became infected by the virus. Their main reason behind their bold act is economic difficulties. This situation in particular is observed on those people who came from the rural areas in search of work. One of the participants in the focus group discussion came to Addis Ababa hoping to have a better work and life, but she ended up as a barmaid, which she believes paved the way for her HIV infection. The structural approach that states economic factors shape sexual experience and the spread of HIV/AIDS best explains her infection. She explained the situation she had been through as follows:

> *I was born from a poor family. I went to Addis Ababa to help myself and my parents. Then I started to work in a hotel as a barmaid. But, my income did not cover my expenses, let alone something to be sent to my parents. So, I began to engage in*

activities that can earn me more money. This includes selling my body to complete strangers. I frequently went to bed with different people. I think it was this activity that exposes me to the virus.

As it is mentioned in the literature review, for the poor it is the here and now that matters, and policies and programmes that recommend deferral of gratification will, and do, fall on deaf ears. In connection with this, Kloos and Damen (2000, 26) wrote that most female sex workers in Addis Ababa came from rural areas in search of work and a better life. They further stated that female dominated and economically caused rural-urban migration in Ethiopia are not circulatory in nature and provide few job opportunities for women besides work as barmaids, prostitutes, and domestic helpers, which make them very vulnerable to sexual abuse.

Those PLWHA who were working in governmental institutions are in a better position, but not sufficiently, than those who were working as daily laborers, house servants and barmaids. These people are now totally dependent on the different service provision organizations in the town. Since they are leading a hand to mouth life, they are not in a position to get a balanced diet which is recommended together with antiretroviral drug. Today, PLWHA receive good treatment through the various organizations. However, there were PLWHA who did not properly follow their medication since they had nothing to eat. A forty two years old participant in one of the focus group discussions described his experience as follows:

I was leading my life as a daily laborer. At one time I found myself on bed. I tried to get up to go to work like the other days. But, that was not possible. The virus had already spread in my body. What makes it worse is that I had nobody on my side. There was no one to feed me. Then I went to Bishoftu hospital and they told me to start medication immediately. However, that was not possible for about a month because I had nothing to eat and I was not a member of any of the organizations to receive food aids.

4.2.2 Housing Problem

The other major challenge that really boggles the minds of PLWHA in the town Debre Zeit, as it is also presented in the case of Aligora, is housing problem. Most PLWHA are living in rented houses. This is mainly because most are migrants to the town. They came from different regions for a number of reasons. So, they preferred to rent a house and pay the monthly charge than to buy a land; in fact they did not have money to purchase their own land. Since the owners are expecting any excuse to expel them from the house, particularly after the disclosure of their sero-positive status, they have to pay the house rent on the exact day or earlier, which is not always possible without any source of income. In this regard a 38 years old participant of the focus group discussion held with both male and female described his experience as follows:

> *I worked as a daily laborer in the various construction sites in Bishoftu. But, at one time, after I disclosed my sero-positive status, I felt sick and stayed on bed for about two weeks. In that month, I had nothing in my pocket to pay for the house rent. I spent what I have on medicines. The day that I should pay the house rent come, and a day passed. Then, the owner of the house came and reminds me. I told him that I had nothing on my hand and begged him to give me a week to pay the rent. However, he was not willing. And in the next day, while I was not around, he broke into my house and put all my staff outside. This was very hard for me. I was disappointed and became angry. I even quarreled with the owner of the house. Then, I took my property and put it with my friend, who is also HIV-positive, for a while.*

However, as it has been pointed out in the focus group discussions held with the males, sometimes PLWHA change their resident frequently not only because they had nothing to pay but also because they disclosed their sero-positive status. For example, there was a person in this group that changed more than ten houses not because he failed to pay the house rent, but because he is HIV-positive. So, the person and Aligora were forced to pay for

the transportation of their household goods to another rented house, which has its own pressure on their monthly expenditure. This is also a major indication of the presence of stigma and discrimination in the town. In fact, one can say that the economic burdens that PLWHA are experiencing in the town are the results of the stigma and discrimination they faced from the society as it is evidenced from the above situations.

4.2.3 PLWHA and their Parents: the Economic Burden

The economic burdens that PLWHA face are also extended to their family. Children and grand parents are the first victims of this pressure. When PLWHA who have families become sick and bedridden, children will be the first victims. They are expected to take care of their parents who are in bed. If the situation gets worse, they are also expected to dropout from school, and go out to look for a job to sustain their own life and the life of their parents.

Grandparents are also expected to cover the whole expenses of their grand children. This, by itself, has a great economic burden on grandparents who, according to the trend of the Ethiopian society, should have to receive support from their children. If a person creates his own family but unable to generate income to support them, the existence of that family for long is in question. Accordingly, the economic burdens of HIV/AIDS on PLWHA are so huge that it even extended up to dispersal of their family.

