Negotiating Gender and Sexuality in the HIV/AIDS Discourse in Addis Ababa, Ethiopia: Contradictions and Paradoxes

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Acronyms

AA	Addis Ababa
AAHAPCO	Addis Ababa City Government HIV/AIDS Prevention and Control Office
AAU	Addis Ababa University
AIDS	Acquired Immuno Deficiency Syndrome
CERTWID	Center for Research, Training and Information on Women in Development
CRDA	The Christian Relief Development Association
CSA	Central Statistical Authority
DHS	Demographic and Health Survey
FDRE	The Federal Democratic Republic of Ethiopia
EPRDF	Ethiopian People's Revolutionary Democratic Front
EWLA	Ethiopian Women Lawyers' Association
FGM	Female Genital Mutilation
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
ISAPSO	Integrated Service for AIDS Project Support Organization
ICRW	International Center for Research on Women
IEC	Information, Education and Communication
LOC	Library of Congress
MHRC	Miz-Hasab Research Center
MOH	Ministry of Health
MOI	Ministry of Information
MSF-Belgium	Medicines Sans Frontier- Belgium
NGO	Non-Governmental Organization
NCTPE	National Committee on Traditional Practices of Ethiopia
OSSREA	Organization for Social Science Research in Eastern and Southern Africa
STD	Sexually transmitted Disease
STI	Sexually transmitted infection
VCT	Voluntary Counselling and Testing

Chapter One – Introduction

1.1. Background

ኔጌቲቭ ፖዘቲቭ ለባትሪ ነበረ፣
ዘመን ተቀይሮ ለሰው ተነገረ።

The terms 'negative' and 'positive' were used to be only for the dry cell,
Now that time has changed, we use them for human beings.

From this Amharic oral poem we could note that the terms 'negative' and 'positive' are not very much familiar to lay people. The couplet may also indicate people's discontent with the way individuals have been identified as 'HIV positive' and 'HIV negative'. As it is known, HIV testing has been considered as one of the most important methods in retarding the spread of the AIDS epidemic. More than showing the unfamiliarity of HIV/AIDS testing to lay people in Ethiopia, the above oral poem might indicate an ambiguity surrounding the scientific HIV/AIDS discourse. I contend that ambiguities and contradictions characterize the AIDS epidemic in Ethiopia. This is because *"...discourse changes, undergoes transformation, and escapes of itself from its own continuity. Contradiction, then, functions throughout discourse, as the principle of its historicity*" (Foucault 1972:152). Following will be a discussion of four of the ambiguities and contradictions surrounding the dominant HIV/AIDS discourse.

The AIDS epidemic has been recognized as the most pressing national health problem in Ethiopia. Studies have proved that the pandemic continues to expand at an alarming speed throughout the country. According to a recent report, 12.6% of the urban population in Ethiopia is HIV infected (MOH 2004). Since the onset of the epidemic, various prevention programs have been undertaken. Mostly HIV/AIDS

prevention education has been conceived as an asset because it provides information and suggests alternatives to individuals, families or groups to prevent the disease and promote health. Although there have been different educational activities to encourage open discussions about HIV/AIDS, it is seemingly paradoxical that many preferred not to talk about the epidemic. I have also noticed that it was common among the public not to use the proper name AIDS since people preferred to call the epidemic '*Ya Beshta/*that disease' and *'Yezemenu Beshta/*the disease of the time'.

Another ambiguous issue in relation to the AIDS epidemic is that individuals who are well informed about the risks of HIV transmission through unprotected sex, continue with high risk behaviour nonetheless. In Ethiopia, a number of studies on sexual behaviour asserted that respondents' attitudes towards AIDS and their protective behaviours did not match the relatively high level of knowledge they have about the disease (e.g. Kebede, Aklilu, and Sanders 2000; CSA and ORC Macro 2001; Yordanos 2000; Yared 1997). This may indicate that when risk of HIV infection was felt, it was still difficult to take all the precautions that might have been considered necessary.

Although the scientific explanation of HIV/AIDS has a wide circulation in Ethiopia, there are other forms of knowledge that are used by the public to give explanation to the epidemic. Religion is very influential in organizing people's lives and shaping belief systems in Ethiopia. Hence, it is very common to come across individuals who say that AIDS could be prevented by avoiding risky sexual encounters and who at the same time believe that controlling the spread of the epidemic depends on God's will. This may indicate that conflicting and contradictory ways of understanding the epidemic are current at any one time, even within one person.

Another area with numerous contradictions and ambiguities is the representation of women and men. The way how certain groups of men and women have been addressed in relation to the AIDS epidemic in Ethiopia deserves close scrutiny. According to my observation, there has been a tendency to link HIV/AIDS with

sexual 'deviance'. I contend that the association of risk of HIV infection with 'deviance' has been highly significant in constructing ways of thinking about women and HIV/AIDS. More specifically, the term 'woman' represents the innocent 'victim' against which 'other women at risk' are constructed as 'deviations'. The division between visible and invisible women is a common feature of representation of women in the AIDS discourse (Richardson 1996:164).

In line with these representations, a number of health education programs in Addis Ababa focus on women. These programs have urged women to take control in sexual encounters whilst at the same time ignoring the processes which make this difficult and, in some cases, dangerous. This is just one example of a contradiction within the AIDS discourse which threatens to disturb how gender and sexuality are traditionally conceptualized. It must be noted that the relationship between gender and HIV/AIDS is one of the unexplored issues in the study of the epidemic in Ethiopia (Rachel 2001; Sehin 2000).

Since the first two AIDS cases were detected in 1986, a number of studies have been undertaken on HIV/AIDS in Ethiopia. The vast majority of non-biomedical research on HIV/AIDS has been behavioural research, usually by survey methods, counting people's sex acts, preferences, partners and reasons for sex, and assessing levels of risk for HIV infection (See Pankhurst et al. 2005). The focus of these studies on informants' sexual behaviours might be related to the assumption that sexual behaviour is shaped by the conscious decisions of rational individuals. Locating the cause of sexual behaviour at the individual level led to individual behavioural interventions with the assumption that if only one could reach HIV-vulnerable people and tell them about the dangers of HIV and how to prevent it, they would quickly take care to safeguard their behaviour.

Such an assumption does not take into account the complexity of the problem of HIV/AIDS. AIDS is a sensitive subject because the disease is passed through the most personal, most secretive and most sensitive of behaviours - sexual relations.

Another reason for the complexity of the problem of AIDS is that persons carrying the disease cannot be physically distinguished from persons not infected. Furthermore, the multiyear latency of the infection before the disease is apparent, contributes to an individual's desire to believe that she/he is not vulnerable. The fact that there is no cure for those infected also contributes to the sensitivity of the subject of HIV/AIDS.

This chapter started by pointing out four of the numerous contradictions and ambiguities surrounding the HIV/AIDS discourse in Ethiopia. I would argue that prevention programs in Ethiopia are not producing expected results because they are not based on the contextual issues into which the HIV/AIDS discourse has been constructed. In relation to research, most of them concentrate on describing the sexual behaviour of informants while neglecting the social aspect of sexuality. I believe it is crucial that the discourse of HIV/AIDS, the system which structures the way that Ethiopians look at the epidemic needs to be understood first in order to be able to find solutions to the problem of HIV/AIDS. "*If we fail to understand the determinants of HIV risk and vulnerability as profoundly social- and by social it means relational, contextual, cultural, political, economic, historical, symbolic and discursive - we fail to understand how best to intervene*" (Dowsett 2003:24).

In studying the problem of HIV/AIDS in Addis Ababa, I contend that attention has to be given to the phenomenon of sexuality, and the way it is shaped and constrained by factors including the complex and unequal relationships between women and men, rich and poor, and between North and South. I would like to argue that most HIV/AIDS health education material, in emphasizing individual choice and personal responsibility, have not addressed the dynamics of power in sexual relations. I believe that power relations and cultural expectations regarding gender and sexuality are likely to influence women's and men's possibilities for acting according to the knowledge they have. According to Gastaldo, *"AIDS has been a plague of paradoxes and disordered relations of power from the interpersonal to the international, the productive to the reproductive, the societal to the sexual"* (1997:113).

1.2. Research Objectives

The present study endeavors to do two things. One of the main emphases would be to analyze how the discourse of HIV/AIDS has been negotiated by the informants in my sample population. The second objective of the study is to explore how HIV/AIDS intersects with a number of other discourses. The major research questions are:

1. How is the scientific HIV/AIDS discourse negotiated in Addis Ababa?

2. How does the scientific HIV/AIDS discourse intersect with religion, tradition, gender and sexuality?

In relation to the previously mentioned research and the problems identified in chapter two, this study will look at the intersection of the HIV/AIDS discourse with some specifically selected discourses on religion, tradition, gender and sexuality, and will only briefly touch upon the economic discourse. More specifically the questions addressed in the thesis are:

a) How do women (and men) use religion and tradition as tools in understanding the scientific HIV/AIDS discourse?

b) How do the HIV/AIDS discourse and the NGO's HIV/AIDS prevention programs deal with the cultural taboo to speak about sexuality?

c) How do women (and men) challenge the traditional taboo to talk about sexuality?

d) Which understandings of gender and sexuality are actualised in the scientific HIV/AIDS discourse?

e) How are the understandings of gender and sexuality negotiated by women (and men) and NGOs?

In the present study, the emphasis is not on the type of information about HIV/AIDS in Ethiopia but on the processes that led to certain facts being known rather than others. It is beleived that the discussions in each chapter would provide information that will provide a better understanding of the four previously mentioned contradictions and ambiguities surrounding the epidemic. A brief account of the theoretical framework selected for the study given below.

1.3. Theoretical Framework

The present study is located within a social constructionist framework. In relation to sexuality, a social constructionist perspective moves the focus of concern from the sexual actions of specific bodies to the cultural and social contexts in which sexuality occurs. A social constructionist framework has been selected for the present study because of its emphasis on the complex relations between meanings and power in the constitution of sexual experience. The framework is considered suitable for the analysis of the local or indigenous categories and systems of classification that structure and define sexual experience in different social and cultural contexts (Parker and Gagnon 1995).

In my study of the problem of HIV/AIDS, I will use Michel Foucault's theories of discourse, power and knowledge. What I found very useful from Foucault's theory is his main assertion that our ways of thinking and acting are historically linked to particular forms of power and social control (1980). Accordingly, the first section of this chapter will briefly look at the social construction of gender and sexuality. In the second section an attempt will be made to show the relevance of the concepts of discourse, power and knowledge for an analysis of the HIV/AIDS situation in Addis Ababa. The third part of the chapter specifically deals with the issue of resistance.

each society. Therefore, we may say that a social constructionist perspective shifts the focus of concern from the sexual actions of specific bodies to the social contexts in which sexuality occurs (Parker and Gagnon 1995:12). It is said that how each woman or man is sexually constructed remains one of the most intimate yet most socially determined elements of human existence (McFadden 1992).

Since sexuality is the outcome of social and cultural processes, it is a uniquely personal phenomenon for each person and is also a life-long process that can grow and change in numerous forms and directions (Ortner and Whitehead 1981; Caplan 1987). For example we find different sexual norms and practices in Ethiopia. In both Christian and Islamic communities in Ethiopia, it is observed that sex before and outside marriage is forbidden. However there are deviations from these standards, deviations that are determined by existing cultural norms of different ethnic groups. Compared to other ethnic groups in Ethiopia, extramarital sexual relationships are prevalent in the Amhara and Tigray ethnic groups in the form of '*Wushima*/lover' (MHRC 2004). Sexualities are not only different across cultures but they are also constantly produced and modified and the nature of sexual discourses and experiences change accordingly (Foucault 1978). An example for this change could be that recently the AIDS epidemic has brought more discussion on the issue of sexuality.

There are mainly two social constructionist accounts. Those who stand on the 'material' side lay emphasis on gender and other aspects of our identity as constructed by our positioning within social institutions and structures like marriage, paid work, and family and the legal system. This group focuses on the physical aspect of experience – on the corporal body, the literal implementation of institutional control, the impact of the social environment, or on factors such as social class or economic status.

The second social constructionist account pays attention to gender and other aspects of our identity as produced by our subjection to discourses. Those who follow this

focus on 'discursive' account, look to the social and linguistic domains like oral communication, visual representation, ideology, culture and power. They recognize gender not as stable and fixed category but as a structure of subjectivity which can vary greatly in different social locations. Here gendering can be seen as a process rather than a '*role*' and the meanings we give to masculinity and femininity as unstable and open to contestation. It means that there are always many and contradictory discourses of gender which are linked with power in different ways. This social constructionist account *"finds echoes in postmodernist theories which are rejecting notions of a coherent unified self, capable of rational reflection and agency, in favour of a model of a self which is fragmented, constantly in a process of formation...*" (Alsop et al. 2002: 81). Here, it is important to mention the symbolic interactionist perspective, another social constructionist account. According to symbolic interactionist perspective sexuality is always 'socially scripted behaviour' and *"gender identity is prior to and determining of the contrasting sexual scripts which shape boys' and girls' conscious entry into and experience of sexuality* (Segal 1997:207).

In this study I consider HIV/AIDS as a discourse because I would like to give emphasis to how we understand the epidemic. When I consider HIV/AIDS as a discourse, I am not saying that the epidemic or the virus is not real. Although discourses seem to encompass almost everything, there does exist a realm of the non-discursive. As Laclau and Moufee said:

> The fact that every object is constituted as an object of discourse has nothing to do with whether there is a world external to thought …An earthquake or the falling of a brick is an event that certainly exists, in the sense that it occurs here and now, independently of my will. But whether their specificity as objects is constructed in terms of 'natural phenomena' or expressions of 'the wrath of God' depends on the structuring of a discursive field. What is denied is not that such objects exist externally to thought, but the rather different

assertion that they could constitute themselves as objects outside any discursive condition of emergence (Cited in Mills 2003:56).

Objects do exist and events do occur in the real world but we apprehend and interpret these events within discursive structures; we are not always aware of the way discourses structure our understanding. The treatment of HIV/AIDS as a discursive construct might be criticized claiming that it has a 'biological reality' with definite consequences for many individuals and societies. It is totally impossible to overlook the importance of the material domain of HIV/AIDS because the virus attacks the human body and people suffer from illnesses and deaths caused by the epidemic. Women have been for example more affected by HIV/AIDS than men because of their physiological body. Women have bigger reproductive surface area than men and hence women, as recipients of the male semen during sexual relationship are more likely to be infected with the virus. Moreover, when women have sexually transmitted diseases, they stay without symptoms for a long time with invisible sores that easily allow HIV to enter their blood stream. Hence, women's vulnerability to the epidemic explains the importance of examining both bodily processes and sexual practices. But we also need to analyse the ways in which these bodily processes and practices are socially constructed. According to Smith (1998: 258) *"Nevertheless, for social scientists, this does not undermine the importance of recognizing the complexities of representation in that we can understand this life-threatening illness more effectively when we are aware of the way in which it is represented and meaningful".*

As stated earlier, the present study analyses the problem of HIV/AIDS using Foucault's concepts of discourse, power and knowledge. Although Foucault has often been interpreted as saying that there is no non-discursive realm, he does not deny that there are physical objects in the world. What Foucault states is that we can only think about and experience material objects and the world as a whole through discourse and the structures it imposes on our thinking. *"In the process of thinking about the world, we categorise and interpret experience and events according to the structures*

available to us" (Mill 2003:55-56). In the case of sexuality, there is a need to focus not only on the incidence of particular behaviours and practices, but on the social context in which sexual activity is constituted. Hence, special attention has to be paid to relations of power in sexual relationships. The following theoretical discussion on discourse is based on my argument that the discursive nature of the epidemic has to be given its due attention.

1.3.2. HIV/AIDS as a Discourse

More commonly, discourse is used in linguistics to refer to extended samples of either spoken or written language. This sense of discourse emphasizes interaction between addresser and addressee or between writer and reader, and therefore processes of producing and interpreting speech and writing, as well as the situational context of language use (Fairclough 1992). On the other hand, discourse is widely used in social theory and analysis to refer to different ways of structuring areas of knowledge and social practice. According to Foucault, discourses can be defined as groups of statements that belong to a single system of formation (1972:107). In this sense discourse should be seen as an overall term to refer to a group of statements, the rules whereby those statements are formed and the processes whereby those statements are circulated and other statements are excluded. *"Discourses are grouped together because of an institutional pressure, because of similarity of provenance or context, or because they act in a similar way*" (Mills 2004:55-56).

In line with this definition, I consider HIV/AIDS as a discourse. My contention is that we think about the HIV/AIDS epidemic in terms of discourse and the structures it imposes on our thinking. Different discourses constitute key entities in different ways, and position people in different ways as social subjects. In a similar vein the discourse of HIV/AIDS provides varying subject positions for men and women in Ethiopia.

Discourses do not carry absolute meanings and present themselves as knowledge, but are rather productions of the ways that reality becomes viewed by us (Alsop et al. 2002:81). This means discourses do not just reflect or represent social entities or relations but they construct or 'constitute' them. An important issue that relates to the productive nature of discourse is the issue of individuals' ability to negotiate with discourses differently. I contend that individuals take up a variety of subject positions within discourses.

I am critical towards the notion of considering individuals as passive recipients of authoritative information. Men and women in Ethiopia do not accept every information on HIV/AIDS even if that information is said to be scientific or 'true'. Individuals try to value information in their own ways as it could be seen in the oral poem at the beginning of this chapter in which HIV testing was looked with a critical eye. Similarly, Foucault (1978) defines discourse as a form of power that circulates in the social field and that can attach to strategies of domination as well as resistance. In the present study my main focus will be to show how my informants negotiate with the HIV/AIDS information that was provided to them. The study aims to show how every form of knowledge on HIV/AIDS is contested as every discourse is a construction and is viable for change. In the following discussion I will try to emphasize the constituted as well as the productive nature of the HIV/AIDS discourse.

1.3.3. The HIV/AIDS Discourse is Constituted

Several discourses cohere to constitute the discourse of HIV/AIDS in Addis Ababa. This study's approach is to analyze how HIV/AIDS intersects with a host of other factors such as gender, sexuality, science, religion and the traditional patterns of life. The HIV/AIDS discourse is hence regulated by its relation to other discourses. As Julian Henriques asserts; "*The systematic character of a discourse includes its systematic articulation with other discourses. ...Every discourse is part of a*

discursive complex; it is locked in an intricate web of practices...." (Cited in Mills 2004:43-44).

As mentioned earlier, the main purpose of this study is to look at the circulation of HIV/AIDS discourse in Addis Ababa by indicating the diverse contexts in which meanings are attributed to the epidemic. Sexuality should be understood and situated within its broader historical, social, and political contexts, and this includes understanding the ways in which sexuality is controlled and repressed in society (Foucault 1978). One of my emphases in the present study is to show how the HIV discourse exists as a result of a web of factors that keep it circulating.

We may see the constituted nature of the HIV/AIDS discourse by looking at its relation to sexuality and religion. As AIDS is a sexually transmitted disease, the different discourses of sexuality have their own contribution to the understanding of the state of HIV/AIDS. In a religious society like Ethiopia, one cannot ignore the part played by religion. Hence, to analyse the HIV/AIDS situation in Addis Ababa, there is a need to take all related discourses into consideration. I say this because I have observed that research as well as prevention activities in HIV/AIDS in Addis Ababa mostly focused on specific issues while ignoring the web of factors that construct the AIDS discourse. Here, my argument is that instead of focusing on a single factor or a few selected factors, research and prevention activities should take in to account the multiple factors that intervene in the construction of the AIDS discourse in Addis Ababa. Regarding this point Foucault said:

> ...I would say that if I am now interested in how the subject constitutes itself in an active fashion through practices of the self, these practices are nevertheless not something invented by the individual himself. They are models that he finds in his culture and are proposed, suggested, imposed upon him by his culture, his society, and his social group (1997:291).

Another point which is of interest is that discourses are not stable but change in accordance with social conditions. This is because they draw upon existing discourses about an issue whilst utilizing, interacting with and being mediated by dominant discourses to produce new ways of conceptualising an issue or a topic (Carabine 2001: 267-269). In my study, I shall try to show how the HIV/AIDS discourse is in the process of change because it is mediated by other discourses like religion, gender and sexuality. As the HIV/AIDS discourses change, I contend that our knowledge about the epidemic also changes. This is because, as it is shown in the following discussion, discourse is infused in power/knowledge networks and constitutes or constructs society on various dimensions.

1.3.4. The HIV/AIDS Discourse Is Productive

What is of major significance to my study on HIV/AIDS is the view of discourse as constitutive- as contributing to the production, transformation, and reproduction of the objects and the subjects of social life. What interested me most in Foucault's theory is his application of the concepts of power and knowledge. In Foucauldian analysis, knowledge, truth and discourse are all socially constructed and historically specific. In other words, knowledge is not separable from the specific location of its production and the power relations within which it is produced. This is important to my study because it deals with HIV/AIDS, an epidemic highly influenced by societal rules and norms related to sexuality and gender. Therefore, at this point, it is appropriate to look at the relationship between the HIV/AIDS discourse, power and knowledge.