According to one of the members of Dawn of the Hope Ethiopia who was engaged in selling vegetables and fruits, his disclosed sero-positive status brought a huge economic burdens on his family and as well as on his parents. He described the situation as follows:

> *After my sero-positive status was disclosed, people stopped coming to my shop. I waited but nobody was coming. The fruits and vegetables began to spoil. It led me to bankruptcy. All my income was closed. Finally, I had no alternatives but to close the shop, and engage in daily labor to sustain the life of my family.*

However, I couldn't run here and there and became effective in the work. Thus, it created a great economic burden on my family. I even failed to cover the school expenses of my children. Therefore, I sent them to my parents. The economic position of my parents is not also good. But, at least, they can feed them.

From this one can infer that PLWHA are sometimes forced to disperse their family because they are unable to feed them. The person in the case had no alternative but to give his children to his parents. One can also infer that the huge economic burdens that he faced because of his disclosed sero-positive status are also transferred to his parents, who are now expected to feed and cover the school expenses of his children. This, in turn, creates economic burden on grandparents, who are required to take care of their grandchildren, which demands a great investment by itself.

4.3 Psychological Burdens of HIV/AIDS on PLWHA

Muller (1997) stated that people affected by HIV infection face grater emotional strain than most people ever do. He further stated that those affected by the disease are shocked or angry or depressed or afraid or guilty or confused or have any number of these emotions at one time. They worry about revealing the diagnosis, about being dependent, about expressing sexuality, about relations with the people they love. He added that the rest of the society not directly infected by the disease reacts with fear and prejudice, making those affected by the disease also feels like outcasts, isolated and lonely.

PLWHA has passed through several psychological pains in their life. These psychological pains greatly affected their lives, and even determined their future directions. The way PLWHA responds to the psychological burdens they face greatly matters in their future life. Besides the psychological problems they will encounter because of their infection by HIV/AIDS, PLWHA will also face psychological challenges from the society. They have to address

these psychological challenges properly so as to make their way very smooth and pleasant in their remaining life.

Among the psychological pains that PLWHA suffers in the town of Bishoftu: fear of disclosing their sero-positive status, fear of stigma and discrimination, fear of rejection, loneliness, insecurity, hopelessness, anger, suicidal attempts, stress and depression are the major ones. Therefore, PLWHA are expected to deal with all these psychological pains that occur the moment they know their sero-positive status.

In this sub-section, therefore, an attempt has been made to present the ethnographic accounts of two PLWHA that clearly show the major psychological challenges they have passed through. In the first part, I will present a case that portrays the challenge of rejection and its consequences. And then I will present a case that shows the depression that PLWHA will face when their goals are frustrated.

4.3.1 Rejection

Although HIV/AIDS by itself creates its own psychological challenges on PLWHA, it is greatly aggravated by non-victims. A great psychological pain will occur when the people that used to treat them well and support them in every way give them their backs after the disclosure of their sero-positive status. Particularly, those people who were once surrounded by friends will be greatly frustrated. If a person who always spends his/her time with his/her friends and enjoys talking with people acquires the virus, he/she might not stand the rejection he/she might face from the society in general and his/her friends in particular. Alonzo and Reynolds (1995) also stated that HIV-positive individuals, their loved ones, and even their care givers are often subjected to rejection by their social circles and communities when they need support the most. They may be forced out of their homes, lose their jobs, or be subjected to violent assault. Loneliness is also a great pain if

a person is not accustomed to it formerly. Lugana's case best explains this situation.

Case Five: A Counselor (Lugana)

I decided to be tested after I became sick and began to spend much time on bed. My friends also informed me that the man I used to go out with was the carrier of the virus. I was really shocked when I heard about the man. Then I decided to get HIV test. Thus, I gave my blood for a test in 2003 and the result shows the presence of the virus in my blood. I felt like dead when I heard my sero-status.

I first disclosed my sero-positive status to my friends, who were living with me in a house we rented. I did this to protect them from the virus because we were using everything together. However, the news was not pleasant for my friends. They began to leave the house one after the other by giving their own different reasons. Finally, I remained alone in the rented house. All my friends moved out and rented another house. It was also my friends that disclosed my sero-positive status to my parents. After this, I began to face challenges in my life.

What really detriment me was the rejection I faced from my friends with whom I shared happy and sad moments in my life. Imagine all of a sudden you find yourself alone. I was surrounded by cheerful friends. We were joking, playing and laughing almost every single night when we gather in the house we rented. But, all that have gone because of my sero- positive status. Don't even ask me how much painful that was. I spent so many nights without sleeping. I have never been alone. But one day I find myself alone. I feel like abandoned. That really hurt me. Everything I have and I do become senseless. I lost satisfaction in my life. I even planned to kill myself.

I was also rejected by my parents, and as well as by the community. I was forced to move from one rented house to the other for several times. I totally rented and expelled from fourteen houses. The owners did not give me convincing reasons when they told me to look for another house. When I faced strong discrimination in Adama, I moved into Bishoftu, where I became a member of Dawn of Hope Ethiopia in 2004. The organization turned my direction and gave me the right way to live positively with the virus. I received a constant counseling service in the organization. And then, I was trained to be a counselor. I am

currently working as a counselor in the organization. I also teach the community at different public gatherings.

Today, Lugana has her own family. She has two HIV-negative children. She also believes that the attitude of the society has changed, and is incomparable with earlier days. I also share her point of view because I was at her house when her neighbor came and called her to drink coffee. She advised the society to treat PLWHA positively and show them love and care. In this way, she hoped, we can reduce the risk of HIV/AIDS. Finally, she expressed her hope and desire to see her children grow up and be the most productive member of the society with their fellow Ethiopians.

Rejection, which might also go with stigma and discrimination, is one of the worst psychological pains that PLWHA face in Bishoftu. Rejection by itself might mean nothing compared to the other psychological pains it will create. It puts a strong pressure on PLWHA to loss their self-esteem, and push individual victims to think that they are useless and unproductive. In such situations, PLWHA will think of committing suicide. In connection with this situation, we have also to remember what happened to Largoni. When she faced a strong stigma and discrimination and when the situation started to influence her daughter's life, added to the frustration created by the loss of her husband, Largoni lost her self esteem and the courage to live. Thus, she planned to commit suicide, which did not actually happen.

When they are exposed to sever rejection, PLWHA also develop stress. When this becomes deep-rooted, it can drive a person to insanity. This happened in the life of Welaros. In line with this, Faulstich (1987) wrote that stress can lead to serious problems if not managed appropriately. He added that exposure to chronic stress can contribute to both physical illnesses, such as heart disease, and mental illnesses, such as anxiety disorder.

Although rejection is a common life experience of PLWHA in the study area, there are people who are living with the virus but faced no rejection from

their family members, blood relatives, and close friends. A woman participant in one of the focus group discussions held with both male and female together, said that she did not experience any pain that come from rejection. She came to know her sero-positive status in 2001. Then, she disclose her sero-positive status to her sister first, and then to all members of the family. She explained her position as follows:

> *I have the knowledge and understanding about HIV/AIDS before I acquire it. I also participated in teachings, seminars, and group discussions about HIV/AIDS. I also worked in anti-AIDS club before I become victim of the virus. I think my previous knowledge enabled me to handle the situations that come in association with the virus. I had a great desire to disclose myself as an HIV patient and teach the community, which I did after a month. But, my blood relatives did not want me to disclose my sero-status to the community in fear of discrimination. However, my relatives and family members respected my decision. Besides my former knowledge about HIV/AIDS, the counseling I received and the life experiences I shared with other PLWHA gives me courage and strength to live positively with the virus. Since I got every baking from my family and relatives, life becomes a lot easier for me.*

From this one can infer that the psychological pains that PLWHA experience can be greatly minimize through giving them the appropriate treatment. If these people are not treated in a different way, or if they are not rejected from their social engagements because of their sero-positive status, the psychological pain coming from it will be greatly reduced. This will, in turn, equip them the courage and strength to reveal themselves as HIV-patient, and participate in teaching the community by using their life experiences. The above case can also teach us that those PLWHA who have a good knowledge and understanding about the virus before they acquire it are in a better position to muddle through the challenges of HIV/AIDS.

4.3.2 Depression

According to Gelder, Mayou and Geddes (1999), depression is a mental illness in which a person experiences deep, unshakable sadness and

diminished interest in nearly all activities. It is a serious psychological condition that affects thoughts, feelings, and the ability to function in everyday life. People also use the term depression to describe the temporary sadness, loneliness, or blues that everyone feels from time to time. Unlike normal sadness, sever depression can dramatically impair a person's ability to function in social situations and at work. People with major depression often have feelings of despair, hopelessness, and worthlessness, as well as thoughts of committing suicide.

Cross-sectional studies of patients at different stages of illness have yielded mixed feelings regarding rates of depression in patients with symptomatic HIV/AIDS, compared to those who are asymptomatic. In the few longitudinal studies following the same people as they get sicker, no increases in rates of depressive disorders over time have been observed (Burack, 1993; Barry, 1996). Recent literature, however, found out the fact that depression is the most serious problem for many PLWHA. A study by Margolese (2003) shows that almost sixty percent of PLWHA display clinical signs of depression and up to seventy five percent display at least some depressive symptoms. HIV positive women are twenty percent more likely to be depressed than HIV positive men.

The following case is presented to show how HIV/AIDS frustrated and then depressed Daren, former army member, from achieving his life goals. The case is presented as follows.

Case Six: Former Army Member (Daren)

> *I served in the Air Force for eight years. I was among the competent members of the Air Force. I also worked very hard to improve my rank in the army and served at several sites: Mekele, Bahir Dar, and Bishoftu. I came to know my sero-positive status when I was selected by my bosses to attain a military training abroad because of my qualified position in the army. Therefore, I started the process to go to Russia for further military training, and one of the processes I had to pass was blood test. I gave my*

blood for a test and the result was very shocking: HIV positive. This was in 1998.