Discourse, power and knowledge

Foucault (1972) claims that all knowledge is a product of particular discourses. He asserts that knowledge does not simply emerge from scholarly studies but is produced and maintained in circulation in societies through the work of a number of different institutions and practices. What I found interesting in this assertion is his perspective

that moves us away from seeing knowledge as objective and dispassionate towards a view that sees knowledge as always working in the interests of particular groups and institutions. Foucault's work helps us to re-examine rules and institutions by challenging the prevailing institutional regime of the production of truth (Smart 1995:202). As Sawicki observes: "*Foucault's theories do not tell us what to do, but rather how some of our ways of thinking and doing are historically linked to particular forms of power and social control; his theories serve less to explain than to criticize and raise questions*" (1995:362).

According to Sawicki (1995), Foucault does not affirm the prevailing general politics of truth but critically questions the self-evident, disturbs the habitual and re-examines rules and institutions. In effect he challenges the prevailing production of truth. I also believe that it is important to re-examine rules and institutions related to the HIV/AIDS discourse in Addis Ababa. Such an approach would be suitable to understand better the contradictions and ambiguities of HIV/AIDS that were mentioned at the beginning of this chapter.

As it was said earlier, discourses are productive in that they have power outcomes or effects and they define and establish the 'truth' at particular moments. Similarly the discourses of HIV/AIDS and sexuality in Ethiopia produce the 'truths' about HIV/AIDS and sexuality in Ethiopia. This is against the absolutist, unitary conception of truth that defines the modern episteme; Foucault proposes a plural understanding of truth. The conception of the subject as a process, a constituted entity, is very important to my analysis of the problem of HIV/AIDS in Addis Ababa. As the present study tries to show, individuals construct themselves while negotiating the dominant HIV/AIDS discourse.

Truth is constructed and kept in place through a wide range of strategies which support and affirm it and which exclude any counter or alternative versions of events (Foucault 1997). There are a set of exclusionary practices whose function is to establish distinctions between statements which will be considered to be false and

those which will be considered true. Hence, each society has its own 'regime of truth' (Foucault 1980). That means there are statements which can be made by authorized people and accepted by the society as a whole, and which are distinguished from false statements by a range of different practices (Mills 2003:74). In my own study this type of discourse analysis will help me to identify the different 'truths' about HIV/AIDS and how these 'truths' are variously taken up and negotiated by the public. In the following paragraphs, I will try to discuss some of the strategies which make distinctions between different statements.

Normalization is one way that power is deployed. The relationship between normalization and discourse is that discourses convey messages about what is the norm and what is not (Foucault 1978, 1990). There are rules and utterances which together make up the social construction of discourse. These rules and utterances restrict us and in effect they establish the norm. It means that discursive structures map out what we can say and what we can consider as legitimate knowledge. Truth is defined in the following way:

> ...by truth I don't mean 'the ensemble of truths which are to be discovered and accepted', but rather 'the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true'. 'Truth' is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements. 'Truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extends it (Foucault 1980:132-133).

This quotation shows that the there is a need to question the forms of truth to which we are accustomed. This means discourses have identifiable effects which specify what is morally and socially acceptable and unacceptable at any given moment in a culture. If we take an example, sex is said to be far more than a way of procreating, or even a way of experiencing pleasure. Rather, it is tied up with meanings and

power; it is a form of knowledge as well as a physical activity; and it involves one's relation to the self as much as one's relations with others (Foucault 1978, 1980).

A useful point to note is that sexual norms are so powerful as they are transmitted through everyday life and it is impossible to imagine the absence of norms that control sexuality. One's sexuality is a matter of socially and historically specific practices and relationships that are dynamic. Sex and sexuality together comprise a set of practices, behaviours, rules and knowledge by which we produce ourselves, and are produced, as 'knowing'- ethical, social and juridical- subjects (Foucault 1978, 1990). We may say that there are different 'truths' on HIV/AIDS and these truths are intricately tied to norms, and different agents are positioned as 'knowing' subjects.

The HIV/AIDS discourse limits what is desirable and undesirable to say about the epidemic. This means that people tend to remain, in the choice of their topics of conversation and in the words that they choose to talk about AIDS and related sexual matters, restricted by societal and personal norms. Moreover people tend to be fairly restricted in terms of the construction of their own desires and needs. It may help us to think of discourses as functioning as sets of socially and historically constructed rules designating 'what is' and 'what is not'. That is, in the case of HIV/AIDS, discursive structures map out what we can say and what we can consider as legitimate knowledge about the epidemic and from what position this knowledge can be articulated.

The AIDS pandemic was and is still mainly perceived in Ethiopia as a medical problem and hence a domain of medical experts. "*Since discourses are tied up with power and serve to reinforce or undermine relations of power between people, the emergence of certain kinds of discourses is interdependent with the social power exercised by medical, judicial and religious communities*" (Alsop et.,al 2002:82). In the case of HIV/AIDS, prevention efforts have focused on 'risk groups' and 'risky sexual behaviour'. A key tactic for imposing and maintaining control is to present

these normative categories as being universal, necessary and obligatory principles to which all our practices must conform (Falzon 1998:50).

In relation to the scientific HIV/AIDS discourse, I would say that medicine tends to exclude other forms of knowledge on the epidemic which are perhaps more relevant to the Ethiopian context. An important point is that the ways of distinguishing what counts as scientific, true or reliable are themselves consequences of how scientific discourses are constituted. "*Medicine has a much more solid scientific armature but it too is profoundly enmeshed in social structures*" (Foucault 1980:109). In my analysis of the AIDS problem, I suggest that rationality and science (as distinctive modes of inquiry opposed, for example, to religion) need to be conceptualised as particular ways of thinking. Here I am not ignoring the materiality of the AIDS disease, and I am not denying that medical treatment is necessary. What I would like to emphasize is that there are always power relations in the HIV/AIDS discourse which work for the interests of certain groups and institutions.

The inferior position provided to traditional medicine could be seen in relation to a broader situation. Setel (1999:194) stresses that in the biomedical encounter with Africa, local medical practice has often been described by public health practitioners as being firmly entrenched as an obstacle to development. She adds that the effect of this perception in international health practice has been the position that culture is viewed as an obstacle to change. In the present study my intention is to challenge this assumption by indicating that lay people in Addis Ababa take up and negotiate both modern and traditional medical practices. I am not interested in deciding whether traditional medicine or the scientific one is more important to the prevention of the spread of AIDS. My main concern will be to look at the mechanisms whereby one form of knowledge becomes produced as the dominant whereas the other is treated with suspicion and is positioned both metaphorically and literally at the margins of society.

A point to note is that the character of power in the case of epidemics like HIV/AIDS is tied to managing populations. Power is implicit within everyday social practices, which are pervasively distributed at every level in all domains of social life. To live in a society is to live in such a way that an action upon another action is possible (Foucault 1997). A very important point here is that power is not essentially repressive and it does not work only negatively by forcefully dominating those who are subject to it since it is not possessed but rather practiced. We need to look at power as the production of effective instruments for the formation and accumulation of knowledge- as methods of observation, techniques of registration, procedures for investigation and research, and apparatus of control (Foucault 1980:102). "*We should think of power not as an attribute (and ask 'what is it?) but as an exercise (and ask 'How does it work?)"* (Gavin and Wickham 1999:5). In my study, I shall make an attempt to analyze how the dominant discourse of HIV/AIDS has focused on examination and measurement as well as on comparing individuals against certain norms. *"The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility* (Lupton 1997:99).

As it will be discussed in the ensuing chapters, the meanings of HIV/AIDS are constantly challenged. In the case of HIV/AIDS, in Ethiopia, even though the scientific discourse plays a big role in identifying people, it is always contested. In *The Archaeology of Knowledge*, Foucault states that the aim of the book was to show "*how it was possible for men within the same discursive practice, to speak of different objects, to have contrary opinions, and to make contrary choices…. In short I wanted not to exclude the problem of the subject, but to define the positions and functions that the subject could occupy in the diversity of discourse* (Foucault 1972:200). Discourses on the human body, medicine and health care that may be identified in such sites as the mass media, medical and public health literature and policy documents, are recognized, ignored, contested, translated and transformed in the context of everyday experience (Lupton 1997:108). The following discussion on resistance will provide more illustrations on how discourses like HIV/AIDS are under

constant challenge. The intersection between gender, sexuality and HIV/AIDS will also be one of the main focuses in the discussion.

1.3.5. Resistances to the Dominant HIV/AIDS Discourse

Dominant discourses governing the organization and practices of social institutions are under constant challenge because of the existence of multiple power relations (Weedon 1987). The HIV/AIDS discourse must thus be seen as changing all the time. Since discourses are always in the process of change, subjects attribute different meanings to them. In the dominant HIV/AIDS discourse in Addis Ababa, we commonly observe a tendency of putting the population in two boxes as 'at risk' and 'not at risk'. I would argue that this dichotomous presentation of men and women in HIV/AIDS discourse ignores the different subjectivities of men and women and their diverse relationships to the epidemic. I would also oppose the presentation of women as 'victims' of HIV/AIDS. The theoretical tools chosen for this study will provide an opportunity to include the concept of resistance. In the following section, I shall discuss resistance in relation to the representation of especially women in the dominant HIV/AIDS discourse.

The emphasis of HIV/AIDS prevention programs on women's economic issues, but not on other micro-power relations, has to be seen in relation to the general tendency of giving a totalizing and universalizing answers to political and moral problems. Hekman (1990) asserts that there is a strong tendency among feminist theorists to appeal to universal concepts to ground their critiques of masculine domination. Martin (1988:11) also discusses the tendency to condemn male sexuality as naturally or intrinsically aggressive among some feminist thinkers who emphasize women's passive victimization or internalization in relation to it. In Ethiopia too, we may notice this universal tendency since women as a group have been considered as victims of culture and patriarchy. The emphasis on Ethiopian women's economic problems might be looked in relation to the influence of Marxism as well as some western feminist theories.

Discourses that constitute Ethiopian women as vulnerable to HIV/AIDS are not localized in a single institution, but permeate every aspect of society. In the forthcoming chapters an attempt will be made to show how economic position, religion, tradition and sexuality are only a few of the factors that intersect to constitute women's subject positions in society and also their relationship with the AIDS epidemic.

What makes Foucault's theory very useful for my study is his focus on the everyday power relations rather than a sovereign power (1994:1972). According to him power operates and circulates at every level of a society. Although Foucault acknowledges that power relations are not independent of economic processes and the relations of production, he asserts that power is constructed on the basis of multiple issues. Consider his views on power:

> Between every point of a social body, between a man and a woman, between the members of a family, between a master and his pupil, between every one who knows and everyone who does not, there exist relations of power which are not purely and simply a projection of the sovereign's great power over the individual; they are rather the concrete, changing soil in which the sovereign's power is grounded, the conditions which make it possible for it to function (Foucault 1980:187).

This quotation reveals the nature of power in local, minute force relations and the micro-practices that arise out of those relations. This concept of power provides a constructive framework to understand everyday power relations between men and women. Based on this assertion I believe that there is a need to look at contextual and local approaches to answer key issues in relation to Ethiopian women's problems and this also includes the problem of HIV/AIDS. This position suggests that instead of appealing to an essential female nature we should attempt to understand how femininity is socially constructed in particular societies. In relation to specific power

relations, the analysis of male dominance must be local and contextual and the resistance to that domination must be specific. In a similar vein, the problems of HIV/AIDS in Ethiopia need to be understood in relation to the contextual and local situation of the women.

Although the suppression of women's sexuality reappears in Ethiopia, men and women resist dominant discourses of gender, sexuality and HIV/AIDS. Individuals are able to resist, reject or deflect power. While power may be everywhere, it cannot control everything, and it cannot operate according to a single logic (Foucault 1978). This point is based on the notion that social representations affect subjective constructions, and subjective representations also work back on social constructions.

> Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power not its points of application (Foucault 1980:98).

As it is shown in the quotation, discourses are not imposed from outside, rather subjects understand themselves in terms of discourses. Individuals are constituted by discourses but they are also capable of resistance to that constitution. In this process freedom is a necessary condition for the existence of relations of power. Smart (1995:195) expresses this view saying that the relation between power and sex is not one of repression and that power relations need to be conceptualized not in terms of repression and law but in terms of positive and productive social technologies, associated tactics, and strategies.

The discussion above shows that discourses, even hegemonic discourses, are not closed systems. As it will be shown in the analyses of my data, even the silences, the gaps and the ambiguities of discourses provide possibilities for revision of accepted

truths. Although there are many factors that position Ethiopian women as dominated, they do also resist dominant discourses. "*The gaps, silences and ambiguities of discourses provide the possibility of resistance, for a questioning of the dominant discourse, its revision and mutation. Within these silences and gaps new discourses can be formulated that challenge the dominant discourse*" (Hekman 1990:189-190).

What Constitutes Resistance?

A useful question to raise in relation to resistance would be the issue of what constitutes resistance. There are different viewpoints on this stemming from different theoretical grounds. First of all I would like to consider resistance as any action that breaks a norm. Resistance normally implies a conscious, coherent strategy. But resistance to dominant discourses may be both conscious and unconscious since discourses involve a high level of indeterminacy, and meanings are always in the process of change. As Moore points out:

> ...We are all subject to discourse and to the various subject positions which are opened up to us in discourse. Such subject positions can be resisted, both consciously and unconsciously, but it is in terms of these positions, even if in contradiction to them, that we construct a sense of ourselves as selves, as individuals and as persons (Moore 1994:48).

Thus, the socio-cultural context of Ethiopia is important in exploring resistances to the dominant HIV/AIDS discourse. As Petchesky (2003:235) has noted, to interpret whether a particular behaviour constitutes resistance or possibly just a resilient way of surviving or coping with necessity, it is important to look carefully at the particular context in which that behaviour takes place and the individual's own understanding of it. Similarly in relation to freedom Falzon (1998:52) asserts that our capacity to act is shaped and directed by our social context, by the forms of life in which we exist. One of my attempts in this study will therefore be to map out resistances to the discourses of HIV/AIDS in Addis Ababa, resistances which mostly came from women who were

in a state of domination. The highly difficult position of Ethiopian women cannot be overlooked, if the socio-economic context is taken into account since it is within this context that women try to negotiate their positions and to constitute their own discourses. In my analysis, I shall try to show how these women used the few options they had to refuse to accept the dominant culture's characterizations of their practices and desires.

There are studies which show that even in very oppressive power relations, there would be resistances. A good example would be the case of Black American slaves. Scott discusses how the slaves had their own 'hidden transcript' that was a 'critique of power' spoken behind the back of slave owners. Folktales, gossips, and songs are part of this hidden transcript (Referred to in Mills 2003:41). This is only a specific example that in order to analyze a power relation, we must analyse the total relations of power, the hidden transcripts as well as the public performance. The present study's emphasis on oral literature has to be looked in this light.

Though I criticize the victimization of women in the dominant HIV/AIDS discourse in Ethiopia, I am not totally supporting the way *'anti-victimhood'* HIV/AIDS prevention activities have been conducted. Even if I intend to emphasize resistances to the HIV/AIDS discourse, I am critical of the tendency of placing resistance in a diametrical contrast to a victimizing perspective. As Oinas and Jungar (2005: 1-2) argue, such an attempt employs an obscured version of resistance as it hides an individualistic perspective to agency. On the same point Moore argues:

> If we accept the view that the concept of the individual or person is only intelligible with reference to a culturally and historically specific set of categories, discourses and practices, then we have to acknowledge the different ways in which the categories 'women' and 'man', and the discourses which employ those categories, are involved in the production and reproduction of notions of personhood and agency (Moore 1994:51).

Foucault points to the ways in which rationalizing discourses suppress discourses of marginalized groups. He also claims that such discourses are sites of resistance. Nevertheless, he was criticized for rarely attending to resistances of marginalized groups (Diamond and Quinby 1988: xvi; Allen 1996:274). I support this criticism since I also believe that Foucault's works do not give proper attention to gender and to women's resistances. Furthermore, some feminists criticized Foucault for being sceptical about a strategy for sexual liberation. For instance, according to Bartky, Foucault's theory of power as productive has been helpful for feminists, but was not intended to explain the institutionalisation of domination, inequalities of resistance, and so actual gendered power relations. He has written on knowing sex, but not on knowing gender (Referred to in Ramazanoglu and Holland 2002:101). He has also been criticized for not explaining why men still dominate so many areas of political and economic life. Consider the following:

> Foucault's theory, for example, does not deny that men are privileged by hidden relations of power, and that these are hard to discover, but he does not enable a researcher to establish why power becomes institutionalised in some ways rather than others, why some 'truths' become discursively constituted as authoritative and powerful while others do not, or how to challenge male power effectively (Ramazanoglu, and Holland 2002:101).

However, Foucault's assertion that bodies are the effects of power, produced in social relations by discourses of sexuality, medicine, education and so on is important. This point is also supported by feminists who agree to his claim that individuals have been repressed through sexuality, particularly through the production of discourses (Weedon 1987; Sawicki 1995). Foucault does not deny that there is sexual repression, but rather focuses his attention on a larger set of productive power relations operating throughout the social body that constitutes individuals as the subjects of sexual experience. He examines the maintenance of social control through a marginalization of 'deviancy'.

One more point in relation to the criticism on Foucault about sexual liberation deserves mention in this connection. As Sawicki (1995:358) observed, Foucault's scepticism concerning struggles for sexual liberation must be understood in the light of his rejection of totalising theories that prescribe universal strategies for human liberation. Foucault insists that points of resistance are present everywhere in the power network (1978). As it was pointed out earlier his discursive analysis of knowledge makes us increasingly sensitive to interpersonal power relations and subtle forms of power (Weeks 1995: 33). Accordingly, the problems that women face in relation to HIV/AIDS are multiple and require specific resistances.

1. 4. Synopsis of the Chapters

The analytical chapters in this study will show the way the dominant HIV/AIDS discourse has been variously taken up and negotiated by my informants. Although the HIV/AIDS discourse intersects with a web of factors, I have tried to be specific by focusing mainly on four discourses that are actualized through the empirical material. The intersecting discourses are religion, tradition, gender and sexuality.

The study has five analytical chapters. The second chapter attempts to give an overview of the AIDS situation in Ethiopia. Although this chapter attempts to mention a few points about the scope of the epidemic and what has been done so far in the area of research and HIV/AIDS prevention, it is my belief that a more detailed discussion of the AIDS situation in Ethiopia is necessary. Chapter three presents the methodology used in the study. Since the study deals with a sensitive topic, a detailed description of the negotiations with the informants was found to be necessary.

Chapter four looks at how the dominant scientific HIV/AIDS discourse is variously taken up and negotiated by my informants. Here my main objective is to show how lay people are constituted by the scientific discourse and the way the discourse provides subject positions. The scientific discourse positions individuals in different ways but it is also, as we will see, resisted. By citing different activities like testing

and counselling, I have tried to show that the scientific discourse has been variously negotiated by my informants.

In the fifth chapter, attempts will be made to analyse the intersection between the scientific HIV/AIDS discourse, religion and tradition. Ethiopians are known for their deep religiosity (Molvaer 1980). In a traditional society like Ethiopia, not only people's understandings of HIV/AIDS but also their views toward life are based on religious explanations. The relationship between HIV/AIDS and religion has been analysed in this chapter by discussing how people's views of the pandemic are shaped by their religious background and beliefs. As Ethiopia is a traditional society, traditional perceptions and practices have serious implications on the way the AIDS epidemic has been understood and spoken of locally.

Chapters six, seven and eight examine the intersection between three separate but intimately connected issues - gender, sexuality and HIV/AIDS. Chapter six mainly deals with the issue of risk and HIV/AIDS. Instead of taking the dominant HIV/AIDS discourse in which the main focus is on certain 'high risk' groups, as a point of departure I have focused on counter-discourses of risk. In this chapter I argue that the focus on identifying high-risk groups has to be shifted towards a perspective on power relations in sexual relationships in general. In my analysis of the power relations that put men and women at risk of infection, I have mainly focused on groups that are normally labelled as 'not highly at risk'. The focus of this chapter is on the relationship between power relations within marriage and the risk of HIV infection.

Chapter seven is closely related to chapter six but it addresses the specific subject positions made available for men and women. The focus is on the 'victim' and 'perpetrator' positions constructed in the dominant HIV/AIDS discourse. As repeatedly mentioned, certain groups of society are labelled as potential victims of the epidemic. I have tried to show how the subject positions of 'victim' and 'perpetrator' are discursively constructed and how they are related to power positions. Since no

discourse is without contestation, the 'victim' and 'perpetrator' positions are not surprisingly resisted. In this chapter, I mainly focus on women's resistances to the victim position.