Imagine you have an excellent opportunity to your career. Going abroad for training is a chance you rarely got in the army. I was very much fascinated when my boss told me that I was selected to attain the training. I felt like all my dreams came true. However, I did not know that I had something in my blood that can destroy my career. I blow my golden chance to build my career because of my sero-positive status. I was frustrated. I didn't know what to do. I started to think about the time that might expose me to the virus. I failed to recognize the exact day. Everything became dark. I was really shocked. Besides, I had to show the result to my boss, which I did after a week. The news then spread into the army. I was reduced from the group which was chosen to attend the training. I failed to see my future directions. People began to talk about me in the army. I hated myself. I also attempted to commit suicide. The purpose of living became vague to me.

I came to know my sero-positive status while I was working at Mekele Air Force station. Then I came to Addis Ababa and attained HIV/AIDS counseling services. I strongly believe that it was this counseling service at Dawn of Hope Ethiopia that turned my life to its normal functioning. Then I was transferred from Mekele to Bishoftu.

People in the town do not have sufficient knowledge about HIV/AIDS. As the result of this, stigma and discrimination are the common experiences of our life. My former friends at the army are not showing me the same face as they used to be. Even those who seem very caring and supportive are only of superficial. I even faced difficulty to hire a housemaid because of my disclosed positive status. People seriously criticized even those I hired. As the result of this, they did not stay for long.

Moreover, the disclosure of my sero-positive status affected not only my life but also my family. This, by itself, has its own psychological burdens on them. For example, my disclosed sero-positive status has its own burden on my son. When I send him to buy something the owners of the shop do not accept the money in return. They simply gave him what he wants. This always creates questions on my son.

All these things really depressed me. Sometimes, I couldn't handle situations that are simple and easy because of my frustration and stress. I also remembered a time that I once said: I gave my blood

for HIV test at one time, but if it is today, with the awareness I have, I will not even give my saliva.

From this case one can infer that the challenges that Daren faced greatly undermined his efforts to build his career. When the extent of his depression became very intense, Daren also planned to commit suicide. Depressed people are not in a position to see their future directions in a normal and settled way. Unless they are exposed to appropriate counseling immediately, they are more likely to isolate themselves from every social engagement, which, in turn, exacerbates their situation.

The second point that could be made in relation to this case could be the goals of the young members of the society are frustrated by their sero-positive status and the resulted psychological burdens in the study area. The depression Daren faced in this regard is very huge since he lost a great opportunity to build his career. Youths need encouragement and support to continue their contributions in the society even if their blood status is positive since they are the most energetic groups of the society. By frustrating the goals of the youth who are HIV-positive to make a difference in their life, the society must not commit the fatal mistake of increasing unproductive members of the society. Aligora's passion to work and change his life was frustrated in such manner. If such situation continues, PLWHA will consider themselves as purposeless, and this, in turn, provokes them to revenge the society. This is what Aligora thought when his goal was frustrated.

4.3.3 Children of PLWHA and the Psychological Pains

Children also feel the psychological pains of HIV/AIDS. They have nothing to do with the sero-positive status of their parents, and even with their own blood. But, they share the psychological pains of HIV/AIDS. Children think about the mistreatments they faced from the society since the rejection and discrimination always create questions in their mind. They also expect an

answer for their questions, which is not easily available for them. So, they grow with their question in mind. For example, Daren's son always questions him when he sense strange treatment from the society. The mistreatment of the society leads children to feel insecure and become fearful within their own community. This might, in turn, lead them to develop violent behavior when they grow up. Before this happened, the society in general and parents in particular have the responsibility to help children grow as responsible, productive and problem solving member of the society.

The following case is about the frustration, depression and the sense of insecurity that were created on the children of Gidoli after she discloses her sero-status to them. It is presented as follows.

Case Seven: A Former House Servant (Gidoli)

> *I went to Bishoftu hospital when I felt sick. But I did not receive the proper treatment that can cure me. I frequently visited the hospital, but with no cure at all for my pain. I began to loose weight dramatically. Moreover, my strength was gone, and instantly I find myself in the care of my children. I thought that I had a problem with my heart. However, the doctors find no symptoms to indicate that. It was on this instance that I was advised by a nurse to take HIV blood test. Then, I agreed with the advice, and gave my blood for a test. The result showed the presence of HIV virus in my blood. This was in August 2006. I did not expect my sero-status to be positive. I do not even recall the event that might expose me to HIV/AIDS.*
>
> *I did not waste any time to disclose my sero-positive status to my children. I told them when all gathered at night. I always remember that day. All my children were at home. I ordered my last daughter to prepare coffee. We were playing and laughing. I looked all of them, they were happy. Suddenly fear began to circulate in my body. Should I tell them? I get in to an argument with myself. Finally, I got the courage and strength to stand before them to disclose my status. When I told them, the room became filled with silence, and immediately with shout, because one of my daughters fainted. I turned a happy night into sadness.*
>
> *They all were crying. They felt like I am dead. They all spent the night without sleeping. They couldn't believe that I am infected*

with HIV/AIDS. They were all frustrated. But, they did not have the courage to ask me how I was infected.