The final analytical chapter deals with the workings of taboos and silences in the HIV/AIDS discourse. Since AIDS is a sexually transmitted disease, open discussion about the epidemic is not that common. In this chapter, I analyse how society normalizes taboos and controls sexuality. As the chapter tries to illustrate, there are different ways in which the repression of sexuality is challenged and resisted by my informants.

Even though the Ethiopian socio-cultural context has been discussed within each chapter, I believe it is imperative to provide a brief description of the socio-cultural context of Ethiopia, the context which I believe is useful in the analysis of the empirical material of the present study. Hence, the following chapter provides a review of both the context and research on HIV/AIDS in Ethiopia.

Chapter Two - HIV/AIDS in Ethiopia: An Overview of the Epidemic

2.1. Introduction

HIV probably started to spread in Ethiopia in the early 1980s. The virus was first detected in 1984, one to two years later than in most other sub-Saharan countries. The first two AIDS cases were reported to the Federal Ministry of Health (MOH) in 1986. Although HIV prevalence was very low in Ethiopia during the early 1980's, it has been increasing rapidly since the early 1990's. A trend analysis of prevalence from 1982 -2003 showed an urban epidemic that rose sharply to a peak over the last 7 years. It is currently estimated that 1.5 million people in Ethiopia are living with the AIDS virus. The estimated national adult HIV prevalence in 2003 was 4.4% of which 2.6% were urban and 2.6% were rural (MOH 2004: iv-v).

Since the onset of the AIDS epidemic in Ethiopia, efforts have been made to control the spread of the HIV virus. The National HIV/AIDS Policy of Ethiopia was formulated in 1998. A five-year strategic framework for the national response to the pandemic was also developed to translate the policy into action. Moreover, a national secretariat with a mandate to coordinate all programs was established under the Prime Minister's Office. The establishment of Regional HIV/AIDS councils and secretariats in all the regions has also been considered as a positive step to prevent the spread of the epidemic in the country (FDRE 1998).

The National HIV/AIDS Policy of Ethiopia states that AIDS would have a large social, psychological, demographic and economic impact on both the individual and the society at large. The policy criticized previous efforts as uncoordinated, poorly targeted and inadequate; and it stressed the importance of concerted efforts to retard the spread of the AIDS epidemic (FDRE 1998). In the general strategic framework for the national response to the epidemic, the promotion of safer sex practice emanating from the societal cultural norm based on the one-to-one sexual relationship

in marriage bond was emphasized (FDRE 2001). On top of policies and strategies, there are a number of HIV/AIDS prevention and control programs run in Ethiopia by different organizations and groups. Despite all efforts however, AIDS remains to be a very serious health problem.

In Ethiopia, the main sources of data on HIV came from a large-scale population based study and small-scale community studies. Blood donors and antenatal care attendees have also been used as major data sources. An important point to note is that each of these data sources has limitations for estimating prevalence in the general adult population of the city. Data on the prevalence of HIV infections have been based mainly on infection rates among pregnant women (prenatal clinic attendees). The data from blood donors for example were initially collected for purposes other than HIV and hence, there could be low participation of certain age groups (Rachel 2001:197). Furthermore, most data are from urban populations and little is known about the occurrence of HIV infections in rural areas, where around 85 percent of the population lives (Kloos and Damen 2000:18-19).

Whatever the actual rate, the prevalence of HIV/AIDS has contributed to falling life expectancy in Ethiopia since the early 1990s. According to the Ministry of Health, one-third of current young adults' deaths are AIDS-related (Referred in LOC 2005:8). Even though there are some research findings which indicate that HIV infection rates are declining, they need to be confirmed since it is not known if these declines are due to a decrease in infection rates or other factors like sampling bias or variable quality of laboratory test data (Kebede, Aklilu, and Sanders 2000).

I would argue that the problem of HIV/AIDS should not be viewed separately from the general health problems in Ethiopia. Studies show that health care is disproportionately available in urban centres. In rural areas where the vast majority of the population resides, the situation is worse since access to health care varies from limited to nonexistent. According to a recent study, less than 45% of the Ethiopian population has access to health services (Habtamu et al. 2004:100). In this case,

traditional medicine and home care remain the major health resources for the majority of the population (Kloos and Damen 2000:15-16).

Ethiopia is one of the poorest nations in the world and most Ethiopians live under extreme poverty. War and natural disasters are also parts of the natural history of the Ethiopian people and society (e.g. Tassew and Daniel 2002: Assefa 2002). Moreover, due to both man made and natural disasters, migration from rural areas to cities has been a major phenomenon. I would say that it would be difficult to have an appropriate understanding of the current HIV situation in Ethiopia without considering the national social and cultural context. This is because it is this social and cultural context that has created the conditions for the spread of the epidemic. Hence, before discussing the relevant HIV/AIDS research works, I will briefly discuss certain aspects of the socio–cultural context of Ethiopia which are related to the current study.

2.2. The Ethiopian Context: A Brief Description

Ethiopia is the oldest independent country in northeast Africa with a history dating back to 2000 B.C. Paleontological studies identify Ethiopia as one of the cradles of humankind (MOI 2004). Conventionally, Ethiopian history began in the tenth Century BC with the visit of the Queen of Sheba, allegedly from Ethiopia, to King Solomon of Israel. Hence, the reference of Ethiopia's 'three thousand years of history' is based on this legend. Bahiru asserts that *"aside from the fact that this association has scarcely any scientific bases, it represents too short a view of the Ethiopian past"* (2002:7).

Ethiopia embraces a complex variety of nationalities and linguistic groups. According to the present federal structure, these peoples existed in nine regional states. The people of Ethiopia altogether speak over 80 different languages with over 200 dialects (Tesfaye 2001; MOI 2004). Languages spoken in Ethiopia belong to two super families called Proto- Afro-Asiatic and Nilo-Saharan. The three language groups of

the Proto-Afro-Asiatic family spoken in Ethiopia are known as Cushitic, Omotic and Semitic. Cushitic and Omotic are the most ancient in the Ethiopian region and the Semitic languages are the most recent. A fourth group of languages belong to an independent family known as Nilo-Saharan (Bender 1976). It has to be noted that Ethiopian people share similar cultural and linguistic identity with many peoples of neighbouring Somalia, Djibouti and Eritrea.

As of early 2004, the population of Ethiopia was estimated at more than 70 million and growing at rates estimated as between 2.1 and 2.5 percent per year (LOC 2005). Ethiopia is the second most populous country in sub-Saharan Africa, with a population growth rate that is among the highest in the world. It must also be noted that only about 15 percent of the population is urbanized while the rest 85 percent of the population lives in rural parts of the country, making Ethiopia one of the least urbanized countries in the world (LOC 2005).

As mentioned earlier, Ethiopia is one of the poorest nations in the world with an annual per capita income estimated to be US$100 (MOH 2004:1). The country has been severely affected by chronic food insecurity and rural poverty. The backbone of the economy is the agricultural sector, which suffers from frequent drought and poor cultivation practices. Since the early 1970s, the country has suffered extreme economic and political turmoil. Catastrophic famines and droughts have occurred frequently, together with a protracted and devastating war (Ezra 2001). Economic indicators also reflect the slow growth of Ethiopia's national wealth and industrialization. Rapid population growth, political instability, economic mismanagement, and repeated natural disasters are all believed to be contributing factors in preventing Ethiopia's socio-economic development (Rachel 2001:61). Moreover, there is a high level of mortality in Ethiopia and this has been attributed mainly to widespread communicable diseases such as tuberculosis, measles, and HIV/AIDS (Ezra 1997:252).

In 2002 the United Nations Educational, Scientific, and Cultural Organization (UNESCO) estimated that only 33.8 percent of women and 49.2 percent of men in Ethiopia were literate (LOC 2005:8). Modern education was introduced to the nation in 1908 by Emperor Menelik in an effort to incorporate new scientific and technical cultures and ideas into the nation. Prior to that time, a well-established traditional system of religious education, for both Christians and Muslims produced the only literate persons in society until modern schools were established (Kiros 1990). Even today, many Ethiopians get their education through Church or Koranic schools.

According to a survey which collected information on the exposure of the population both to the broadcast and print media, 86 percent of women and 73 percent of men in Ethiopia have no exposure to the mass media (CSA 2001). Listening to the radio is the most common way of accessing the media. Nevertheless, only about one in ten women and one in four men listen to the radio at least once a week. This information is important because it provides an indication of the exposure of men and women to family planning, health, and other information. As the figures indicate, men have a higher exposure to the mass media than women (CSA 2001).

In an illiterate society like Ethiopia, the role played by religious and traditional institutions cannot be ignored. The forthcoming discussion focuses on the significance of religion and tradition in the Ethiopian history as well as in the lives of its people. The focus is important because the degree of one's adherence to the norms of a given religion and tradition may exert an influence on his/her mode of life, including sexual and reproductive behaviour (Rachel 2001:150). Hence, in a highly religious and traditional country like Ethiopia it becomes important to consider the role and influence of religious and traditional tenets in influencing people's attitudes towards sex, fertility, and sexually transmitted diseases.

2.3. A Traditional and Religious Society

As the earlier discussion might have hinted, Ethiopia is a highly traditional society. Respect for tradition has been considered one of the dominant traits of Ethiopians. The nation's traditions have deep historical roots and have great force in the minds of people. In his description of the Ethiopian society Aspen noted that '*the history of the state and the people, and the religious traditions that have existed at state and local levels, have all contributed to an immense cultural stock from which people choose elements by which they compose their ontological meals*' (1994:337). It could be said that Christianity, Islam and animism have exerted much influence in the development of complex and diverse cultural traits in Ethiopia. Although there is no reliable statistics on religious affiliation in Ethiopia, clearly by far the largest faiths are Orthodox Christianity and Islam. Each religion is thought to constitute perhaps 40 to 45 percent of the population. It is also documented that there are still a few *Felasha,* Jewish communities, in Ethiopia (MOI 2004:16).

In order to have a better understanding of current social and cultural events in Ethiopia, it is important to look at specific historical developments of the nation. Hence the following paragraphs will examine the historical facts that led to the dominance of Orthodox Christianity and the Semitic culture in Ethiopia. I hope the discussion would highlight the reasons why Orthodox Christianity and the culture of certain ethnic groups have been dominant in the present study.

Modern Ethiopia traces its origins to the highly developed Axum Kingdom, whose centre was located in what today are the northern regions of Ethiopia. History tells us that the Semitic groups of Ethiopia have played the most dominant role in the country's history (Levine 1965). The kingdoms and empires that successively emerged in the country have invariably been under the control of particularly the Tegregna-and Amharic-speaking peoples of northern and central Ethiopia (Bahiru 2002:7).

Orthodox Christianity was introduced to the ancient Aksumites from the Byzantine world in about 340 A.D. It was a few centuries later that Islam was introduced along the Red Sea coast, spreading thereafter into the center and south. Although followers of different religion live mixed in Ethiopia, Orthodox Christianity is most strongly represented among the Amhara and Tigray, Islam among the Oromo, Somali, Afar, particularly those in the southern highlands, Gurague, and Sidama in the southwest (LOC 2005:7).

Two crucial institutions have guided Ethiopia's history – the monarchy and the Ethiopian Orthodox Church (Belay 1992). Although, both Christianity and Islam are widely followed, Orthodox Christianity has been the most dominant and historically old religion in Ethiopia. The creed, in its Orthodox form, came to express the cultural identity of a large section of the population. As it was mentioned earlier, the religious influence of Orthodox Christianity can be observed in the day-to-day activities of the people. This is because following the religious rules and rituals is considered as appropriate and sometimes mandatory to fit into the social system (Bahiru 2002:8).

As it was mentioned in the introductory chapter, the present study attempts to analyse the intersection between the discourses of religion and HIV/AIDS. Before going to the analysis of this relationship however, it is useful to briefly look at the historical and theological roots of the Ethiopian Orthodox Christianity. This is because the Orthodox Church has played a major role in creating Ethiopian historical and national identity on the basis of Biblical traditions, consciously claiming that Ethiopia had inherited the glory of Israel and had itself become a new Israel. It was in the fourteenth century that the Ethiopian Orthodox Church formulated the political ideology of Solomonic descent. *"Until 1974, when the last Solomonic emperor, Haile-Selassie, was overthrown, this ideology was used to legitimise the country's temporal and religious institutions on the basis of the Biblical traditions of ancient Israel"* (Wudu 2003:96).

The Ethiopian Orthodox Church is the oldest national church in Africa and has a long historical tradition. Even if Ethiopia follows the main beliefs and rituals of Orthodox Christianity, it is easy to notice the strong native flavour of its religion. Ethiopian Christianity has its peculiar indigenised form, with significant Judaic influences (Pankhurst 1992; Ullendorff 1965). The Church is known by its name '*Tewahido*' (oneness), a name given based on its Biblical Cannon. Different from Christians who believe Christ to have two distinct natures, one divine and one human, Monophysites or followers of Orthodox Christianity in Ethiopia believe Christ has a divine nature in which the human nature is contained (Belay 1992; Berhanu 2000). Chapter four of this study focuses on the influence of this Biblical cannon of Orthodox Christianity in more detail.

According to Wudu (2003:89), twentieth century Ethiopian rulers tried to build national identity and a modern country out of a multi-cultural and multi-religious society. Hence, Orthodox Christianity was used to promote modern national identity. For example, Emperor Haile-Selassie (r. 1930-74) sought to build a modern national state within a framework of 'religious uniformity' under the Orthodox Church, with Amharic as a national language.

Although the role of Orthodox Christianity in bringing national unity was emphasized by the Emperor, the Church was not capable of playing a significant role in this process. "*The Ethiopian Orthodox Church was an obstacle to secularisation, modern changes, and, importantly, to the emergence of an inclusive national identity.*" (Wudu 2003:96). Moreover, the attempt to create religious uniformity under the Orthodox Church and national curriculum marginalized other cultural, religious, and linguistic groups in Ethiopia. Haile-Selassie's policy did not bring about any change because of opposition from the Muslim community (Wudu 2003:89-90).

Islam came to Ethiopia by way of the Arabian Pensula in A.D 610 (LOC 1993). From about the middle of the seventh century, the Christian Aksumite Empire entered a process of decline because of the rise of Islam (Bahiru 2002:8). As it was mentioned

elsewhere, 40% of the Ethiopian population is follower of Islam. Ethiopian Muslims are adherents of the dominant Sunni, or the Orthodox branch of Muslim. *"The beliefs and practices of Ethiopian Muslims are embodied in a more or less integrated amalgam of three elements: the Islam of the Quran and the Sharia, the rituals and organization of religious orders and the worship of saints"* (LOC 1993:120). A point worth mentioning would be Ethiopia's place in Islamic religion. There is a historical fact that followers of Prophet Mohammed who fled away from persecution because of their faith found refuge in Ethiopia. Because of the hospitality of Ethiopians towards the refugees it is said that Prophet Mohammed ordered his followers not to make war on the Ethiopians. This historical fact is mentioned as a reason why followers of Islam have had high regard for Ethiopia ever since (Belay 1992:128).

In Ethiopia we see the co-existence of very diverse strands of religious habits and practices. According to Ullendorff, the doctrinal position of the Ethiopian Orthodox church was always unenviable, caught as it was between the deeply rooted Judaic customs of the country and the necessity to maintain its theological prestige as a truly Christian body (1965). Alongside Christianity and Islam, we find magical practices and prayers as well as a whole body of superstitious beliefs. Belief in the '*Zar*/spirits' is common to almost all indigenous systems, some closely resembling in name and function with the spirits recognized by neighbouring Christians or Muslims (LOC 1993:124). Close to 5% Ethiopians officially follow traditional religions but it is estimated that the actual influence of traditional religions is much more pervasive, affecting the practices of many of those followers of the other major religions (NCTPE 2003:14-15). In his study of the Amhara people of Ethiopia, Aspen asserts that *"... new and seemingly Non-Christian elements are not presented as opposed to Christianity but conceptually at least within its general framework (1994).*

As mentioned earlier, tradition also has a strong influence on Ethiopian peoples' way of life. Being a traditional society, Ethiopia has a number of practices that have strong influence on the spread of the AIDS epidemic. There are studies which assert that Ethiopian tradition and society are extremely repressive regarding sexual expression,

especially women's sexual expression (e.g. Hammond 1990:40; Rachel 2001:55; Prouty 1986). Traditional practices like female genital mutilation, early marriage and abduction are three of the main practices that have relation to the AIDS epidemic. Hence, in chapter six, an attempt will be made to explore the relationship between the epidemic and traditional practices, related to gender and sexuality. It must also be noted that most of the harmful traditional practices have no religious basis even though some tend to be associated with religion in the popular mind (NCTPE 2003:14-15). For example, female genital mutilation is generally practiced and is held to be a religious duty.

2.4. HIV/AIDS in Ethiopia: A Brief Research Review

Prior to the emergence of AIDS, studies on sexuality were either confined to small-scale ethnographic works, or to research focusing on fertility and family planning behaviours (Kidane 1990). Since the onset of the AIDS epidemic, a number of studies have been conducted on HIV/AIDS in Ethiopia. These studies raised numerous topics ranging from the specific characteristics of the AIDS virus in Ethiopia to the economic and social impacts of the epidemic. Among these studies are medical researches that were undertaken with the intention of acquiring more knowledge on the nature of the AIDS virus in Ethiopia. According to these studies, the relatively virulent HIV-1 is the major AIDS virus in the country, with transmission largely through heterosexual contact and to a lesser extent through mother-to-child transmission, traditional surgical practices and blood contact (Kloos and Damen 2000:16).

Since the onset of HIV/AIDS, a number of small-scale behavioural studies have been conducted. It is possible to say that the majority of these studies have been surveys targeting narrowly defined population groups such as prisoners, students in urban centres, out-of-school youth, travelling merchants, and street children (e.g. Zawde et al., 1998; Mulatu and Haile 1996; Shabbir and Larson 1995; Teka 1993; Kebede et al. 1991). To date, there have been very few large-scale comprehensive surveys

examining people's reproductive and sexual attitudes and behaviours in Ethiopia. Since it would be difficult and also unnecessary to discuss all these studies, I will select and discuss only two surveys which I believe are more related to the present study.

The largest survey in Ethiopia is the 2000 *Ethiopia Demographic and Health Survey (DHS)*. This is the first comprehensive nationally representative population and health survey which collected information on knowledge of HIV/AIDS and other sexually transmitted infections (CSA 2001). According to the survey, knowledge of AIDS is very high among Ethiopians but residents of rural areas are less likely than those in urban areas to have heard of AIDS. The study related the difference of awareness to respondents' education. The DHS survey states that community meetings are the most important sources of information on AIDS for both women and men (80% and 71%, respectively). For rural residents, community meetings are the single most important source of information on AIDS. Moreover, friends, relatives and health workers are important sources of information on AIDS for both men and women. The DHS survey further stated that young respondents are more likely to mention school as a source of information on AIDS (CSA 2001:159-160).

In relation to ways of avoiding the spread of HIV/AIDS, abstaining from sex, using condoms, and limiting the number of sexual partners have been identified as important in the survey. Most respondents (53% of women and 70% of men) believe that having sex with only one partner is the single most effective way to avoid contracting HIV. The survey result also shows that only 37 percent of women and 55 percent of men believe that a healthy looking person can carry the HIV virus. Moreover, 58 percent of women and 72 percent of men recognize that the HIV virus can be transmitted from a mother to her child. Although more than fifty percent of the population had awareness about mother to child transmission of the AIDS virus, the following figures indicate that detailed information was not observed during the survey. Only one in four women and one in three men are aware that HIV/AIDS transmission can occur during pregnancy, about one in ten women and men are aware

that this transmission can occur during delivery, and two in five women and one in two men are aware of transmission through breastfeeding (166-167).

In 1991 the Ministry of Labour and Social Affairs conducted a study with the title "*Survey of Adolescent Fertility, Reproductive Behaviour, and Employment Status*". The survey used a representative sample of never married adolescent men and women in urban Ethiopia. Results from the survey indicated that both men and women disapproved of male and female premarital sex. The survey further stated that, despite conservative views, about 50 percent of never married men (15-29 years old) and 19 percent of never married women reported having sexual experience (Cited in Rachel 2001: 8-9).

As the above two surveys tried to illustrate, there have been efforts to provide information on people's awareness of HIV/AIDS in Ethiopia. Since I intend to focus on specific areas of research that are directly related to the present study, the following sections will discuss three specific areas. Studies on the relationship between HIV/AIDS and specific groups of the population will be discussed first. Then, a review of studies on the gender aspect of HIV/AIDS in Ethiopia will follow. Finally, the research work on HIV/AIDS prevention efforts will be briefly discussed.

2.4.1. Research on Specific Social Groups

As it was stated earlier, there are a number of studies on HIV/AIDS which specifically focused on certain groups of the community. Especially during the early stage of the epidemic in Ethiopia, the focus was on identifying high-risk groups and their sexual behaviour. Among this high risk groups are commercial sex workers, unmarried young men and women, truck drivers and soldiers. Truck drivers were identified as a high-risk group because of their close links with commercial sex workers. Another highly mobile group which were believed to be exposed to multi-partner sexual contacts were soldiers. According to a study, about half a million

soldiers had been demobilized and reintegrated into the rural economy of Ethiopia by the mid-1990s (Dercon and Ayalew 1998).

Since there are a number of studies dealing with the relationship between HIV/AIDS and certain social groups, I will only discuss samples of works which dealt with the youth and commercial sex workers. One example of such studies is "AIDS and College Students in Addis Ababa: A Study of Knowledge, Attitude and Behavior", a research on six colleges in Addis Ababa (Beyene et al. 1997). The study tried to assess the knowledge, attitude and behaviour of 1214 students regarding HIV/AIDS. According to the result of the study, students' attitudes towards the disease and their protective behaviours did not match the relatively high level of knowledge they have about the disease. The researchers' forwarded a recommendation that there is a need for offering more education on AIDS to college students.

Studies on sexual behaviour and HIV/AIDS have shown that in spite of adequate knowledge of HIV/AIDS among Ethiopian adolescents, there seems to be less risk perception. In Shabbir's study for example, 91 percent of adolescents were found to have heard about AIDS and 85 percent of them believe AIDS exists but only 18.6 felt that they themselves could be infected by the HIV virus (Cited in Yordanos 2000). According to a finding of a study, an overwhelming proportion of the sexually active students have high-risk sexual behaviour despite the current threatening situation of the AIDS epidemic. The study recommended that researches should focus on the power dimension in relationships cultural values regarding sexual behaviour and economic dependency (Yordanos 2000).

We find a number of studies in Ethiopia on the interface between HIV/AIDS and commercial sex workers (Pankhurst et al. 2005)*. Most of these studies state that commercial sex workers in Ethiopia are highly vulnerable to HIV/AIDS. I am critical towards most of the studies on commercial sex workers for not being gender

* For a comprehensive list of studies on HIV/AIDS and commercial sex workers, please refer to Pankhurst et al. 2005.

sensitive. This is mainly because the studies focused on women and did not give proper attention to the role played by the clients of the women in transmitting the AIDS virus. Moreover, most of these studies do not give sufficient attention to the socio-economic and cultural conditions that promote commercial sex work. As Pankhurst noted, *"there have been little attempts to study the lives, concerns, and efforts of the women who engage in commercial sex* "(2005:40).

2.4.2. Research on the Gender Aspect of HIV/AIDS in Ethiopia

The increase in the number of HIV positive women in Ethiopia reflects their greater biological vulnerability to the disease. Statistical data indicate that in Ethiopia more women are affected by HIV/AIDS than men. As recent data show, among the total population, 3.8% male and 5% female citizens have been infected with HIV (MOH 2004:v). I contend that the difference in infection rates between males and females deserves closer scrutiny.

Although there has been special emphasis on women's issues on the AIDS policy as well as the strategic framework for preventing the epidemic, I may say that the gender aspect of HIV/AIDS has almost been ignored by researchers. I came to this conclusion because the number of the studies which dealt with the gender aspect of HIV/AIDS in Ethiopia is very few. As the previous section tried to show, a number of studies on HIV/AIDS focused on specific women's groups like commercial sex workers but it was only a few studies which specifically analyzed how gender is related to HIV/AIDS.

Although studies that specifically dealt with gender issues are very few, a numbers of studies have raised the gender aspect of the epidemic in relation to other issues. The difference between men's and women's awareness and perceptions of risk of infection are among the areas that some of these studies tried to look at. To cite a few examples of data on these specific issues, women in general were said to be less knowledgeable about the important ways to avoid contracting the illness than men.

According to a survey cited earlier, 37 percent of women and 19% of men in Ethiopia have no knowledge of sexually transmitted diseases. In relation to talks about the epidemic, one out of four women and one out of two men currently married or living with a partner had discussed the prevention of HIV/AIDS with her or his spouse/partner (CSA 2001:170-171).

Like this survey, some of the results of the studies on awareness of HIV/AIDS raise an important issue which is the power relationship between men and women. An example would be the difference between men's and women's capacity to use condoms. Men were twice as likely as women to mention using condoms (36% and 17%, respectively). The use of condoms during last sexual intercourse with a spouse or cohabiting partner is negligible among both women and men. Thirteen percent of women and 30 percent of men reported condom use with a non-cohabiting partner during last sexual intercourse. Further more, men reported having more sexual partners than women (7 percent and 1 percent, respectively). It was further indicated that sexual intercourse with multiple partners is higher among women age 15-19 and men age 40-49 (CSA 2001:170-171). These statistical figures clearly indicate that women have less power in sexual relationships than men. Chapters six and seven of the present study specifically deal with the connection between HIV/AIDS and men and women's power relations in sexual relationships.

One of the few studies which specifically dealt with the gender-sensitivity of prevention programs was that of Sehin Teferra's work (2000). The research tried to review related literature and scientific works on HIV/AIDS in Ethiopia with the aim of critically analyzing the available data in terms of their gender-sensitivity. The study also looked at the works done by a sample of NGOs, government institutions and others working on HIV/AIDS to look at how much gender differences were taken into consideration in the organizations' intervention against HIV/AIDS.

It was noted in the study that the majority of the studies analysed by the researcher were not gender-sensitive. In relation to HIV/AIDS prevention activities, some

organizations were commended in the study for undertaking gender mainstreaming in a structured, constructed fashion, for example, through hiring a gender specialist and establishing quota systems. It was stressed in the study that prevailing attitudes towards men, women and sexuality had made it difficult for women to benefit as much as men from the work done by NGOs. An important criticism towards intervention programs in Ethiopia was the focus on prostitutes without giving due attention to the clients of the women. It was also noted in the study that even those forms of intervention that target men tended to focus only on increasing condom use, one of the few effective strategies available to prevent HIV transmission (Sehin 2000).

Bethlehem Alemu's thesis with the title "Social Stigma of HIV/AIDS in Addis Ababa-Ethiopia: A Gender Perspective" is a study aimed at illustrating how the alarming rate of HIV/AIDS transmission in Ethiopia is linked with the public's negative attitude towards and denial of the issue in general (2000). The researcher focused on gender roles, culture, education and socio-political and economic situations as contributory factors towards the stigma of HIV/AIDS. According to the findings of the study, despite the seriousness of the problem of HIV/AIDS, respondents did not discuss the epidemic very often. The research noted that there is a pervasive stigma attached to HIV/AIDS. Furthermore, most respondents of the study acknowledged that they would not like to work, live or befriend people with the virus. It was noted that many women in long-term relationships, having no negotiating power over their sexuality, could not insist on the use of condom to protect themselves from STDs and HIV. The researcher recommended that efforts should be made at empowerment of women, enabling them to make informed choices and articulate their desires and dislikes. The study also stressed the need to deconstruct the cultural constructions of male and female sexuality in Ethiopia.

The research on 'Gender and HIV/AIDS in Ethiopia", by Miz-Hasab Research Center (2004) could be mentioned as the most significant study so far for its analysis of the relationship between gender and HIV/AIDS. This study was undertaken in two

regions of Ethiopia using methods including a survey, focus group discussion and key informant interview. The objectives of the study were: to understand the basic cultural norms, values, assumptions, beliefs, perceptions, and attitudes that put women and the community at large vulnerable to the AIDS epidemic. The study also aimed at informing policy and program interventions to bring about fundamental changes in individual and societal thinking towards gender (2004).

One of the areas that the study looked at was knowledge on HIV/AIDS. It was stated that both men's and women's knowledge on HIV/AIDS is relatively high but the study also mentioned that that males have more information on HIV/AIDS compared to women. This was mainly explained by the fact that women are not expected to attend public meetings. Furthermore, the study focused on the relationship between harmful cultural practices and HIV/AIDS. Reported harmful practices listed in this study include female genital mutilation, widow inheritance, abduction, wife sharing, and polygamy. Commercial sex work was also mentioned as one factor which puts the general population at risk of HIV infection.

The study recommended that those traditional beliefs and practices which enhance the spread of the epidemic need to be questioned. What makes this study different from similar studies is its focus on social capital that might assist to reduce the spread of HIV/AIDS. It states that all communities studied have elaborate traditional structures which can be used to identify and change those gender related norms and practices which enhance the spread of HIV/AIDS. The study also stressed the strength of community leadership and the important role religious leaders can play in changing cultural norms and practices that put men and women vulnerable to HIV infection. However, I am critical towards this study for not providing appropriate attention to the relationship between gender, religion and HIV/AIDS.

Rachel's (2001) dissertation, entitled '*Sex, Sexuality, and the Meaning of AIDS in Addis Ababa, Ethiopia*', is a study that examined a number of issues relating to young people's premarital sexual attitudes, behaviour, and of HIV risk perception. The study

looked at various issues relating to premarital social and sexual relationships, mate selection, and marriage with the aim of understanding how beliefs about appropriate sexual conduct relate to young people's expectations of and ideas regarding their relationships. Furthermore, the study looked at the relationship between idealized standards of sexual conduct and individuals' ability and willingness to take sexual risks and protect themselves against AIDS.

According to Rachel, open and free discussion of sex is difficult in Ethiopia because sex is emotionally laden and inspires feelings of pleasure, confusion, shame, guilt, and even fear. She asserts that such feelings will influence young people's understanding of sex and sexual health, and how they put their knowledge into action on matters related to AIDS. It was mentioned that young people, especially women, were at times reluctant to talk about sex during focus group discussions and when they talked their comments were abstract, reluctant, and often times vague. According to the findings of the study, in Ethiopia AIDS is negatively associated with amoral behaviour, promiscuity, and uncleanliness (Rachel 2001:12).

Rachel's study concludes that social and political instability, population mobility, widespread prostitution, resistance to condoms, and a high prevalence of STDs have facilitated the rapid spread of HIV in Ethiopia. The findings indicate that young Ethiopians' premarital social and sexual relations are in a state of transition. Despite evidence that both men and women are having premarital sex, the ideal sexual standard for both men and women is abstinence, the study asserts. It was stressed that while abstinence may be idealized for men and women, the actual standard that governs young people's behaviour is a double standard permitting men greater sexual freedom.

I commend Rachel's work for specifically addressing some ambiguities and paradoxes related to men's and women's sexual lives. One of the major conflicts that emerged from the study is that young women in Addis Ababa are having sex in a context in which there is still a high premium on female virginity. Moreover, women

adhere to a standard of abstinence but some women are having premarital sex. This is evidence that there is conflict between the normative and the actual practice. The study also indicates that a significant proportion of sexually active men and women engage in high-risk sexual activities. Further more, both men and women have low levels of HIV risk perception. An important point the study mentioned is women's lack of power in their sexual relationships and their inability to initiate and enforce preventive behaviours such as condom use.

I am critical towards Rachel's study for employing focus group discussions. Rachel stated that she used different data collection methods because she felt that sexuality and AIDS were complex and emotive issues that could not be adequately explored using a single data collection method (2001:9). The two methods she used were survey and focus group discussions. According to her, the focus group discussions were meant to collect data on assumptions, values, attitudes and beliefs that underpin prevailing behavioural practices towards sex and sexuality. In the same study Rachel admits that Ethiopia is a *'closed society'*; a society in which, at least publicly, sex is shrouded in silence. I believe it is unlikely that respondents would be comfortable to discuss sexual matters in a group. The researcher also stated that the study included individuals with different age and sex in one group. Mixing different groups might hinder some participants especially women to openly discuss certain issues, again due to the sensitivity of the subject.

2.4.3. Research on HIV/AIDS Prevention Programs

Another focus area that relates to the present study is the evaluation of HIV/AIDS prevention programs. Although there are a number of studies which tried to evaluate the work of specific NGOs or institutions, there are very few studies which have attempted to provide a general evaluation of what has been done in the area of prevention. Following will be a brief discussion of two studies which tried to evaluate the contribution of NGOs in preventing the spread of HIV/AIDS.

'The Role of NGOs in the Prevention and Control of the Spread of HIV/AIDS: The Case of Selected Organizations in Addis Ababa City Administration' is a study which tried to review the contribution of selected NGOs in light of the internal and external factors that affect these NGOs and the actors involved in the field (Fasikawit 2002). The study pointed out that the existing poverty and the congested living conditions of Addis Ababa facilitated the easy transmission of the disease. According to the study, the NGOs were faced with the challenges of enabling their beneficiaries to deal with poverty and at the same time prevent the transmission of the virus. It was further stated that unless the urban poverty is reduced, NGOs' contribution to the prevention of the spread of the virus would remain overshadowed.

Fasikawit emphasised that both the external environment and the NGO's internal capacities were the most important elements in managing the development programs. According to the study, NGOs are faced with the challenge of enabling the community to reduce the level of poverty through incentives and capacity building programs. The situation in the organizations selected for the particular study indicated that they encountered role confusion in dealing with the prevention and control of HIV/AIDS. Moreover, the organizations were identified to have less developed manpower than the programs require to effectively address the issue. It was recommended that NGOs undertaking prevention programs through awareness creation should not be over ambitious in achieving behavioural change in the target population. The study stressed that NGOs should focus on building the capacities of their staff members and the community so that the effort is jointly undertaken to reduce the impact of the disease on development. Moreover, the need for coordination of efforts to bring meaningful changes in the fight against AIDS was emphasized in the research.

The other study, 'Evaluation of CRDA/Donors Supported HIV/AIDS/STDs Projects' (1998) was sponsored by CRDA (The Christian Relief and Development Association). The objective of the evaluation was to find out the status of HIV/AIDS projects and to identify the strengths and constraints encountered during

implementation. The evaluation was also envisaged to explore the degree of participation of beneficiaries. It was concluded in the study that there was lack of active involvement of the local government agencies and in most cases the community or beneficiaries in the planning, implementation and monitoring activities. The researchers recommended that continuous and sustainable projects should be developed in order to bring about long lasting behavioural change.

I am critical towards the two studies on HIV/AIDS prevention activities for not giving due attention to the gender aspect of prevention programs since most of the NGOs selected for the studies had HIV/AIDS projects that specifically addressed women. Furthermore, the studies did not try to critically look at the scientific HIV/AIDS discourse which was the discourse used by the organizations.

2.5. A General Critical Remark on Previous Research

The advent of HIV/AIDS brought to light the need for better understanding of behavioural and social aspects of the epidemic including individual and collective sexual behaviour, contextual issues, and sociological aspects of partnering, that had not previously been explored (Mann et al. 1992). In Ethiopia too the research on the subject of sexuality was very limited before the spread of HIV/AIDS. As this chapter's review of previous research might have indicated, today we have so many studies on sexuality and HIV/AIDS. It must also be noted that a significant number of the studies on HIV/AIDS in Ethiopia are epidemiological studies which tried to give answers to questions about who, when, where, and how people become infected (e.g. Abera et al. 2003; Mengistu and Jones 2003). As Kloos (2000:15) asserts such studies cannot fully explain the great disparities in the prevalence of HIV/AIDS among communities and regions.

As the brief review of research might have indicated, most of the studies on the social aspect of HIV/AIDS concentrated mainly on statistical figures barely analysing the deep-rooted conceptions of sexuality in the society. In relation to this Pankhurst

asserts that "*Questionnaire responses have been taken at face value, and there has been a tendency to reduce people to statistics and to silence the different voices of those most concerned, with little attention to the struggle of individuals*" (Pankhurst 2005). Given the complexity of human sexuality, it is unlikely that statistical research methods alone will be able to give a large picture on sexual attitudes and behaviours. Sex surveys are subject to reporting bias, such as over-reporting and under-reporting of sexual behaviours, depending on varying social expectations of different groups (Rachel 2001: 200 –201). A methodological problem of HIV/AIDS research is that gathering meaningful survey data may be difficult due to a strong social stigma.

Another shortcoming of previous research on HIV/AIDS is their tendency to focus on specific social groups that are labelled as '*high risk groups*'. As it was discussed earlier, the main focus so far has been on groups like commercial sex workers, students and truck drivers. There are studies in which these groups have been identified as the reasons why children, adolescents and the large population have increasingly become infected by the HIV virus (e.g. Kloos and Damen 2000:12). It is however important to recognize that HIV/AIDS is severely affecting all groups of the society in Ethiopia.

Unlike most of the studies discussed in this chapter, the present research looks at the construction of the HIV/AIDS discourse in Addis Ababa. The forthcoming chapters attempt to show the intersection between HIV/AIDS and other discourses like religion, science, tradition, gender and sexuality. Emphasis will also be given to how informants differently negotiate with the HIV/AIDS discourses.

In this chapter I have argued that the connection between HIV/AIDS and power relations in interpersonal relationships have not been thoroughly researched in previous studies. Moreover, I would say that women's resistances to the epidemic have not been given due consideration. In the current study I will try to show the effect of power in the spread of HIV/AIDS. An attempt will also be made to look at the different ways in which men and women try to resist the AIDS epidemic.

Chapter Three: Research Methodology

3.1. Introduction

As it was mentioned in the introduction chapter the main objective of this study is to show how the dominant HIV/AIDS discourse is taken up and negotiated by my informants in Addis Ababa. The study also tries to analyze the intersection between different discourses in the construction of the AIDS discourse. These intersecting discourses include gender, sexuality and religion.

The present study could be labeled as sensitive because it deals with the issue of HIV/AIDS. One of the reasons why the subject of AIDS is so sensitive is because the disease is passed through the most personal, most secretive and most sensitive of behaviours - sexual relations. The fact that a cure has not been found for those infected also contributes to the sensitivity of the subject of HIV/AIDS. Hence, informants' inhibition from sharing information and their experiences with me was very well acknowledged during the study.

Before the commencement of the data collection process, I was well aware of the power inequalities between me and my informants. I was cognizant of the effect of this power inequality on the research result and the information to be acquired. I recognized that my own sex, social status and other social characteristics in interaction with my informants' own social characteristics and experiences could increase or lessen the sensitivity of my research topic. The influence of my assumptions, sympathies and biases on the research process was very well acknowledged. As Hammersley and Atkinson said, the researcher is powerful and inescapable influence. What the informant says is always influenced by the interviewer and the interview situation (Referred in Maxwell 2005:109). This means

that the researcher is part of the world he or she studies and has to take responsibility for the knowledge produced.

This chapter has five subsections. In the first section it discusses the study area and the informants. Negotiating research relationships will be the issue that will be discussed in the second section. The following two sections will deal with the data collection methods, and the challenges during fieldwork and the different mechanisms used to overcome these challenges. The last section raises some points related to the validity and generalizability of the present research.

3.2. The Study Site and the Informants

Addis Ababa, the capital of Ethiopia, is the study site for the present research. I chose Addis Ababa as my research site mainly because of past familiarity with the city and the added richness of working in a diverse urban centre in Ethiopia. Most of all, Addis Ababa was selected because it is reported to have one of the highest concentrations of HIV/AIDS cases in the country. According to recent surveillance reports, the HIV prevalence rate in Addis Ababa amounts to 12.4%. These days 57% of the hospital beds in the city are occupied by AIDS patients. If the epidemic continues unchanged, predictions say that there will be 40,000 to 60,000 new HIV/AIDS-cases every year. The overall ratio for infected male and female amounts to 1:1.2 indicating the need to analyze the gender aspect of the epidemic (AAHAPCCO 2006).

As the capital and the largest employment centre, Addis Ababa is a city where almost all ethnic groups live. However the major ethnic groups are, Amharas 48.3%, Oromos 19.2%, Guragies 17.5%, Tigrians 7.6% and others all together 7.4%. Regarding religion, 82% of the population is Orthodox Christian (FDRE Parliament 2005). Founded in 1886, and established as the capital city in 1889, Addis Ababa is a relatively new city that has expanded to be the only major urban centre in Ethiopia in the span of 100 years. The city experienced rapid population growth, and in more

recent years the population has dramatically increased as refugees from the war-torn countryside have streamed in looking for job and security. According to the data from the City Administration, currently the population of Addis Ababa is expected to be 3.5 to 4 million (2005). Berhanu and White stressed that migration has been a key factor in the growth and expansion of Addis Ababa over the last four decades (Referred in Rachel 2001:61). As it will be discussed in chapter six, rural women migrated to Addis Ababa in search of a better life.

The study was conducted at Kebele* 47 of Lideta Kifle Ketema† (sub-city) of Addis Ababa. Lideta is one of the highly populated sub-cities of Addis Ababa. The sub-city is situated at the centre of the city and is also a place close to the country's major market place, *Merkato*, the biggest open market in Africa. I can say that Lideta is favourable for selecting samples because people from different ethnic and socio-economic groups of the society live together in the sub-city. However it must be noted that most of the population of the sub-city is known to be very poor. Problems of urban poverty in this city section are exacerbated by high density of low-income residential areas.