In the next day, they all stayed in the house. They didn't go to school, and I didn't force them. However, they were all depressed. They didn't even eat their breakfast. Then, I started to talk to them. I told them that everything would be all right. But, they were still shocked. Days passed in the same situation. However, after a time, things began to change. They began to give me more care and support in every way. However, their efforts emanated from their fear not to lose me. My last daughter once asked me who is going to take care of her when I am gone. She developed a sense of insecurity.

I talked with Gidoli's last daughter, who is fourteen years old when I went to her house for the first time with Ato Getachew, a social worker at Dawn of Hope Ethiopia, Debre Zeit branch. I saw a sad face. Anybody can tell that she was depressed and looked frustrated.

Gidoli continued...*My first son dropped out from school, and start working as a daily laborer to sustain our life. As a first born, he always thinks that he has the responsibility to take care of the family. This, by itself, created a great burden on him. Sometimes, he became angry when things went wrong in the house. We were poor even before my sero-positive status. But, my sero-positive status created a sense of insecurity and depression on my children.*

From this case, one can infer that the first challenge that children of HIV-victim parents face is accepting the status of their parents. This is followed by frustration and depression, which is the result of the development of a sense of insecurity as it is described in the case.

Children of HIV victims can sometimes face challenges even to recognize their parents as HIV-patient. They also frustrate when they think about the sero-positive status of their parents. When children came to know the sero-status of their parents, they tend to associate it with immediate death and became too frightened to loss them. The situation become highly frightening to them if both parents are victims of the virus, or if they are brought up by a single

parent who become infected with HIV virus, which is presented in the case of Gidoli.

Children receive love, support, care, and other necessary provisions to their life from their parents. Losing them will lead to the end of all these things. Therefore, children of HIV victim immediately feel insecure when they recognize the sero-status of their parents.

In addition to this, children are also compelled to look after their parents who are bedridden. This might force them to give up their education, and look for a job. Thus, children are forced to take major responsibilities, which are beyond their abilities, to sustain their life. This will create a huge stress on them. This, in turn, leads to the frustration of their goals. This can be evidenced from the life experiences of Gidoli.

CONCLUDING REMARKS

No one person is responsible for the existence of the AIDS pandemic. Yet, ultimately, all people must accept the task of dealing with its consequences. AIDS is intimately bound with health care in general, racism, homophobia, sexism, religion and class issue. But the virus doesn't care. It's only interested in replicating. While the achievements of the global responses to date should not be underestimated, neither should the challenge ahead. HIV/AIDS is a catastrophe in slow motion, and it is essential that the world community pace itself for the long haul. The tasks ahead calls for clear vision, renewed will and greatly increased resources. It also calls for greater determination to use the resources in the interest of everyone.

The HIV/AIDS crisis requires an unprecedented response. It requires communities, nations, region, the public and the private sectors, international organizations and non-governmental groups to come together in concerted, coordinated action. A sustained, coordinated programmes is needed to deal with HIV and AIDS in all regions of Ethiopia. Every one, both professional and lay, should have to be given role to play in these programmes. No body can be left out in the combat against HIV/AIDS. Success in making a difference in tackling the spread of HIV/AIDS and improving and supporting its victims can only be achieved through the involvement of every sections of the society. As it is pointed out in the structural approach, social transformation aimed not merely at the reduction of the risk but at the redress of the social and economic inequalities and injustices should not also be forgotten. Moreover, through advocacy and social mobilization, the silence, stigma and fear surrounding HIV/AIDS must be broken down to allow for an effective local and national responses to the epidemic.

The social challenges that PLWHA are experiencing in the town of Bishoftu have their own negative impacts on their economic well-being. As can be seen from the case of Aligora, it is their disclosed sero-positive status that leads PLWHA to face problems in securing a job and a house to rent. The psychological burdens are also associated with the society's response to their disclosed sero-positive status. In this regard, therefore, the psychological and economic challenges that PLWHA are experiencing in the town of Bishoftu are greatly chained with the major social challenge: stigma and discrimination. The three cases presented under this sub-section in chapter four, clearly indicates that PLWHA experience their first stigma and discrimination from the people they know better: parents, blood relatives, neighborhood (as in the case of Largoni), close friends, colleagues (as in the case of Balermo), and spouses (as in the case of Welaros). However, these people are supposed to be the first counselor and care giver to the victims because of their well-acquaintance with them. But, the reverse is true as it is presented in the cases. This might be emanated from the lack of the necessary knowledge and understanding about the virus.

Therefore, the only way we can achieve a society free from stigma and discrimination associated with HIV/AIDS is through effective implementation of awareness raising methods which should involve the life experiences of PLWHA. However, in the presence of stigma and discrimination it is very difficult to fully exploit the life experiences of the victims in the battle against the disease. So, a great deal of work is expected from the concerned bodies in drafting a policy and method to reach to the society in a coordinated fashion to this end.