The most important reason for purposefully selecting Kebele 47 was because it was the place where I grew up and I am very familiar with‡. Mainly due to cultural reasons, sexuality is said to be a subject which most Ethiopians would feel uncomfortable discussing with a stranger. Since I knew a lot of people in this Kebele, I thought I would be in a good position to find individuals who would be willing to take part in my study. The second section of this chapter will discuss the type of negotiations that took place between me and my informants prior to data collection.

The first major undertaking of the study was to develop some criteria for selecting participants. The respondents were purposefully selected taking into account the

* Kebele is the smallest local administrative unit in Addis Ababa
† Kifle Ketema (Sub-city) is an administrative unit in Addis Ababa. There are 10 *Kifleketemas* in Addis Ababa. The study cite Lideta Kifleketema has nine kebeles.
‡ I have done three qualitative studies in Kebele 47 of Lideta Sub-city on Female Prostitution, Gender and Poverty and Gender and Education.

difference in their life experiences. For this I had to do some background study to identify men and women with different experiences and social status. I gave more emphasis to the sexuality of informants since my study is about HIV/AIDS, a sexually transmitted disease.

My informants can be divided into two groups as those from Lideta and those from the NGOs. The total number of individuals who participated in the study as informants was 79. Unlike previous research, the present study did not focus on 'high-risk' groups but on newly weds, young men and women, and people who have stayed in marriage for more than 15 years. I selected 40 ordinary members of Lideta sub-city since my intention was to look at how the HIV/AIDS discourse was taken up and negotiated by ordinary citizens, not members of a certain group.

The informants were from different age groups. The youngest informant was 17 years old while the oldest was a lady of 75 years. The purpose of selecting men and women from different age, marital status, educational and work experience was to include a variety of responses. Among the 40 men and women interviewed at Lideta sub-city, the number of men was only 9. This was because the study's focus was more on women than men. Housewives, widows, divorcees and single men and women were all included in the list of informants. In relation to economic status, as most of the residents of Lideta, the majority of the informants were poor men and women. Most of the informants of the study were Orthodox Christians and this was because, the number of Muslims and followers of other religion were limited in the area.

Different HIV/AIDS prevention programs have been carried out by governmental and non-governmental organizations in Addis Ababa. Most of these programs are education, information and communication programs aimed at raising awareness and encouraging people to adopt protective behaviours. As it was mentioned in the introduction chapter, I am interested to look at how the HIV/AIDS prevention discourse has been negotiated by the public. Two organizations selected for the study are Medicines Sans Frontier -Belgium and Integrated Service for AIDS Project

Support Organization, ISAPSO, a local NGO*. The organizations have undertaken various activities including creating awareness about the epidemic and providing medical and social support to vulnerable groups. Both organizations also worked with the community building the capacity of health centres, schools and sub-city administrations. Hence attempts were also made to include in the study some of the organizations and schools that the NGOs worked with.

I purposefully selected the two NGOs mainly for their specific programs on women. Another reason for selecting them was the prior contact I had with members of the two NGOs. Thirty-three individuals, most of whom were women, were interviewed at the two organizations. The informants included project coordinators, social workers, IEC experts, nurses and counselors. The beneficiaries of the NGOs included in the study were mostly women who were actively participating in the HIV/AIDS prevention activities (for the list of all the informants see Appendix 3).

At the final stage of the data collection period, I also conducted interviews with two associations, namely the Lideta Sub-city Women's Association and The Ethiopian Women Lawyers Association (EWLA). Members of these two associations were included because some informants at Lideta mentioned these associations during interviews. I was convinced that it would be worthwhile to include the two associations so as to have a better understanding of the empirical data from Lideta. Hence, interviews were conducted with three leaders of the Lideta Sub-city Women's Association and the public relations officer of EWLA. In addition, interviews were held with a member of the Addis Ababa City Administration HIV/AIDS Prevention and Control Office and the Ethiopian Orthodox Church HIV/AIDS Prevention and Control Department. All in all the informants in the second group of participants were 39 adding up to the total number of respondents which was 79.

* For the brief profile of the two NGOs please refer to Appendix 2.

3.3. Negotiating Research Relationships

Negotiating relationships with informants are aimed to allow the researcher to ethically gain the information that can answer the research questions of the study. Although every researcher has to give due consideration to how to negotiate research relationships with informants, this task has to be seriously dealt with in a study on sensitive matters like the issue of HIV/AIDS and sexuality. As it is well known, AIDS is a sexuality transmitted disease that is attached to fear and stigma. Hence, building a relationship of trust with my informants was considered as priority in the research process. This trust is mainly based upon a belief in the integrity of the researcher that shared secrets will not be revealed to anyone else. As it is said the relationships that the researcher creates with participants are an essential part of the methods of the study. How the researcher initiates and negotiates these relationships is also a key design decision (Maxwell 2005:82).

The establishment of trustful relations between my informants and myself was not easy, since some informants seemed to be suspicious of my intentions. Two of the individuals I selected for my study turned down my request telling me that they did not trust researchers because they use the information they get from informants for purposes other than what they said they would. "*It is not unusual for the powerless or the disadvantaged to treat the researcher with skepticism, fearing that cooperation will bring in its wake only their further exploitation*" (Ranzetti and Lee 1993:101).

Although some looked at me with suspicion, I must say that my effort to negotiate research relationships with my informants was minimized because of my prior knowledge of most of my informants. Because a number of the informants knew me since I was a child, I easily got permission to conduct interviews with most of them. Moreover since my father was a respected resident of the community, most of the informants said they felt obliged to help me by accepting my request for interview. I believe that the close relationship between my family and most of the families of the informants gave me not only an opportunity to be allowed to conduct interviews but

also to gain the trust of most of my informants. Furthermore, my familiarity with my respondents and the study area enabled me to have informal visits. That means I was able to contact informants without being watched by people as a stranger. The informal visits were useful to decide how and when to conduct interviews. During these visits I was able to recognize for example the difference between my informants interest in my research.

There were some ways in which I could see from the start that most informants accepted me and my work positively. For example a number of informants said it must be the responsibility of every family in the neighbourhood to support a woman who is making efforts to pursue her education. Three informants even used the common Amharic expression '*Balwoldishim Lije Nesh'* /Even though I didn't give birth to you, you are my daughter'. Considering me as their daughter, these informants mentioned that they were proud of me for pursuing higher education. I felt the difference in the educational status between me and my informants was one of the reasons for the special and respectful treatment I got during my fieldwork. Although the elderly men and women were in a power position in relation to me because of age, prior to the data collection I realized that the educational difference could create distance or an unequal power balance between me and my informants. This point will be further discussed later in this chapter.

I was aware of the fact that my prior knowledge of my informants could have its negative impact on my study. Since the topics of HIV/AIDS and sexuality are sensitive and private, it is understandable that some informants might feel that their shared secrets during interviewing might be revealed to other members of the community. I believe this suspicion was the reason for two very close neighbours to turn down my request for interview.

Even though I had a very good prior knowledge of most of my informants, I decided to have casual contact with most of them prior to data collection. In most cases, I paid visits to my informants' houses twice before the interview. During these visits, I

mostly discussed with informants issues that are not directly related to my topic. The topics of our discussion included family matters and general life issues. During this period, there were times when I attended weddings, christening and burial ceremonies. In the Ethiopian society, participating in such social activities is considered very important. Most of all, attending burial ceremonies and paying regular visits to the family of the deceased are cultural obligations one has to fulfill in order to have a good relationship with community members.

I must say that my gender facilitated the relationship I had with most of my informants. Being a female, I was able to visit my female informants at their houses whenever I wanted. I acknowledge that this might not have been easy for a male researcher even if he was close to the family like I was. A number of times I had meals and attended coffee ceremonies with my informants. As will be discussed in chapter four, coffee ceremony is important in creating a situation where community members socialize with each other.

Negotiating relationships with beneficiaries of the NGOs was difficult because of their low interest in spending time with researchers. As I found out later, the reason was that a number of researchers came and interviewed them. They seemed to be fed up of being interrogated. I had repeated visits to the drop-in-centre of one of the NGOs so as to have a good relationship with the women beneficiaries there. I expressed interest in their lives and what they were doing at the NGOS. I tried to spend time so as to know informants well and to create a good relationship prior to the interviews. There were times when I attended training programs with the women even though I had no special interest in those particular trainings. In one of the NGOs, I played outdoor games with beneficiaries like table tennis with the intention of creating closeness between me and the women. I can say that these contacts helped me to engage in more open informal discussions with my informants.

I found the visits before the interviews very important since they helped me to learn what is meaningful and significant to ask. I believe that the informal discussions at

the visits provided information about my informants. The discussions also provided me with contextual information, a different perspective from interviews. Although I knew most of the informants at Lideta, I had very limited information on how far they would be willing to respond to all the questions I prepared. With the help of the information I acquired about informants during earlier visits, I was able to set aside some of the questions I thought would be offensive or personal to some individuals.

3.4. Data collection and Analysis

The main question I asked myself before deciding on data collection methods was which ways of information gathering would help me to have a better understanding of the HIV/AIDS situation in relation to my research objectives. This is because decisions about research methods depend on the specific context and issues that have to be studied. I decided to employ qualitative research methods for the study. In-depth interviews, observation and document analysis were the methods selected to gather data for the study. These methods were believed to be useful to probe deep into the issue of sexuality, gender and HIV/AIDS since all the three issues are sensitive and delicate. In the following paragraphs, I will discuss each of the methods used for data collection and the analysis employed.

It was difficult for me to decide how far I would be able to ask personal questions related to informants' sexual lives. The questions of the interviews ranged from family history to opinions regarding HIV/AIDS and related discourses like gender and sexuality. Opinions on religion, tradition, and economic and other issues relevant in the construction of the HIV/AIDS discourse were collected from the interviews. Some of the substantive questions relating to opinions on sexuality and HIV/AIDS, however, were developed in the field. I also drew upon daily experiences and observations that I had acquired living in with the community. Through continuous contacts with informants and their situations, insights on substantive issues of interest emerged and took root. For instance, some of the issues related to my research were discussed over coffee ceremonies held just before the formal interviewing. These

issues provided insights that were translated into questions. As Maxwell says: "*Unstructured approaches allow you to focus on the particular phenomena being studied, help to have contextual understanding" (2005:80).*

As it was mentioned earlier, interviews were held with two different groups, one of the groups consisting of selected men and women residents of Lideta Sub-city of Addis Ababa and the other group having staff of the NGOs and their beneficiaries. The two groups were asked different types of questions. The first group was asked questions both general and specific in nature. The interviews were aimed at getting information about how the HIV/AIDS discourse as well as related discourses of gender and sexuality were negotiated by informants. Informants in the second group were asked questions which were mostly related to their work at the NGOs, questions about what they were doing and what difficulties they had encountered in their activities. (For list of all the questions please refer to Appendix 1)

During the interviews, a special effort was made to ensure confidentiality and privacy. Hence, men and women couples were separately interviewed so that each one of them could express his/her views without inhibition. There were some informants who insisted that specific parts of our conversations should not be used in the study. When such requests were made, it was difficult for me to give informants answers about what I would use and what I would not use from the information they provided. I had a dilemma of not knowing to what degree I could reveal the stories of my informants. Given the sensitivity of the matter, tape-recording was not attempted and instead, detailed hand written notes were kept.

Prior to the interviews, I acknowledged the fact that men might not feel comfortable discussing their sexual lives with me. Surprisingly, except one informant, the men did not show signs of discomfort while being interviewed. I noticed that the women were comfortable discussing the subjects of HIV/AIDS and sexuality. It was easily understandable that the situation would have been different with the women if the interviewer were a man. The importance of the researcher and the informants same

sex relationship was expressed by some informants. An example of this would be the repeatedly used expression, '*I wouldn't have told you this if you were a man*'.

The second data collection method used in the study was observation. Through observation data were obtained on the way beneficiaries negotiated with HIV/AIDS prevention education information. Emphasis was also given to the level of participation of men and women in the different activities of the programs. I also tried to see how gender differences were taken into account in the various activities of the two organizations selected for the study. Hence, activities like peer education sessions, dramas, coffee ceremonies and lectures on HIV/AIDS were attended. The observations were found to be useful in providing information on the participants and the meanings participants attach to the programs. They also helped to understand the contexts in which HIV/AIDS program activities occur. The data obtained through observation were believed to support that data from interviews and documents.

The third data collection method used in the study was document analysis. Two types of documents were analyzed. The first type included policy documents while the second one comprised literary works. All available documents on the area under study including the National AIDS Policy document and the Federal Level Multi-sectoral HIV/AIDS strategic plan 2001-2005 were reviewed (FDRE 1998). The focus has been on how these documents addressed the gender differences between men and women in relation to HIV/AIDS transmission and prevention. The documents were found to be useful sources of ideas for questions that were pursued through interviewing and observation.

Literary works were also used for the study. Although the majority of the literary works used were oral literature, I decided to classify them here as documents because most of them were obtained in written form from different sources like books. The study tried to see how HIV/AIDS and the issues of sexuality and gender have been presented in the literature. Before going to another topic, I think it is important to briefly discuss why I chose to include oral literature in the study.

Oral narratives have a major role to play in transmitting and perpetuating the deeply entrenched norms of society. The folk-tales, legends, oral poetry and so on embody and express the culture and history of the society as well as the people's philosophy of life. I believe that these different forms of expression are untapped sources that give invaluable information about the people of Ethiopia. Compared to formal settings and languages, attitudes and thoughts are much freely expressed in the different forms of oral literature. Through oral and written literature, people express their feelings and emotions. Hence, I would argue that information on sensitive matters like HIV/AIDS and sexuality are more easily available in literature rather than formal interviews. In countries like Ethiopia, where the majority of the population is illiterate, it is not written but oral literature that is a significant means of expression.

From the oral literature, jokes, oral poems, proverbs and graffiti were used for the study. These four forms of oral literature were selected since sexual issues are said to be more freely expressed in these four than in other forms of literature. Except a few of them that raised the issue of HIV/AIDS, all the literary works were on gender and sexuality. Two hundred seventy-two jokes, twenty-six oral poems, twenty-one proverbs and seven graffiti were collected for the study. Even though I have collected quite a large number of oral literature, it is only a selected few that have been cited in the text. A few poems were also used.

During data collection of literary materials, I benefited from my background in the field of literature. Since I taught Amharic literature for more than ten years, I did not have difficulty in selecting the kind of literature I needed for the study. About fifty of the jokes were collected by three young men at Lideta who were identified to have had a good exposure to the types of jokes I wanted for my study. Two students at Addis Ababa University also helped me to collect some graffiti. The rest of the collection of literature was taken from books and university senior essays.

I consider interpretation of data as a process of knowledge production in which researchers are accountable for the meanings they produce. This is mainly because researchers interpret their selection of data through their own ideas and values, and in terms of their chosen theory. The conclusions of a study are framed by the general approach used for the investigation and by the researcher's location in the process of data collection. "*However closely you aim to represent and respect your research subjects, human life is so complex and multifaceted that researchers constantly have to make decisions on selecting, refining and organizing their perceptions to avoid drowning in data*" (Ramazanoglu and Holland 2002:159).

The initial step I took to analyze data was to read the interview transcripts, observational notes and documents collected for the study. While reading the data, I tried to develop tentative ideas about categories and relationships. The data were organized into broader themes based on the key concepts inspired by the general theory used in the study. General concepts such us 'gender' and 'power relations' were specified in particular cites, for example in terms of: how women negotiate with HIV/AIDS. The major topics of each chapter were the themes in which the data were categorized first. Then the data were again categorized into smaller themes. Specific oral literature works that were related to the subtopics were also identified.

Finally I would like to mention that I made most of the work in interpreting my data while I was on the field. As Ezzy (2002:73) asserts: "*Researchers make many choices during data collection that are integral to how data are analyzed and will be analyzed-choices, for example, about what or who to sample, what to ask, what to pursue, and what to ignore*". Hence analyzing data is a process of selection and organization on which the researcher's prior assumptions and expectations are brought to bear. Here I would like to mention the power of language in producing meaning.

3.5. Some Fieldwork Challenges

Although some of the challenges discussed below are common to any research, most of the challenges I encountered during the study were related to the sensitivity of the topic of the study. In this section first I will look at the challenges that emanated from the specific nature of the study. Then I will try to discuss some of the problems I encountered during interviewing and observation. In most of the discussions I have attempted to present in parallel, some of the ways in which I had tried to overcome the challenges.

Prior to data collection, I acknowledged the limits of interview-based research for delicate issues like sexuality and HIV/AIDS. In the selection of informants, the focus has been on finding individuals prepared to talk about their sexuality. During interviews, I tried to encourage my informants to talk more and most of the informants were cooperative. However, this can say nothing about how talk about sexuality is organized in 'naturally occurring' environments such as talk between partners (Silverman 2000).

Due to the sensitivity of the subject of sexuality, it was difficult to get all the data that I wished to have. This is because a number of the informants were somewhat uneasy to discuss the topic due to the notion that open talk about sexual matters is improper and indecent. The informants' uneasiness to freely discuss the matter made the data collection process long and sometimes tiring. Repeated visits were necessary to gain the trust of informants. Most of all, I had to reassure my informants that the study did not have any intention to probe into their personal lives but aims at finding out general information about the epidemic. Moreover, I had to convince these informants that the information they provided was useful for the fight against the epidemic. It was after they were convinced about the significance of their contribution that some of these informants showed interest in taking part in the interview.

A few female informants were hesitant to discuss issues of sexuality because they were afraid that their partners might be disappointed. There were two women who were afraid that their neighbours might not feel good about them if they found out that the interviews were on private matters like sexuality. One of these women said, "*What would people say if they knew that I am talking about such things*". Asking my female informants about intimate and sensitive topics like sexuality and HIV/AIDS meant that I was asking them about a private area of their lives. Most of the informants were not at ease discussing with me their relationships with their sexual partners because such relationships are regarded in the community as the ultimate privacy. Hence, most of the time it was difficult to get specific responses to the questions that were directed at their private sexual lives.

Protecting informants' anonymity was one of the issued discussed before interviews. A number of my informants reminded me again and again that their names should not be revealed in the report. I had to reassure them that their personal information would not be exposed. I have found out that most of these informants had never been interviewed about their private lives before. The uneasiness of some of the informants can also be seen in relation to their perceptions of research and the way research findings are disseminated to the public. I say this because there were a few informants who wanted me to assure them that their stories would not be told on the mass media especially on television and radio. Furthermore, some respondents felt uneasy discussing HIV/AIDS issues due to the stigma attached to the epidemic. This was mainly because they had fear about people's speculations that those selected to be interviewed were individuals infected with the virus.

One of the techniques I used to encourage discussion during interviews was sharing with informants my general understanding about the epidemic. While some asked very few questions about me, others asked a great deal and tried to know me better. I believed that self-disclosure can help lessen any disturbing effects of a respondent's own disclosures on a sensitive topic like HIV/AIDS. For example I discussed the cases of relatives and friends of mine who lost their lives because of AIDS. I also

encouraged informants to discuss anything they wanted to, regarding my research. I believe that such discussions helped to create an easy atmosphere and encouraged informants to be more active during interviews.

Making the way the interviews were conducted more informal was found to be vital in promoting dialogue between my informants and myself. Furthermore, I tried to be flexible and highly responsive to individual differences, situational changes and emerging new information. I did not determine in advance the order and the actual working of the questions and I was free to pursue certain questions in greater depth. Some questions which were not thought of when formulating the interview guide cropped up during the interview. I tried to make the informants do most of the talking during interviews while interrupting cautiously when necessary.

Informants were sometimes not at ease to answer some of the questions especially those that dealt with personal sexual lives. Whenever I sensed this, I would rephrase the questions or keep them for later use. There were also many occasions when I left out questions. I did this whenever I sensed that informants might have found the questions intruding on their personal integrity. Furthermore, whenever informants showed disinterest in my questions, I would try to ease the interview atmosphere by raising other social matters like family or life issues in general. Hence I had to carefully observe the reactions of informants to each and every question.

During the first few interviews I learned that informants preferred to respond to more general questions than specific ones. Starting with more general and open-ended questions and then proceeding to the personal ones was found to be a useful way to make the interview process smoother. Informants' uneasiness to respond to personal questions is understandable in relation to the sensitivity of the subject and the general tendency to label individuals with certain sexual opinions as 'deviant'.

During interviews and observations, I tried to give serious considerations to appearances, body languages and all the non-verbal cues since all these transfer vital

information about the respondents and their views. As Ribbens argues, the researcher using interview methods need to be sensitive and able to take cues from the person being interviewed: suiting the interviewing style to the individual concerned (Referred in Edwards 1993:194).

Another challenge was some informants' doubt about the significance of their contribution to the research. Mainly due to this reason some informants preferred to give limited and concise information leaving out details that I expected to get. When asked to provide details, the response of these informants was that they did not think trivial personal matters were important. One woman said for example: *"I am an illiterate woman. How does my opinion matter? What I think about any issue is not important. It is better if you ask educated individuals"*. This was the kind of attitude some of the women had regarding the importance of their viewpoints. The response indicated that the informants entered a situation that is new and unfamiliar to them. Ken Plummer asserts that it is often difficult for informants to grasp what is entailed, particularly in the case of the more open and fluid types of interviews where informants are expected to play a central role (Referred in Edwards 1993:191). Those of my informants with higher education seemed to be more familiar with academic studies and the respondent's role in a research.

As mentioned earlier, I was able to sense that my educational situation had effect on my relationship with my informants. I say this because some of my informants were hesitant even to be willing to take part in the interview because they felt that there would not be any important information that they could give to 'a university lecturer'. Comments like '*how could these trivial matters be useful to an educated person like you?*" were common. The reaction of these informants is understandable since a teaching position at the university is a highly prestigious academic position in Ethiopia. Moreover, a female lecturer would get more respect because of the limited number of women in such a position.

Although my educational experience had its own contribution in winning my informants' respect, I had to make extra efforts to convince some informants that the information they were providing was important to me. In order to minimize the power imbalance between my informants and myself, I would not enter into a discussion about my career unless I was pressed to do so. Mostly I tried to redirect conversations about my career to discussions on family and other community issues. In this way I attempted to avoid a too hierarchical relationship between me and my informants. Once the interviews were over, however, I gave them as much information as they wanted about me and my profession.

There were some informants who questioned the significance of this kind of research on HIV/AIDS at the particular moment. For these individuals, a timely move was to provide solutions to the people affected by the epidemic. This opinion is very understandable since AIDS is seriously affecting so many lives and that priority should be given to those who needed practical support. Three informants suggested that what was needed was not research but medicine and financial support to people suffering from AIDS. It was a big challenge for me to explain my research objectives so as to enable them to understand that there is still a need to do more research and that I intended to look at the problem in a new way.

Most of my informants were poor men and women. I was able to sense that a few of the informants expected payments for their participation in the study. A few others told me their personal problems and asked me if I could help. I had to inform respondents that they would not be provided with money or other benefits for their participation. It was also difficult to turn a deaf ear to the problems I was informed about, since some of the families had serious problems in life that required assistance. There were many times when I shared advices with the informants, or alternative ways of solving their difficulties.

I acknowledge that I had to give something to the participants of my study in return for the time and inconvenience of being involved in my research. To provide help in a

small way I bought vegetables and other groceries that some of the men and women were selling. A number of informants also asked for advice on their children's studies in which I provided my opinion. All in all I tried to show my informants that I was not disinterested in their personal issues. Most of the time I was drawn into my informants' problems knowing that I was not able to help. Some informants were either in, or close to, tears during some parts of the interviewing. I have to mention that there were times when these encounters led to emotional exhaustion also on my part.

Most of the interviews at Lideta took place at the private homes of the informants. One of the problems encountered during interviews was the intrusion of other individuals. To minimize informants' uneasiness and intrusions of others, I tried to select opportune moments for the interviews. I tried to conduct interviews mostly when other family members were not around. I conducted most interviews early afternoons because that was the time when other family members were likely to be at school or at work. The mornings were not found the best times for interviews since most women would be engaged in performing household chores. I also made a notice that most women seemed to prefer interviews to be held when their partners were not around. Hence, I chose not to use weekends for interviews. There were also a few informants who preferred the interviews to be taken outside of their homes to avoid the intrusion of family members. In this case, interviews took place at my father's house very close to their houses.

Privacy was mainly difficult during interviews since most of the houses of the respondents had one or two rooms. In most of the houses it was not easy to have free discussions while the rest of the family was in the same room or in the next, listening to our conversations. I found it very hard to ask members of the family to leave the rooms and stay outside since a number of my informants were not aware of the need to conduct interviews without the presence of their family members. During interviews I observed that some of the female respondents were making sure all the time that our conversations were not overheard by people around. Hence I had to be

quick in reading informants' faces and redirect conversation whenever there were intruders.

Most of the time family members tried to remove themselves from sight when they were told to leave but there were times when they would be heard chatting together making the interviewees uncomfortable. It was difficult to have in-depth conversation about a sensitive topic without the benefit of privacy. Another problem was the frequent interruptions during discussions since most of the women had to perform household chores as they had little spare time for my interview. During these interruptions, I tried to be patient as much as possible. As Lewis asserts, negotiating relationships with informants requires sensitivity and patience (2003:62).

It was found out during data collection that some informants had been asked to involve in various research endeavours mainly surveys. Due to this, respondents seemed not to be too enthusiastic in participating in my research. This was especially the case with members and beneficiaries of the two organizations working on HIV/AIDS. These informants told me that they spent a considerable time of their work providing information to researchers and officials of government and non-government organizations. They also complained that the majority of the researchers did not share the results of their studies with them. For this reason, some members of the organizations were not welcoming until they were convinced about the importance of my study. I promised that I will give them copies of my research document.

3.6 Some Issues on Validity and Generalizability

As it was discussed in the introductory chapter, the existence of different claims of knowledge about the epidemic has been acknowledged in the present study. It is known that the issue of what is valid knowledge in the social sciences involves the philosophical question of what 'truth' is. As mentioned earlier, criteria of validity

differ according to ontological and epistemological assumptions that shape particular knowledge claims and particular notions of research. In this thesis I hold that there are multiple realities that are knowable only through representations of culture, or deconstructions of discourse and language, with no single truth or accessible reality.

During my fieldwork I tried to pay attention to the impact of the research process on the situation under study. Truth has to be looked at as negotiated in a local context and involves both the researcher and the informants. How the researcher construes the multifaceted process of conflict and negotiation of truth claims is an aspect of methodology. "*There is no knowledge that is separate from the specific location of its production and the power relations within which it is produced*" (Ramazanoglu and Holland 2002:138).

I would argue that it is possible to have a notion of validity without assuming a direct line to Truth. I support Kvale's assertion that validation has to be considered as investigation, continually checking, questioning and theorizing on the nature of the phenomena investigated (1989:8). Although researchers take different approaches to the problems of interpreting experience, I argue that there is a strong case for taking people's accounts of their experiences as a necessary element of knowledge and actual power relations. It is important to specify how the knowledge is produced and substantiate particular knowledge claims. Hence, the empirical data of the present study is believed to shed light on the informants' processes of negotiations with the HIV/AIDS discourse in Addis Ababa. As Blaikie asserts:

> As a general rule, qualitative researchers view the social world as processual rather than static, as being about the dynamics of social relationships between social actors rather than the characteristics of individuals and the relationships between abstract concepts. They argue that, as the participants are engaged in social process, social researchers who wish to adopt the participants' view of social reality, and provide an insider's point of view, should also view social reality in the same way (Blaikie 2000:252).

As the quotation shows, research is a process involving both the researcher and the informants. It means that knowledge claims emerge as conflicting interpretations that are communicated and negotiated among people who share decisions and actions. As Salner (1989: 66) noted, the researcher must interpret his or her research results not in terms of a search for certainty, but, rather as part of the project of an on-going scholarly debate or 'conversation' in which 'reality' is socially constructed. Similarly, the main objective of the present study is to provide detailed analysis of my informants' negotiations with the HIV/AIDS discourse.

Another point that has to be raised in relation to the relevance of the present study is the issue of generalizability. There is criticism that any one person's experience will be limited, partial and socially located, and so cannot be taken as general knowledge of how social phenomena are organized as social relations. Although the present study was conducted in a specific area in Addis Ababa, I think that the result of the research could have relevance to our understanding of how women negotiate the threat of HIV/AIDS in Addis Ababa and other cities beyond the site in which it was conducted. In discussing the possibilities for generalizing from qualitative research, Scholfield has argued that:

> At the heart of qualitative approach is the assumption that a piece of qualitative research is very much influenced by the researcher's individual attributes and perspectives. The goal is not to produce a standardized set of results that any other careful researcher in the same situation or studying the same issues would have produced. Rather it is to produce a coherent and illuminating description of and perspective on a situation that is based on and consistent with detailed study of that situation (Cited in Blaike 2000:254).

To provide a coherent and illuminating description of a situation, the researcher needs to specify (at least as far as possible) what criteria are being used and why, and how local or general these criteria are (Ramazanoglu and Holland 2002:115). Similarly, I

tried to get the data that were considered relevant to develop knowledge of women's understanding of HIV/AIDS and NGOs work with HIV/AIDS in Addis Ababa. The informants' processes of interpreting and acting on HIV/AIDS may be seen as a guide to what other people might do in the rest of Ethiopia.

3.7. Conclusion

I would like to conclude the chapter mentioning that I do not think of the challenges discussed in this chapter as 'obstacles' to the research process. Rather, I would say that the difficulties are an intrinsic part of the data. As Rachel (2001:64) stressed: "*While data are the product of interviews and discussions, they are also part of a larger social context in which they are asked*". Hence, the social context had a serious influence on the data collection process. As discussed earlier, the sensitivity of the subject of HIV/AIDS influenced how the interviews could be conducted and this inevitably had effect on the outcome of the research.

Most of the discussions earlier in this chapter present some of the efforts made to reflect upon the effect of the unequal power relations between me and my informants. The power of researchers to interpret their selection of data through their own ideas and values, and in terms of their chosen epistemology, remains dominant (Ramazanoglu and Holland 2002:115). This means that it is not possible that I could set aside my own language, life and understandings when I produced my interpretations of the data. Research needs to be taken as an inter subjective process of exploring, revealing, and thereby constructing meaning and self-insight in the collective subject. In relation to the negotiations in the research process, I would like to emphasize the role of language. Experiences have to be expressed in some language (oral, written, body, sign) that is already part of a specific way of thinking in a particular culture, period, and location. (Ramazanoglu and Holland 2002:124).

Chapter Four - Negotiations with the Scientific HIV/AIDS Discourse

4.1. Introduction

The most dominant statements regarding HIV/AIDS in Addis Ababa originate from the rule that the transmission of HIV/AIDS could be prevented by scientific means. These statements widely circulate in HIV/AIDS prevention programs of government and non-government organizations throughout the nation. Although experts play important roles in disseminating information, the scientific HIV/AIDS discourse is an impersonal system which exceeds the individual, and which structures what statements are possible to say and the conditions under which certain statements on HIV/AIDS will be considered true and appropriate. Hence my informants at Lideta as well as those at the NGOs had almost similar responses regarding the AIDS epidemic and its ways of transmission.

In this chapter, I will attempt to make an examination of the ways that the scientific HIV/AIDS discourse was negotiated by my informants in their quest to maximize their health status. In the first section I will look at how the biomedical information about the epidemic was taken up by my informants. Here the emphasis will be mainly on informants' understanding of what HIV/AIDS is.

The AIDS epidemic in Addis Ababa could be seen in light of the power issue, where the epidemic logic rationalized power as control, regulation and hegemony, in the production of health. As Gastaldo notes: "*AIDS has been a plague of paradoxes and disordered relations of power from the interpersonal to the international, the productive to the reproductive, the societal to the sexual*" (1997:113). In the second section, focus will be given to power relations in the scientific HIV/AIDS prevention interventions. In this section, the general objective of HIV/AIDS prevention programs is seen as government of the population. To investigate the power relations in HIV/AIDS prevention programs, counselling and testing activities will be analyzed.

Furthermore, four activities that allow the participation of beneficiaries will be discussed.

4.2. The Biomedical Knowledge Negotiated

As it was mentioned earlier, the scientific HIV/AIDS discourse is a dominant HIV/AIDS discourse in Addis Ababa. The major objective of most HIV/AIDS prevention activities I observed was to 'control' and 'prevent' the spread of the AIDS virus. Most of my informants both at Lideta and the NGOs were aware of what HIV/AIDS is, how it is transmitted and how it can be prevented. In some places emphasis has also been given to the issue of how to treat people living with AIDS. According to my observation, some of the questions that the HIV/AIDS prevention education programs attempted to answer include what is AIDS? What are HIV's major routes of transmission? How can one prevent HIV infection?

As it was stated earlier, the cause of AIDS is said to be a Human Immunodeficiency Virus. Information about this virus has been provided to the public through the mass media and the various HIV/AIDS prevention programs conducted by both governmental and non-governmental organizations in Addis Ababa. During my fieldwork, I asked my informants what the epidemic is. This was how two women at Lideta defined AIDS:

It is an epidemic which kills after a lot of sickness. The person with the disease loses weight tremendously. It is a dangerous disease that I can't explain (Informant.5).

AIDS is a sexually transmitted disease caused by risky sexual contact. It is a disease which has no cure (Informant 26).

Although there had been a lot of education programs regarding the medical definition of HIV/AIDS, most of my informants at Lideta found it difficult to define the epidemic. For these informants, the fact that the AIDS virus destroys white

blood cells that are essential to the body's immune system was not that important. Most of them preferred to list the kind of symptoms an AIDS patient exhibits. A number of the informants said it was difficult to explain the epidemic and this may indicate that the medical description of the virus is alien to most of the general population.

Different studies proved that there is a large percentage of awareness of the epidemic. The Ethiopia Demographic and Health Survey (CSA 2001), the first comprehensive nationally representative population and health survey conducted in Ethiopia, has indicated that a very high percentage of Ethiopian women (85 percent) and men (95 percent) have heard of AIDS. In addition, three in four women and nine in ten men believe there is a way to avoid getting AIDS. Even though it was said that there is a high level of general awareness among the public about the way of HIV/AIDS transmission, a number of my informants believed that HIV could be transmitted by eating and using the same toilet with a person who lives with the AIDS virus.

Similarly, a study in Ethiopia, Tanzania and Zambia showed that there was incomplete understanding of HIV and AIDS and many respondents of the study did not understand that there is a difference between HIV and AIDS and what the longevity of a person with HIV is and how the disease progresses. Fewer than one-third of the respondents in Ethiopia's survey knew the difference between HIV and AIDS. The study also showed that people with opportunistic infections such as tuberculosis, herpes zoster, and chronic diarrhoea often are assumed to have HIV and, as a result, are also physically isolated and otherwise stigmatised. Furthermore, people often do not believe that opportunistic infections in those with HIV and AIDS are treatable and curable (ICRW 2003:16).

As I mentioned earlier, in most of the awareness creation programs I attended, beneficiaries were provided with the information about the nature of the AIDS virus and how the virus attacks the immune system of the body was explained in detail during some of the programs. According to some of the members of the NGOs

working on HIV/AIDS, beneficiaries did not show much interest on such scientific information about the epidemic. The notion of being sceptical about scientific knowledge can be looked at in relation to individuals' perception of how the natural world functions. As it will be discussed in detail in the next chapter, Ethiopians believe in God as maker of destiny. For individuals who believe that secular world phenomena do not happen without being dictated by supernatural reality, scientific logic could not be convincing. As Messay (1999:196) puts it: '*Given the reluctance of the African mind to apprehend the world as unfolding according to inner laws, little wonder it didn't suspect the possibility of scientific knowledge and technical manipulation.* Instead, it inclined to the belief that physical properties and events could be modified by mere spiritual invocation. This is what a peer educator at one of the organizations said:

It is always difficult for me to teach my group members about the difference between HIV and AIDS. Many of the women in my group don't understand that one could have the AIDS virus but he can live without exhibiting any sign of sickness. In our society the virus is very much associated with sickness and death (Informant 56).

The fact that beneficiaries were not used to dealing with medical information may be the reason why most of them found it difficult to understand the difference between HIV and AIDS. These included the basic biomedical analyses that explained AIDS through infection by blood-borne transmission of a retrovirus – a form of explanation which might be quite alien to the 'common sense' understandings of many societies and epistemologies. This point could be elaborated in relation to leprosy, an ailment which is surrounded by a high level of fear and stigma. In their study on leprosy health education in Ethiopia, Malborg and Carlsson (1994) said the following:

> For the Amhara peasant wife, bacteria and aerial infection are unknown concepts. The idea that leprosy is transmitted by procreation is not enough to explain the spread. Neither is there any other obvious explanation of how the ailment should travel from a leper to another person to be found in her

> knowledge of the world as we see it. A theory that is so totally at odds with her cultural thinking is naturally regarded by her as nonsense (Malborg and Carlsson 1994: 6).

In HIV/AIDS prevention programs, I would argue that the knowledge of lay individuals like the woman mentioned in the quotation has not got the appropriate attention it deserved. As it was mentioned in the introduction chapter, one of the internal regulators of discourse is the notion of the academic discipline. This is a larger-order discursive grouping which determines what can be said and regulated as factual or true within a given domain. In the case of HIV/AIDS, the pandemic was and is still mainly perceived as a medical problem. The enduring hope has been that once the 'causative agent' of the 'disease' has been identified, a cure or a vaccine will soon be invented and the epidemic will be 'controlled'. We could say that the institution of modern medicine is firmly rooted in the idea that health is some kind of given: a normative state which can be resorted by defeating the abnormality of disease. However, the AIDS pandemic has shown itself to be a more complex phenomenon than many had expected. Basing himself on his study of HIV/AIDS in Tanzania, Setel (1999:243) concludes: '*In the age of AIDS international biomedicine has come into its own as a social force mediating bodily discourses, disciplinary practices, and subjectivities of persons in many locations in sub-Saharan Africa'*. According to Setel, medicine has become an African technique of knowing and defining persons from the social space within, hence acting upon their subjectivities (1999:243).

During interviews with my informants, I observed a tendency of not trusting the medical information or a sense of detachment from it. For most informants, the fact that there is no scientifically discovered medicine for the epidemic indicates that the solution to the epidemic is beyond human capacity and comprehension. Moreover, the AIDS virus has a period of latency which makes the epidemic problem more complicated. The position of medicine may be enhanced by its role in testing and treating opportunistic infections, but at the same time its inability to offer a cure

undermines its authority as well as trust in science and in 'Western expertise'. A woman at Lideta said:

It is difficult to trust those who do research on the epidemic because we hear different stories about the virus. If the scientists were good at knowing all about the epidemic, they would have discovered the cure for the disease. The fact that there is no cure for AIDS is a good indication that the virus is unknown and mysterious (Informant 2).

The unpredictability of the transmission of the virus may justify that science could not provide all the information about the transmission of the virus. Even though the limitations of the scientific knowledge are clearly understood as it could be seen in the above quotation, it is considered as the 'truth' and the only means to discover new knowledge about the AIDS epidemic. I argue that since science has the legitimacy to stay on top, it excludes other equally valid forms of classification and knowledge which were perhaps more relevant to the Ethiopian context. As Sherr (1993: 44) says, this exclusion stems from the unquestioning belief in a medical science which, with its tests and medicines, has previously delivered cures and understanding. "*Scientific knowledge entitles HIV/AIDS professionals to control the boundaries of normality and thus to construct 'normal' bodies. Individuality has been constructed based on symptoms, disease, or lifestyle; control over these processes is at the core of medical care*" (Foucault 1991:144).

My informants' lack of interest in understanding the virus and the scientific HIV/AIDS prevention information may be seen as a way of resistance to the dominant biomedical discourse of HIV/AIDS. Lay people are not helpless, passive and disempowered but try to change their situation. Though the biomedical discourse of HIV/AIDS is dominant, it could be resisted since power is productive rather than simply confining.

> What makes power hold, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and

> produces things, it induces pleasure, forms of knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (Foucault 1984:61).

Most of my informants at Lideta preferred to use other names to the epidemic rather than the scientific name 'HIV/AIDS'. All of these men and women knew the scientific name of the epidemic. Some used the name 'HIV/AIDS' a few times during our conversation but preferred to use other names. They preferred to use names like '*that disease*'; '*The Killer disease*', 'The *Unmentionable*', and even '*The Idiot*'. This might indicate that not only the virus concept but even the name of the epidemic itself is alien to them.

According to the information from members of the NGOs, during the first few years of the epidemic AIDS was very much known in Ethiopia by its name '*Amenminit*/slimmer disease', a name given to the epidemic based on the major symptom on AIDS patients which is tremendous weight loss. There were two informants who described AIDS as '*Yeseytan Beshta*/the devil's disease' indicating the informants' difficulty in understanding the virus concept. Juhasz (1993:154) asserts that "*AIDS is a scientific puzzle unsolved, a frightening example where nature has yet to be contained by science. Nothing could be more meaningless than a virus*". Similarly, my informants' reluctance to use the name 'HIV/AIDS' may also indicate the meaninglessness of the term 'virus' to them.

One informant at Lideta said '*I don't believe that AIDS exists*'. Some members of the NGOs told me that they came across individuals who equated AIDS with '*Gunfan*' /common cold' and who said *'there is no AIDS after 10 p.m.'*. The notion of disbelieving the existence of the virus can also be looked in relation to the newness of the biomedical discourse of HIV/AIDS.

It was found out during the study that some of the activities undertaken by the two NGOs focused on providing information on biological and medical facts but not on real life situations. If we take condom distribution for example, beneficiaries were provided with condoms but their real life situation was not seriously considered. In relation to this, one commercial sex worker said: *"I have lots of condoms at home but I don't know how to use them especially with men who insist on sex without condom"* (Informant 78).