In the absence of an affordable and effective cure or vaccines, health education directed at modifying risk behavior is the only way in which the disease can be contained. In this regard, the involvement of PLWHA in teaching the community will be a lively experience for the rest members of

the society. Thus, by providing the required love and care to PLWHA in the country in general and in the town of Bishoftu in particular we can effectively employ all the human resources in our hand to bring about the intended behavioral change in the community.

Children are the future hope of every country. They need the support and love of their parents in particular and the community at large to function properly, and to prepare them both physically and emotionally to take the responsibilities that is waiting them ahead in the community. However, the disclosed sero-positive status of their parents, as can be seen from Gidoli's case, and the subsequent negative responses of the society, presented in Largoni's, Welaros' and Balermo's cases, are robbing them of all these things. So, by taking the necessary care and support away from them, the community is sowing hatred on the children in the town. If this trend continues, it won't be long before the society reap what it sow. Therefore, we all have to take part in instigating hope and courage in the minds of children of HIV victim parents so as to help them be effective in their coming life.

Although NGOs have a great help in addressing the multifaceted problems of HIV/AIDS and PLWHA, there is a great tendency on the part of PLWHA to totally depend on the assistance of these organizations. Supporting the life of PLWHA is one thing and inculcating the idea of dependency is another thing. Thus, NGOs have to shape their programmes to help PLWHA work and be the productive members of the society. In connection with this, most of the NGOs discussed in chapter three are undertaking programmes that will enable PLWHA to be independent of the aids they used to entertain from the organization. These includes providing them training in different fields and organizing them in income generating activities. This can also help PLWHA to concentrate on their work and minimize the pains of the disease.

The burdens of HIV/AIDS on PLWHA are so many in the town of Bishoftu, which can only be solved through a coordinated effort of the society. The

country has already experienced the burdens of the disease. Therefore, before the very existence of the country is put in question, every citizen should have to contribute its own part in the battle against HIV/AIDS, and in assisting its victims.

BIBLIOGRAPHY

Alemu Abebe (2002). *A Study of the attitude, knowledge, belief and practice of students of higher learning institutions towards HIV/AIDS: The case of Kotebe College of Teacher Education.* Senior Essay. Addis Ababa University.

Anannia Admassu (2000). *"Coping with the Challenges of AIDS: The experience of persons living with HIV/AIDS in Addis Ababa"*, in North East African Studies, vol. 7, No. 2: Michigan State University Press.

.... *Coping with the Challenges of AIDS: The experience of persons living with HIV/AIDS in Addis Ababa and their relations with institutions rendering health and counseling services.* M.A Thesis, Addis Ababa University.

Barnett, Tony and Whiteside, Alan (1996). *HIV/AIDS and Development: Case Studies and Conceptual Frame work.*

.... (2002). *AIDS in the Twenty-First Century: Disease and Globalization.* Pal grave: Macmillan.

Barry, P. (1996). *Psychological Nursing.* 3rd Edition. New York: Lippincott Raven publishers.

Berer, Marge and Ray, Sunanda (1993). *Women and HIV/AIDS: An International Resource Book.* Information, action and resources on women and HIV/AIDS, reproductive health and sexual relationships. Pandora: an imprint of Harper Collins publishers.

Birenbaum, A. and Sagarin, E. (1976). *Norms and Human Behavior.* Praeger, New York.

Brandt, A. (1987). *No Magic Bullet.* 2nd edition. New York: Oxford University Press.

Burack, J. et al. (1993). *Depressive Symptoms and CD4 Lymphocyte Decline among HIV-infected Men.* JAMA270: Available: *http://www.thebody.com*

Central Statistical Agency (2006). *Demographical and Health survey (2005)* Maryland: ORC Macro.

Cohen, Desmond (2006). *Poverty and HIV/AIDS in Sub-Saharan Africa.*

De Bruyn (1992). *Young people at Risk: HIV/AIDS among American's Youth Adolescents.*

Essex, Max and Mboup, Souleyman (2002). *"Regional Variation in the African Epidemics,"* in Max Essex, Souleyman, Mboup, Phyllis J. Kanki, Richard, Marlink and Sheila, Tlou (ed.) AIDS IN AFRICA. New York: Kluwer Academic/Plenum Publisher.

Eyassu Ephraim (2000). *Analysis of the Macro- economic Impacts of HIV/AIDS on the Ethiopian Economy and its Implication on Development.* M.sc Dissertation: development Studies.

Fassika Melesse (1998). *Urban-Rural Socio-Economic Interaction: A Case study of Debre Zeit Town and the adjacent rural Areas.* M.A. Thesis, Addis Ababa University.

Faulstich, M. (1997). *Psychiatric Aspect of AIDS. American Journal of Psychiatry,* 551-556. *http://www.psychiatronline.org*

Federal Ministry of Health/National HIV/AIDS Prevention and Control Office (2006). *AIDS in Ethiopia Sixth Report.* Addis Ababa, Ethiopia.

Fleishman, J.A. and Vogel, B. (1994). *Coping and Depressive Symptoms among People with AIDS.* Health Psychology. Available: *http://www.thebody.com*

Frewoin Daniel (2000). *The knowledge and attitude of parents towards HIV/AIDS and their role in raising the awareness of their children about HIV/AIDS.* Senior Essay. Addis Ababa University.

Gelder, M., Mayou, R. and Geddes, J. (1999). *Psychiatry.* 2nd edition. Oxford: Black Well.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* Prentice-Hall, Englewood Cliffs, New Jersey.

Graham, John (2001). *Cities of Ethiopia: Debre Zeit and Adama. http://www.addistribune.com/Archive/2001/11/02-11-01/*

Gray, J. (1999). *"The difficulties of Women Living with HIV Infection."* Journal of psychological nursing and mental health services 37(5): 39-45.

Guest, Emma (2001). *Children of AIDS: Africa's Orphan Crisis.* London: Plato press.

Habtamu Demele (2004). *Socio-economic Consequences of HIV/AIDS on women living with the virus and their coping strategies: case studies in Addis Ababa.* M.A. Thesis, Addis Ababa University.

Hubley, John (2002). *The AIDS Hand Book: A Guide to the Understanding of AIDS and HIV.* New York: Macmillan.

ILO (2004). *World of Work:* Development of Communication and Public Information, First Global Analysis: HIV/AIDS to have Major Impacts on World of Work No 52.

International Federation of Red Cross and Red Crescent Societies (2003). *Community Home Based Care for People Living With HIV/AIDS.*

Jira Mekonen (2005). *The HIV/AIDS epidemic and its devastating consequences on the life of women in Nekemte, Eastern Wolega zone.* M.A. Thesis. Addis Ababa University.

Kelly, J M (2001). *Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV/AIDS.* ADEA working Group on Higher Education.

Kloos, Helmut and Damen Haile Mariam (2000). *"Community based organizations and poverty alleviation programs in HIV/AIDS prevention and control in Ethiopia: preliminary survey"* in North East African studies, VOL. 7 No. 2: Michigan State University.

Kulczyzki, John *Debre Zeit, Ethiopia. www.ethiopiaarpcus.org/pages/Posts/Ethiopia/debrezeit*

Lyons, Miriam (UNDP, issues No. 30). *HIV and Development Programme. The Impact of HIV and AIDS on Children, Families and Communities: Risks and Realities of Childhood during the HIV Epidemic* (http://www.updp.org/hiv/publications/issues/english/issue.30e.htm)

Manjas, Barbara, Oliver, Catherine and Luna, Brenda (1998). *"Psychological Responses"*, in Mary Ropka and Ann Williams (ed.) HIV: Nursing

and Symptom Management. Sudbury-Massachusetts: Jones and Bartlett publishers.

Margolese, N. (2003). *Psychological factors related to long-term survival with HIV/AIDS: Clinical Psychology and Psychotherapy* 2: 249-66

McCann, James (1995). *People of the Plow: An Agricultural History of Ethiopia, 1800-1900.* London: The University of Wisconsin Press.

Mermin, Jonathan and Granich, Revben (2001). *HIV, Health and Your Community: A Guide for Action.* Berkeley: The Hesperian Foundation.

Mesfin Kahetu, Dereje Kebede, Shabir Ismail, Edward Sanders, Dawit Wolday, Tsehaynesh Messele, Belete Tegbaru and Alemayehu Worku (2004). *"Behavioral Survey of HIV/AIDS Infection in Asosa, among the General Population and Commercial Sex Workers."* In Ethiopian Journal of Health Development: Vol.18, No. 2, PP. 75-81. Addis Ababa, Department of Community Health: Addis Ababa University.

Ministry of Health (MOH) (2000). *AIDS in Ethiopia.* Disease Prevention and Control Department. Third edition.

Morse, Edward and Simon, Patricia (1998). *"Compliance: Challenges and Strategies,"* in Mary Ropka and Ann Williams (ed.) HIV: Nursing and Symptom Management. Sudbury-Massachusetts: Jones and Bartlett Publishers.

Muller (1997). *Handbook of coping with HIV/AIDS.* New York: Wiley.

OPEC FUND NEWSLETTER (2005). *Children, AIDS and the Millennium Goals.* Vol. XII, NO. ½: UNICEF.

Parker, R. (1991). *Sexual culture, HIV transmission, and AIDS research.* J.sex res28: 77-98

———— (2001). *Sexuality, Culture, and power in HIV/AIDS Research.* Ann.rev. Anthropol.30:163-79

Piot, Peter and Bartos, Michael (2002). *"The Epidemiology of HIV and AIDS,"* in Max Essex, Souleyman, Mboup, Phyllis J. Kanki, Richard,

Marlink and Sheila, Tlou (ed.) AIDS IN AFRICA. New York: Kluwer Academic/ Plenum Publishers.

Rushing, W. (1995). *The AIDS Epidemic: Social Dimension of an infectious disease*. Westview press, Inc. U.S.A and U.K.