Most of the commercial sex workers attending the HIV/AIDS prevention programs had similar opinion about condom use. The women stressed the importance of the information they got about condom but all doubted its applicability in real life situation. According to a study, giving people information about health risks is unlikely to change the behaviour of more than one in four people, and these are generally the better educated and the more affluent members of a social group (Campbell 2003:10). This is mainly because health-related behaviours such as condom use are determined not only by conscious rational choice of individuals, on the basis of good information, but also by the extent to which broader contextual factors support the performance of such behaviours. Similarly an informant at Lideta said:

If we look at most of the HIV education programs, the focus has always been on providing information but there is always a need to find out if that information is applicable in real life (Informant 37).

The quotation may indicate that the social dimensions of the AIDS epidemic have been marginalized in the biomedical discourse of HIV/AIDS. Furthermore, it shows that the social construction of AIDS is a complicated matter that should not be looked at based on simple biological determinism because in one village a certain set of factors determines the spread of the AIDS virus, but elsewhere different sets are likely to be prevalent. The pandemic is contextualized differently by different groups of people depending on location, occupation, gender, age, etc. As Foucault asserts:

'*medicine, as no other human enterprise, cannot represent a level of knowledge that can raise itself above culture'* (Cited in Jungar and Oinas 2004:98).

There are evidences in my empirical data which indicated the importance of shifting some of the attention on biomedical information on HIV/AIDS to the cultural context of Ethiopia. The beneficiaries of the two NGOs told me that one of the activities that had a serious impact on them was the speech made by people living with the virus. Although only very limited number of HIV positive individuals in Ethiopia have volunteered to speak publicly about their health status, the few men and women have made a considerable impact in creating awareness among the public. I attended a speech made at a factory by an HIV positive woman and observed that there was a lot of eagerness to know about the experience of the speaker. This was what one of the attendants of the program said about the woman and her story:

I never saw a person who is willing to say that she is HIV positive. I heard a lot about AIDS. I always thought that AIDS is the problem of the prostitute, or the promiscuous men and women. Today when a young and beautiful person like Fanaye exposed herself and told us that she is infected with the AIDS virus, I realized that anyone could be a victim (Informant 73).

The quotation indicates that people seemed to look for tangible evidence to prove the existence of the epidemic. In the way common people look at reality, they tend to look at nearness and tangibility of phenomena and objects rather than abstraction and theory which are far away from concreteness. Proverbs like '*Mayet Mamen New*/Seeing is believing' have wide acceptance in the Ethiopian society. The fact that people learn about the epidemic more from people living with the AIDS virus may also relate to the point that the medical discourse has been looked at with suspicion. Similarly, some informants at Lideta suggested that information/ education on HIV/AIDS should be concrete. Two had criticism on flyers on HIV/AIDS saying that they used long sentences and heavy words which made the texts difficult to comprehend. They said they were much interested in flyers and

posters with pictorial presentations. A female student mentioned that she found flyers with pictorial presentations on condom use quite useful.

As stated in the introductory section of this chapter, one of the issues that deserves due consideration is the power relations in HIV/AIDS prevention interventions. I would argue that the issue of power is important to analyze negotiations with the scientific HIV/AIDS discourse. With the help of the empirical data from Lideta and the NGOs, the following section will specifically deal with power relations in the scientific HIV/AIDS prevention interventions.

4.3. Power Relations in the Scientific HIV/AIDS Prevention Interventions

As it was stated earlier, the problem of HIV/AIDS has to be seen in light of the power issue. In this section I will attempt to look at two areas of power relations in connection to the AIDS epidemic. The first discussion will generally look at the HIV/AIDS epidemic prevention discourse as a government of population. In this section the power relations between the population and the government as well as beneficiaries, NGOs and the West will be discussed. The next part of this section analyses the power relations in specific types of HIV/AIDS prevention activities undertaken by the two NGOS. These activities include, drama, peer education, coffee ceremony and lectures and discussions, activities that are considered to be participatory at different levels.

4.3.1. The Government of Population

It has been long since the problem of HIV/AIDS has been considered as a national issue in Ethiopia. This consideration entails that it should be the government's responsibility to protect the population from the epidemic. The scientific legitimacy of the AIDS prevention discourse gives the government of Ethiopia and other agencies the authority to play a particular role in the development of HIV/AIDS prevention programs. This means the government, policy-makers and other

institutions and agencies can provide the 'facts' about the pandemic. In Ethiopia the programs on HIV/AIDS ranged from workplace up to homes of individuals telling people to keep themselves away from the risk of HIV infection. This was what an expert at one of the NGOs said about her work:

Our major work is to identify those who are at risk of HIV infection and make them aware of the ways of HIV/AIDS transmission. We provide them with information that would enable them to protect themselves from infection (Informant 45).

The activities of the government are predominantly those of collecting and calculating data on the characteristics of the population (births, deaths, rates of disease, levels and types of employment, etc.). In order to govern the population, knowledge is gathered on each individual body. The operation of disciplinary power pervades relations in families, schools, hospitals, work, etc. This is mainly because the scientific knowledge passed on to the client is claimed to save lives and enrich experiences. A clinical psychologist who worked on HIV/AIDS said:

> I was a professional. I could interview, assess, diagnose and hopefully cure. Like many other professionals, I was shielded from scrutiny by my mask of accomplishment, but perhaps I was also shielding myself from any true realization of the cause of difficulties in those with whom I was working, and perhaps shielding myself from offering anything other than superficial intervention (Ussher 1993:128).

Since the onset of HIV/AIDS in Ethiopia, there have been efforts to obtain knowledge about the virus and the magnitude of its transmission. As the above quotation indicates, most of all, much has been done to identify the sector of the population that was likely to be directly affected by the pandemic. To this effect, quite a number of studies have been conducted in Ethiopia using statistical analyses to identify and categorize the population in terms of risk. As the second chapter of the study tried to highlight, these studies presented figures and rates of infections recommending

special programs for those members of the 'risk group' and the 'infected'. The country's HIV/AIDS policy document also indicates that, prostitutes, truck drivers and the youth are among the groups that are 'at risk' (FDRE 1998). This is what a woman at Lideta said:

I know it is important to have information about the epidemic but I feel that too much money and energy have been used to obtain information about the extent of the problem of AIDS. I say this because I feel that most of the resources on HIV/AIDS have to be allocated on creating awareness about the epidemic and helping those that have been affected by the epidemic (Informant 25).

I would argue that what the different statistical analyses on HIV/AIDS in Addis Ababa did was to construct identity. As it will be discussed in detail in chapter six, people in Addis Ababa are put into different pigeon halls labelled as 'at risk' and 'not at risk' 'infected' and 'not infected'. I would say that this categorization reduces morality to politics and sexuality. Not only the studies but some of the HIV/AIDS educational programs I happened to observe constructed the same identity since they also dwelt on categorizing people as 'at risk' and 'not at risk' and 'infected' and 'not infected'. According to Ussher (1993: 132): "*it is positivism which positions the issue of AIDS as apolitical, the clinician and client as de-sexed, as gender neutral, stripped of class, age, ethnicity. It is positivism that encourages the clinician to categorize and diagnose, to research and treat objectively*". There has been a tendency to obscure the irreducible plurality of habits, practices, experiences, and desires within the many different sexual subcultures. One example of the danger of this obscurity is the false sense of security women and men have while they are in marital relationship. Similarly some of my informants were gave me answers about their safety in their marriages. This was what an elderly woman said about the issue.

I always pray and thank my God that all my four children are married. Although I am not worried about my children, how can I not be worried about my relatives and neighbours? There are bars and brothels everywhere. One can not turn a deaf ear to

the problem since a generation is being wiped out because of the epidemic (Informant 5).

The quotation shows that the twist in the logic of safe sex which encourages those in marital relationship to view unpaid intercourse as 'safe' makes it difficult for married men and women to perceive themselves as 'at risk'. This is no coincidence, since the media and prevention programs describe women as at risk through socially disapproved 'dangerous' sex. As I said, the construction of 'dangerous' sex prevents most women from perceiving themselves to be at risk of HIV infection because they view themselves as engaging in 'ordinary' or 'normal' relationships. Hence it is assumed that marital sex is 'regulated', 'checked' and 'safe', and that it may only be infected by the 'outside', by contaminating 'others'. This issue of marriage and risk will be further discussed in chapter six.

As indicated earlier, HIV/AIDS prevention education is an educational experience that gives professionals and patients/clients elements for building up representations of what is expected from 'healthy' sexual relationship. To give an example to how the notion of dichotomy has its roots in various activities, I will mention an article written on the national newspaper '*Addis Zemen*' about the death of Mr. Zewdu Bekele, a man who played a vital role in the fight against HIV/AIDS in Ethiopia. Mr. Zewdu lived with the AIDS virus for more than ten years and he was the first person to form an association for people living with the AIDS virus. This was what was written about his sudden death:

> The death of Zewdu Bekele is an evidence to the fact that anyone with the AIDS virus would die, be it a person who has lost weight due to sickness caused by AIDS or who looks physically well. His death reminds us that AIDS is a killer disease with no mercy (*Addis Zemen*, 6 January 2005).

The quotation shows that the dichotomy between the 'sick' and the 'healthy' has deep roots in the discourse of HIV/AIDS in Addis Ababa. It is my contention that the

newspaper should not have gone in to the details of describing the physical appearance of Mr. Zewdu before his death. The description shows that effects of health care as a disciplinary regime can extend into the most private and personal aspects of life. It is clear that a dualist construction of bodily being served well the development of a medical science in which the corporeal body could be mapped, measured and experimented on without moral impediment (Shildrick 1997:17).

Two informants at Lideta complained that the information on HIV/AIDS mainly comes from top officials in forms of policies serving the interests of those in power. This opinion may imply that HIV/AIDS prevention information is intended to reinforce health patterns conceived by the government for the population. We may say that when HIV/AIDS prevention education aims to produce changes in behaviour, it becomes mainly normative. Thus, 'healthy behaviour' is presented as the norm, and all other behaviours become deviant. The principle behind the norm of behaviour is that somebody else besides the individual knows best what is appropriate or good for the person. In relation to this point, this is what Gastaldo says:

> What health education does construct is identity. Health education is an educational experience that gives professionals and patients/clients elements for building up representations of what is expected from 'healthy' and 'sick' people. These social roles are reinforced by a complex system of rewards and punishments. Health education is an experience of being governed from the outside and a request for self-discipline. From inside, health education is a constructive exercise of power that improves the medical gaze; through the promotion of health, it circulates everywhere in spheres that are new to bio-medicine (Gastaldo 1997:118).

As the quotation indicates, the validity of the practices of health promotion is maintained and enhanced by the legitimation of science, by the use of the scientific warrant. In the case of HIV/AIDS, by delineating social categories where

prevalence is high, it sets up 'risk management' as the goal. The demand to know intimate details about the individual is a common feature of the HIV/AIDS discourse. The problem regarding this categorization of people could be best exhibited in what a Kenyan woman living with the virus said:

> Here I am, an ordinary person with what is rapidly becoming a most ordinary virus. I have stopped feeling sorry for myself and I have now learned to live, think and even act positively. I have come out of my hideout, and I have found a stage where I can tell the world over that I am not a victim but rather I am a messenger. A messenger of hope...Tell me I am not a number, a statistic, but equal partner in this struggle (Hunter 2003:225).

Some of the women beneficiaries I interviewed at the two NGOs had a similar opinion to what the Kenyan woman said. Even though they didn't use the word 'statistics', they complained that they came across a lot of enquiries about their lives. The same is true in the HIV/AIDS prevention programs where individuals are interrogated time and again to disclose information about their sexual lives. This is what Reid said:

> A critical approach to the HIV epidemic requires that the production of health and the production of knowledge become sites of contestation and re-articulation. Epidemic conditions rationalise and augment regulatory power regimes. They create a logic of crisis which structures and justifies the regulation of social production. This logic re-inscribes subordination in the practices of beneficence and may insidiously assert authority beyond any justifiable mandate (Reid 1999:99).

As I mentioned in the methodology chapter, most of the beneficiaries of the programs of the two NGOs were not that much keen to allow me to interview them. What they asked me was '*what makes your study different from the studies of those many others who came here before you?*' This was a difficult question that I was not able to

provide answer readily. In fact I was doing the same thing, asking them questions about their personal lives and trying to know about their behaviours and habits. The informants were complaining that they didn't benefit from those coming to ask them questions about their lives. It was also difficult for me to explain to them that my research could be any different in that regard. Most found it difficult to understand the immediate importance of my study and this could be looked at in relation to the fact that research and its results are not directly related to their day-to-day life experiences but are simply scientific exercises benefiting 'the other'. This was what one commercial sex worker at one of the NGOs said:

I have been asked about my life and my work since I started to participate in this program. It is good that we share our experiences with others but some ask very personal questions. The thing is that there is nothing we get in return for exposing our lives in to the open (Informant 78).

As the quotation indicates, medical professionals, the political elite, and other powerful groups have more or less free hand to impose their own culturally constructed risk assessments on the general public. This could be related to human sciences which were brought into administration and management to differentiate bodies, and to compare and classify houses, behaviours and wages. The information on HIV infection rates and identifying which section of the population is likely to be more affected by the epidemic seems most self-evidently to be adding to the sum of human knowledge. This may at the same time play a role in the maintenance of the status quo and the affirming of current power relations (Mills 2003). As mentioned earlier, some of my informants expressed their concerns regarding the unnecessary focus on obtaining information about infection rates instead of focusing on saving lives with practical activities. This point could be looked at in line with Foucault's assertion about human science.

> I believe that the human science do not at all lead to the discovery of something which would be the 'human'- the truth about man, his nature, his

> birth, his destiny; in reality, what the various human sciences are dealing with is something very different from man: systems, structures, combinations, forms, etc. (Foucault 1999:100).

I would argue that the meaning of HIV/AIDS must be understood as negotiated. Subjects respond in various ways, including direct rejection and attack on the value and legitimacy of the health workers' attentions. Other forms of resistance include; non-cooperation, silence, escape, avoidance and, most commonly of all, concealment (Lupton 1997:104). This was what a woman beneficiary at one of the organizations said:

We have been asked about our personal lives all the time. When we had sex last time and what type of method we used to protect ourselves from HIV infection. It is so intimidating to answer such questions so I refuse to tell them the truth. I know that some of the women in our group don't tell the truth but make up stories not to offend our teachers (Informant 76).

As the quotation indicates sexuality grew to be the dominant theoretical lens through which issues of individual and collective behaviours were analysed. Bailey (1993) noted that the modern science of sexuality has increased the scope of power and pleasure through classification, enumeration, elaboration and specification. In the very process of what seems like constituting oneself as an individual, producing knowledge about oneself only makes one an object of discourse, an object of power/knowledge. Hence, population has become the target of statistical analysis and intervention measures (Foucault 1990:146).

In the case of HIV/AIDS, the efforts made to collect information about people's behaviours systematically deny to bodies and individuals the protection of privacy and secrecy. Code made analogies between this and 'an all-powerful God' who, as all-seeing, is able to know even the darkest secrets of a sinner's heart (Code 1991:143). During my fieldwork I found that not only beneficiaries of prevention programs but

those working on HIV/AIDS had criticisms regarding the people who came to them to 'look at' and sometimes to 'supervise' their works. While I went to interview people at the two organizations working on HIV/AIDS, I found that the staff of the organizations were fed up of researchers, non-government and government officials and others who would like to get information about their work. I asked a project coordinator at one of the NGOs about what these individuals needed. Her reply goes:

So many people come to us and look at what we are doing. What they want to know is almost similar. They ask us about what type of services we have been delivering and who are the beneficiaries of our programs. Sometimes these people destruct us, taking up a lot of our time. Researchers come to collect data but there is no way we could find out about the results of these studies (Informant 47).

According to the staff of the two organizations, the current strategy has been to focus on the whole population rather than specifically address 'risk groups'. The extension of HIV/AIDS risk discourse to the whole population signals an important shift in relation to sexuality. It implies that rather that constituting a hierarchy of sexualities defined and articulated in terms of categories of risk, techniques of governance in relation to HIV/AIDS may be disruptive of the 'at risk' and 'not at risk' binary via an extension of a micropolitics of self-surveillance to the whole population.

Some of the informants at Lideta said the government of Ethiopia and NGOs have shown keen interest in the issue of HIV/AIDS not out of genuine concern. One informant said work on HIV/AIDS has been considered as a 'hot cake' because those organizations implementing HIV/AIDS projects have been provided with a lot of funding. The focus of the government on policies and meetings, instead of dwelling on practical issues related to the epidemic was said to be a means of obtaining more aid from Western countries. As Dreyfus and Rabinow put it: "*The individual was of interest exactly insofar as she/he could contribute to the strength of the state. The lives, deaths, activities, work and joys of individuals were important to the extent that these everyday concerns became politically useful*" (1986: 139).

Some of my informants told me that the government of Ethiopia seemed to exaggerate the problem of AIDS because of its interest to divert the attention of the population from other social and political issues. Similarly a Zairian actor claimed that "*taxi drivers in Kinshasa say that AIDS comes from Mobutu's (Zairian President). He has thought it up so that all the men will not spend their money on prostitutes.*" In the mid -1980s, there was a joke in Kinshasa that SIDA – the French acronym for AIDS – stood for *Syndrome Imaginaire pour D'ecourager les Amoureaux/* Imaginary Syndrome to Discourage Lovers (Setel 1999:239 -240). Similarly, some of my informants said the high statistical figures about the prevalence of HIV/AIDS should be looked with suspicion.

This time around we hear shocking news about AIDS on the media. The number of HIV infected people is so high that it seems exaggerated. We commonly hear that the AIDS prevalence will be this or that percentage in the year 2010 or so. In ten years time the number of infected people would triple. Although this kind of stories might help to realize the magnitude of the problem of AIDS, they do more harm than good because they create a sense of fear and hopelessness. It seems that the government wants to scare its people (Informant 36).

The quotation indicates that statistical figures on AIDS prevalence are looked with suspicion. According to one peer educator, '*fear has a tendency of creating a sense of denial'*. I noticed that there were also some doubts about the accuracy of the methods used to measure the prevalence of the epidemic since most of the statistical figures are based on estimates but not accurate data. Estimating the prevalence of the epidemic in ten years time based on present data does not take into account the efforts to reduce the prevalence in the years in between.

Earlier on, I tried to make a point that the government of Ethiopia creates new possibilities for intervention into private lives of the people in which issues of individual sexual and reproductive conduct interconnect with issues of national policy

and power. Here I have to emphasize that I am not trying to identify the government as a guilty party that repressed the population intentionally. But I am simply showing the tactics employed in order to administer sex, bodies and life. Foucault maintains that the traditional dualistic understanding of power is insufficient. According to him, the polarisation of the oppressor and the oppressed, the sovereign and the subjects are categories which fail to untangle the manifestations and potentials of power (Referred in Mills 2004:49).

Relations with the West

The issue of HIV/AIDS in Ethiopia related to power relations between the West and Africa. A number of my informants criticized the West for imposing on the way HIV/AIDS prevention programs were undertaken in Ethiopia. Patton claims that western science today is slowly consolidating around a particular construction of 'Africa AIDS'. According to him, one important part of this construction is the idea that Africa and Africans are already lost to the pandemic (Referred in Jungar and Oinas 2004:98). The *'othering'* process is frequently evident in the international community's attitude to the problems of less affluent countries. As Campbell notes:

> The multinationals seldom have any intentions of conceptualising themselves as part of their host communities. They often seem eager to fund or manage whatever change is deemed necessary among the locals 'out there', but less willing to engage in debate about how their own ideas or practices might serve to promote or undermine the strength of these communities and impact on local people's lives and well-being (Campbell 2003:193).

Some of my informants aired their concerns about the types of prevention activities which were said to be 'westernized'. They mentioned that information, education and communication activities were copies from the West. Just because AIDS is a

global phenomenon, strategies of containment which have worked in one place may not work everywhere in the same way. This was what a young man at Lideta said:

I can say that most of the education activities on HIV/AIDS are copies of what has been done in other countries. They are not conducted based on Ethiopian history and culture. As you know, every country has its own peculiarity and that peculiarity has to be taken into account. Look at the brochures on HIV/AIDS. They present abstract medical concepts that are too difficult for ordinary people to grasp (Informant 3).

The quotation presents an opposing view to Western influence on HIV/AIDS programs. Mills (2003) gives a historical background to the Western influence on developing countries asserting that Westerners in the colonial period imposed systems of classification on the colonized countries which they proposed as global objective systems of knowledge. She asserts that these classifications were, in fact, formulated from a Western perspective with Western interests at their core. Furthermore, Mills criticizes the ways in which Western humanism has privileged the experience of the Western masculine elite as it proclaims universals about freedom, truth, and human nature (Mills 2003).

Similarly, there has been an argument that the scientific inquiry and pursuit of AIDS across the African continent represented a new form of hegemony extended over Africans under the rubric of international health (Setel 1999:240-241). Altman noted that globalization urgently requires the creation of effective mechanisms for international governance in areas other than those traditionally viewed as global security or economic concerns. He said health could be mentioned as one of these areas (2003).