Sebsib Belay (2000). *The socio-cultural impacts of HIV/AIDS on young adults in Bahir Dar Town*. M.A. Thesis. Addis Ababa University.

Shitaye Alemu, Nuru Abseno, Getu Degu, Yared Wondemkun and Solomon Amsalu (2004). *"Knowledge and Attitude towards Voluntary Counseling and Testing for HIV: A Community Based Study in North West Ethiopia."* In Ethiopian Journal of Health Development: Vol. 18, № 2, PP. 82-89. Addis Ababa, Department of Community Health: Addis Ababa University.

Singer, M Ed (1998). *The political economy of AIDS*. Amityville, NY. Baywood.

Smith, Raymond (ed.) (2001). *Encyclopedia of AIDS: A Social, Political Cultural and Scientific Record of the HIV Epidemic*. New York: Penguin Books.

Solomon Kebede (2004). *Knowledge and attitude of Addis Ababa University female students towards HIV/AIDS: with particular reference to preparatory origin students*. Senior Essay. Addis Ababa University.

Stine, Gerald (2002). *AIDS UPDATES 2002: An Annual Overview of Acquired Immune Deficiency Syndrome*. New Jersey: Prentice – Hall, Inc.

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

---------- (2005). *AIDS in Africa: Three Scenarios to 2025*.

---------- (2006). *2006 Report on the Global AIDS Epidemic: Overview of the Global AIDS Epidemic*.

UNAIDS Ethiopia: *NEWESLETTER, ISSUE 3:* United Printer.

United Nations (2005). *Population, Development and HIV/ AIDS, with particular emphasis on poverty, Economic and Social Affairs* (www.un.org/esa/population/publications/concise2005/popdivHIVAIDS.PDF.)

United Nations (2006). *The Millennium Development Goals Report*. New York.

Vaillancourt, Denise Chakraborty, Sarbani and Taha, Taha (2005). *The World Bank Operations Evaluation Department: Evaluation of the World Bank's Assistance in Responding to AIDS Epidemic: Ethiopia Case Study*. Washington D.C: The World Bank.

World Bank (2002). *The Relationship between HIV/AIDS and Development: The Integration of HIV/AIDS Issues in to the Environmental Assessment Process for World Bank*. Report No 2. South Africa Overt Port 4067.

.... (2005). *Ethiopia: A Country Status Report on Health and Poverty*. Vol II: Africa Region Human Development and the Ministry of Health Ethiopia.

Yemane Berhane (2004). "*The AIDS Pandemic is still expanding its horizon: Comprehensive, harmonized and large scale responses needed.*" In Ethiopian Journal of Health Development: Vol. 18, No 2, PP. 67-69. Addis Ababa, Department of Community Health: Addis Ababa University.

Yonas Endalamaw (2000). *The knowledge, attitude, awareness and belief of people towards HIV/AIDS in Awash Melkassa Town: East Shewa Zone in the district of Adama*. Senior Essay. Addis Ababa University.

APPENDICES

Questions used in the Interview

1. When and how do you know your sero-positive status?
2. What did you feel when you hear that you are HIV positive?
3. What do you think are the factors that expose you to HIV/AIDS? Do you really remember the moment that you feel you might be infected by HIV/AIDS?
4. What was your job before you know your sero-positive status?
5. How do you explain your relationship with the society in general and your co-workers in particular before you know your sero-positive status?
6. How often you visit health centers before your sero-positive status?
7. How much did you know about HIV/AIDS before you became infected? Have you ever participated in any conferences, seminars and public discussions about HIV/ADS before you acquire the virus?
8. How do you explain HIV/AIDS before and after you acquire the virus?
9. To whom did you first disclose your sero-positive status? And why? What was his/her response?
10. Did you disclose your sero-positive status to the society? Why?
11. How do you measure the response of the society to your HIV positive status?
12. What are the burdens that you face because of the disclosure of your sero-positive status? Did these burdens extend to your family? (If any)
13. What are the psychological burdens that you suffer because of your HIV positive status?
14. What measures do you take to overcome the burdens of HIV/AIDS?
15. Are you a member of any of the organizations that are working on HIV/AIDS in the town? Why?

Plate 1: Home-based-care providers taking care of one of the patients

Plate 2: Home-based-care providers washing the clothes of the victims

Plate 3: Daren preparing to give his personal testimonial to people in Bisheftu

Plate 4: Students attending personal testimonial of the victims

Plate 5: An orphan receiving financial aid. The person behind her is Balermo

Plate 6: One of the poultry farming established by the victims in Bisheftu

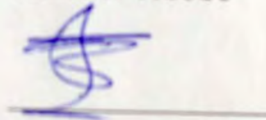
Plate 7: Daren providing educational material to the orphans under Down of Hope Ethiopia, Debre Zeit branch

Declaration

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

Candidate

Name Samuel Tibebe

Signature 

Date of Submission December, 2007

Place Addis Ababa

This thesis has been submitted with my full approval as an advisor.

Ayalew Gebre (Dr.)

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