Some of my informants at Lideta told me about the rumour that condoms coming from the West were impregnated with HIV virus. Only two of these informants mentioned that the suspicion might be true. Similarly, in the former Zaire,

nationalist sentiment linked contraception and condom use to Western population control strategies, which were viewed as a form of imperialism. Setel (1999:240) asserts that all of these 'conspiracy theories' –of some of the world's poorest people have been dismissed as scurrilous rumour in the West. Yet these 'rhetorical defenses' have *"an eerie ring of truth about them when viewed in the specific contexts of histories of the effects of Western power relations upon Africans and their bodies"* (Setel 1999:240).

The use of condom was criticized by a number of my informants not only for traditional and religious reasons but because it was believed to be unsafe to use it. Some of the respondents said they strongly believed that all condoms in the market were of such a poor quality that they break easily. Moreover, they explained that condoms coming to poor countries like Ethiopia are not produced with care and hence they are unsafe to use. Some of the respondents criticized wealthier European countries and the USA for not giving sufficient emphasis for the quality of condoms sent to the developing world. An informant at Lideta said:

I think that AIDS is what the Europeans fabricated in one of the laboratories to send it to Africa to wipe us out of the earth so that they could use our resources as much as they want. The condoms they send us, I believe are also ways of HIV transmission not ways of controlling the spread of the virus. The fact that AIDS is spreading at an alarming rate regardless of all the efforts to control it is an indication that there is something with the condom itself (Informant).

This and similar comments can be considered as a reaction to the HIV/AIDS discourse which pinned down AIDS on Africa, stating that Africa is the source of the AIDS virus. As it was known, in the first few years of the epidemic, AIDS was thought to have started in Africa, understood as a tropical disease. There was a claim that HIV or a related virus might have originated from Central Africa. The notion of AIDS as an African threat serves as a focus of ideology in much the same way as the idea of AIDS as a 'gay plague'. In both cases AIDS serves as a metaphor

through which more general fears are transmitted, and which displaces and condenses underlying tensions (Wallman and Sachs 1988:45).

As it was said earlier, the construction of AIDS as the problem of 'the other' could be looked at as a resistance to the discourse which associates AIDS epidemic to Africa. Africans' resistance could have been expressed in considering the Western sexual culture as polluting and a cause for the spread of HIV/AIDS. Susan Sontag (2000) tells us that in Zaire and other countries in Central Africa the counteraction has begun and many academicians, doctors and other educated people believed that the virus was sent to Africa from the United States as an act of bacteriological warfare aimed to decrease the African birth rate. In similar vein, a few of my informants at Lideta said they believed that AIDS came from the West.

As I stressed repeatedly, where there are imbalances of power relations between groups of people or between institutions/states, there will be a production of knowledge. Discourses should not be seen as wholly cohesive, since they always contain within them conflicting sets of statements. In this case, the discourse of HIV/AIDS cannot be seen as a simple unitary whole. The controversy around the source of HIV/AIDS is supported by this point since the accused turned the table by citing the prejudice of the accuser, and producing conflicting sets of statements on the issue. It also indicates a tendency to extend the contagion metaphor from the AIDS virus to stigmatised groups or 'deviant' lifestyles which are constituted as a threat to keeping tradition.

It was mentioned earlier that some of my informants were criticizing the West for dictating the HIV/AIDS prevention programs in Ethiopia. Some of the activities of the NGOs were blamed for not having continuity. Informants said programs were mostly organized in relation to the World AIDS Day or other specific occasions. They added that one method of awareness creation was used only for sometime and would be substituted by another one. According to them, NGOs organize their programs to

impress the Western donor community, irrespective of the interests of the beneficiaries. One of my informants had the following criticism:

It is quite common to see a big amount of money spent on activities like bazaars and exhibitions but most people are not interested to attend such programs. The work on HIV/AIDS requires a lot of commitment, but nowadays people choose to work on the epidemic because it pays well. Donors spend a lot of money on AIDS, money which is mostly spent on salaries and conferences instead of helping the victims of the epidemic (Informant 37).

The major limitation of programs created under the influence of the West was said to be a failure to give due consideration to the differences between beneficiaries. A number of informants criticized IEC materials like flyers for addressing the whole population instead of having a certain target group. For instance some informants criticized schools that distributed IEC materials that promote condom use. These informants strongly argued that priority should have been given to abstinence. A project coordinator said:

With regards to targeting different groups, we need to identify the needs of our audience first. Our programs need to take into consideration the demand of the audience. For instance we don't talk about abstinence to sex-workers. We need to identify the social strata, IEC for whom? Why? What we distribute as IEC materials in high schools, factories and also other places are similar. Women need specific IEC materials which are concerned with their gender specific relations to the epidemic. Men too need such materials (Informant 48).

The points mentioned in the quotation support my earlier argument that imparting knowledge about how to avoid health risks needs to go hand in hand with creating contexts where people are most likely to put that knowledge into action. Furthermore, the criticism on HIV/AIDS prevention strategies indicates that individuals negotiate with structures rather than simply submitting to them.

Disciplinary structures do not simply demarcate certain types of knowledge as belonging to particular domains, but also lead to the construction of distinct methodologies for analysis (Mills 2004: 62). In the following section I will specifically look at how the methods of science in general and that of the disciplines of medicine and psychology in particular played a major role in constructing subject positions in the HIV/AIDS discourse in Addis Ababa. For this purpose, I have selected two major practices namely counseling and testing.

HIV/AIDS Voluntarily Counselling and Testing as Practices of Surveillance

Two of the major activities on HIV/AIDS in Addis Ababa are testing and counseling. The following paragraph taken from an interview with a social worker sums up what social workers and counsellors at the two organizations told me about the reasons behind the provision of HIV/AIDS counselling and testing services to the public:

If you think you have been at risk or you just want to know your status for certain, you could obtain a free VCT, Voluntary Counseling and Testing, service today at many VCT centres in Ethiopia. A blood test is the only method to detect HIV infection. But, HIV usually cannot be detected in the blood through the test for three months after the infection takes place. This means that if you are worried about something that happened a few days ago it will be three months before a test will give a definite result. At a VCT centre, all counseling and testing are handled in private and with complete confidentiality. A counselor will explain to you how the test is done and how the result will be given. You will have an opportunity to discuss why you think you are at risk, what result you might expect and how you might cope. Then a doctor or nurse will take a small sample of blood to test for HIV antibodies. Then you will receive the test result and post counseling (Informant 50).

Although counseling and testing are considered highly important in the fight against HIV/AIDS, a number of my informants did not seem to be enthusiastic to use the services. This could be mentioned as one of the contradictions surrounding the epidemic since HIV/AIDS prevention education programs emphatically inform the public that such services are useful in the fight against the epidemic. Related to this, the number of individuals in Ethiopia who came out and told the public about their HIV positive status were said to be very limited. Contrary to this, it is said that in other African countries more and more individuals living with the AIDS virus had been involved in prevention programs (Setel 1999). In order to have a better understanding of these contradictions, I will try to look at how testing and counseling services have been taken up and negotiated by my informants.

Testing

As it is known, HIV is the virus associated with AIDS. On exposure to HIV, the body reacts by producing an antibody. This antibody can be detected in a test. One cannot deny the importance of HIV testing because it helps one to know his/her health status. At a national level too, it is obvious that a country needs to have information about the number of HIV infected people in the whole population.

In our program we encourage people to use voluntary testing services. Unless they have mandatory reasons, people are reluctant to find out about their seropositive status. I had tried to talk to some of our beneficiaries about why they were not willing to find out about their status and they replied that they didn't want to be labeled as 'infected' if they have the virus (Informant 49).

The quotation indicates that HIV antibody testing involves as it does procedures of risk assessment and risk identification. I would argue that discourses of health, risk and diagnostic testing are highly interrelated and HIV antibody testing has to be understood as a technology of surveillance medicine that is a technology which serves to make risk management the responsibility of individuals. Testing induces the

internalisation of new norms and the management of one's sexual practices and health, in the interest of minimising illness and HIV transmission. In relation to the power of surveillance medicine Foucault asserts: "T*his form of power cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it*" (Cited in Nettleton 1997:212).

As stated earlier, testing is said to be a voluntary practice where people come to testing centres to find out about their seropositive status. Most of my informants at *Lideta* stressed the importance of HIV testing since it would help the tested individual to know his/her health status so that he/she could take appropriate measures based on the test results. This indicates that a defining feature of the techniques of surveillance medicine is the way they deploy a logic of giving responsibility for surveillance to patients themselves. It is exercised not primarily through direct coercion or violence (although it must be emphasized that these strategies are still used from time to time), but rather through persuading its subjects that certain ways of behaving and thinking are appropriate for them (Lupton 1997:99). Some informants mentioned the importance of testing but when asked if they could be willing to take the test, quite a number of them said they preferred not to find out about their status. Some of them said unless forced, they wouldn't want to be tested. A young man said:

I know that testing is important in preventing the spread of HIV/AIDS. This is because, it is only by testing that we know our status. Testing is important because it helps one to avoid risk if he is not infected. And if the person is infected, he will take care of himself and protect others from infection. But if you personally ask me whether I will be willing to take a test, to be honest with you, I don't want to take a test and know my status (Informant 30).

In Ethiopia hiding secrets especially information related to one's personal problems is considered quite important. '*Gebena Medebek/* keeping private matters secret' is a highly used phrase in the Amharic language discourse. The various proverbs, children

stories and jokes on keeping secrets also indicate how much the society values secrecy. An example of a widely used proverb is *'Kaf Keweta Afaf'*, meaning if you tell something to someone, then the information will definitely reach everyone'. The notion of keeping ones personal problems to oneself may have its own influence on HIV/AIDS prevention endeavours in Ethiopia. The following woman was asked about what she would have felt about exposing her status if she were HIV positive. She said: "*I would rather die than tell the public that I am HIV/AIDS positive. Why do I tell that? To make my enemies happy and my friends sad?*"(Informant 13).

Like this woman, a number of my informants told me that they did not want to be identified as 'infected' if the HIV test result would turn out to be positive. Lupton has argued that since the logic of testing involve the identification of those defined to be 'at risk', that is, of those positioned as having a potential to develop a certain condition or disease; it involves self-identification in relation to risk categories (Referred in Adkins 2002:110). As stated earlier, the central strategies of disciplinary power are observation, examination, measurement and the comparison of individual against an established norm, bringing them into a field of visibility. But the woman in the above quotation resisted to be visible.

During the interviews some of my informants tried to explain to me that being identified as having HIV is quite different from having other life-threatening problems. Two of my informants described a death caused by AIDS as *'Yemot Mot/* the death of all deaths'. One even compared it to cancer and said '*dying of cancer is much better than dying of AIDS*'. Her reason for preferring cancer over AIDS was the following:

If one dies of cancer, people would feel sorry for him because that is something of God's making. But if someone dies of AIDS, it is considered as a death that one brought to himself as a result of his sexual immorality. A person with the AIDS virus lives with a sense of shame knowing that people would think that he has done

something bad. I think living with this feeling of shame is more painful than having the virus (Informant 26).

This quotation indicates that it is not only self-assessment and self-identification in relation to risk categories which are at work in the techniques associated with HIV testing but subjects are classified and socially ordered through a securing of a confession as to the 'truth' of their sexuality. Waldby describes the bio-administrative techniques involved in testing, including counseling, the taking of a blood sample, biochemical analysis of the sample, the reporting of results, and, if the test is positive, a confessional test for what she terms a transmission identity. According to Waldby, each seropositive subject is asked to review sexual practices and to provide a history of their sexuality so that they can be positioned in the classificatory schemas of AIDS epidemiology as a transmission type (Referred in Adkins 2002:110).

AIDS appears in metaphors, metaphors of invasion, which Susan Sontag (2000) describes as the military metaphor. AIDS patients are considered as victims of the HIV invasion. Sontag discusses the moral baggage attached to being HIV-positive. According to her, the sexual transmission of the illness has been considered by most people as a calamity one brings on oneself since AIDS is understood as a disease of perversity. She says that to get AIDS is precisely to be revealed. AIDS elicits so much guilt and shame. According to her (2000), the metaphors of AIDS cannot be distanced just by abstaining from them but they have to be exposed and criticized.

During my fieldwork, I was able to attend programs in which people living with the HIV virus were invited to deliver speeches. I had a chance to observe how being a member of the 'infected group' made individuals feel like leading a life full of guilt and shame. During one of the education programs I attended, a woman who was living with the AIDS virus said, "*I decided to come out and teach the public because I want to save lives. Wherever I go, I say 'Inen Yayeh Teketa* /a commonly used Amharic proverb with the meaning 'Learn from my mistake". Although educating the

public using individuals living with the virus seemed a workable strategy, the way these individuals have been presented needs to be criticized.

If testing points to the potential of a future condition or disease, such knowledge will lead to appropriate forms of self-disciplining of behaviour to ensure potential conditions or diseases are not passed on to others. This shows how power is a relationship which is dispersed and which operates at different levels through sets of specific practices. "*Power is rather like a colour dye diffused through the entire social structure and is embedded in daily practices*" (Turner 1997: xii).

I don't want to be tested because I don't want to know if I have AIDS. If I have AIDS, my family would feel ashamed of me. Neighbours would look at the whole family differently. 'Metekwakomia mehon alfeligim/ I don't want people to point fingers at me' (Informant 4).

As the quotation indicates, sex has become a target for intervention into family life. As it was said, the discourses and practices of medical experts create the divisions healthy/ill, and normal/perverse. Waldby asserts that "*HIV testing is best understood as a technology through which the virus is personified, as diagnosing a type of person who is seropositive, a type of person who is often defined in terms of categories of sexual identity*" (Referred to in Adkins 2002:111).

Some informants told me that HIV/AIDS test results may not always be reliable. These informants' scepticism towards HIV testing may be related to the reliability of testing itself. I was told stories of individuals who got different test results. There was an informant who said: "*Who would trust our laboratories with poor facilities which don't detect even the causes of simple diseases?*" Some mentioned incidents when people with the virus got negative test results and vice versa. The HIV test has limitations in that it can take up to 12 weeks for the body to produce sufficient antibody to record a positive test. In this interim (or window) period, an individual may test negative, yet still be infected and able to transmit the virus to others. Until

the test is improved upon it has specific limitations: it cannot tell the source of infection, how long one has been infected, or whether one will go on to develop AIDS. With regards to the uncertainty of a scientific truth Kendall and Wickham (1999:112) argue that *"Basically when one is close to a scientific experiment, one can see the fallibility, the manipulation, the skill - in short, the social negotiation of the experiment".*

Individuals' scepticism regarding the reliability of HIV tests has been exhibited in different ways. According to a study in Africa, 53 percent of women who were said to have received counselling and testing did not return for their results. It may well be that such women have little understanding or power to refuse to be tested, but they can make their personal decision by avoiding test results (Sherr 1993:47). As many women attend antenatal clinics anyway, and provide blood samples for other tests, it is easy to include them in seroprevalence studies. The Ethiopian Annual reports of HIV/AIDS have results of such studies. This shows that ethical procedures and the rights of women need much greater examination in this grey area of practice.

I was told by my informants that most people in Ethiopia decide to take HIV testing mainly for mandatory reasons like immigration requirements. It was mentioned during the interviews that a large number of poor women who plan to go to Arab countries for work take HIV test as a requirement for a visa. This is because true choice may be elusive, and there may be elements of coercion or subtle persuasion which affect whether women proceed to HIV testing. A young woman said: *"I will never be willing to take HIV test unless I am forced to do so"* (Informant 31).

Resistance to testing could be considered as a way of challenging the process of identification associated with AIDS. Two of my informants told me about a group of HIV positive individuals who tried to spread the AIDS virus in a form of a campaign. The name of the group is said to be '*Shamo*' (an act of throwing something on the air so as to be caught). My informants explained to me that '*Shamo'* implies that this

group of HIV infected people spread the AIDS virus to HIV negative people as a form of revenge for being stigmatized and discriminated. I would say that members of the *'Shamo'* group may practice unprotected sex as a way of resisting governmentalization, especially the tyranny of identification.

Counseling

In our culture we don't normally talk about sex and matters related to it. In a very secretive society like ours it is unlikely that people talk about their sexual lives with a total stranger. We confess our sins to priests not to anyone else (Informant 32).

This quotation indicates that the socio-cultural context is important in designing prevention programs. John McLeod has recently reminded us that "*almost all counselling and psychotherapy research has been carried out from the discipline of psychology*" (Cited in Silverman 2000:93). One consequence has been a focus on quantitative studies concerned with the attributes of individuals. This has meant that linguistic and sociological issues, such as social context and language use, have been downplayed (Silverman 2000:93). According to a counsellor, seeking counselling services is not common in Ethiopia.

Most of our beneficiaries are not willing to attend counseling programs because of the deep-rooted misconception that those in need of psychological treatment are the mentally disturbed and the insane. It has been a challenging task for me to convince our beneficiaries that counseling services are for anyone. We also tell them that mental illness is like any other illness and it is very wrong to consider it as shameful (Informant 46).

Foucault argues that confession is an important communication strategy that has been used to circulate knowledge about individual bodies. According to him, people are supposed to reveal their sins to their parents, to the priest, to the doctor and to the

teacher (Referred in Gastaldo 1997: 113). Foucault's point could be related to the Ethiopian context. In Ethiopia, the fact that counseling services were not highly sought for may be because in the Ethiopian tradition confession is related to the religious ritual of telling ones sins to a priest, a religious practice called '*Nuzaze*/confession'. According to my informants, sexual matters are one of the frequently raised issues during confessions at the Ethiopian Orthodox church. At confession, the believer brings his/her stories of sexual activity which he/she considers as a sin. This could be like extra-marital affair which he/she tells to his/her priest, *'yenefs Abbat/* Confessor Father' in secret. The priest then orders the 'sinner' to perform a religious practice called '*Sigdet'* (an act of bowing). The issue of confession will be further discussed in chapter eight.

As noted earlier, confessing ones HIV status is related to moral standards as being sexually active is equated with being promiscuous. It may not be surprising if people do not visit counseling offices as expected, when telling sexual secrets could be easily related to the religious confession of sexual sins. During a panel discussion on Ethiopian Television, a priest of the Ethiopian Tewahido Orthodox Church revealed a result of a study which shows that people were afraid to be associated with AIDS:

In Addis Ababa, there are more than 60 burial places in our churches. In these places, on average 9-10 people are being buried daily. It is easy to suspect that a number of these deaths are cause by AIDS. We dispatched questionnaires to find out about what families of the deceased would say about the causes of the deaths of their loved ones. We were very surprised to find out that not a single family wrote on the questionnaire that the cause of the death was HIV/AIDS (28 March 2004).

The quotation indicates that there is a strong silence surrounding the AIDS epidemic and people have still been afraid to open up even to the Church. The families of those who died of AIDS often preferred to hide the nature of their problem and collude in denial. Most of them emphasized that it is so difficult for people with the virus to expose their status mainly due to stigma and discrimination. They gave me specific

examples of individuals who suffered because they were badly treated for having the virus. The discrimination goes as far as mothers throwing their children out of their house. My informants told me stories of people living with the AIDS virus who were beaten and starved to death. One informant told me a story of an HIV positive man who owned a butchery. The man was severely beaten by a group of men for selling meat to the community. This man was forced to close his shop. Given the stigma and terror that surrounds the disease in the public, we may say people living with the virus live in fear of rejection and they are often reluctant to seek out services like counseling.

As it was said elsewhere, HIV/AIDS has turned out to be one of the most meaning-laden of diseases in the world. According to the beneficiaries of one of the NGOS, some women were not willing to come to the organization for support. This was because some associated the office of the organization with AIDS. Informants told me that the drop-in-centre for commercial sex workers was called '*The AIDS house*'. The women said they were all suspected to have the virus. Visiting the drop-in-centre made these women visible to, and inserted them into technologies of socio-medical surveillance. Hence, stigma can be seen as a consequence of labeling processes.

Informants noted that people tend to avoid the subject of HIV/AIDS as much as they can mainly due to fear. A fear aroused by the HIV/AIDS epidemic is more than simply a concern about a new and possibly incurable disease; it also underlines our uncertainty about contemporary moral stances (Weeks 1995). It was the opinion of a number of informants that some HIV/AIDS prevention information has been presented in ways that pushed the public away from activities on the epidemic. From the IEC materials I collected I found that some of the messages on HIV/AIDS focused on fear contributing to stigma rather than behaviour change. Moreover, the messages do not express hope for controlling the spread of the virus. The following sentence from a flyer could be taken as good example showing how some of the information delivered could create fear among the audience:

Although there are life-prolonging drugs, they are expensive and they require thorough medical follow-up. Anyone with AIDS dies.

Even though the sentence holds a fact, a fact that AIDS is a killer disease; the message could have been presented in a subtle manner. The writer did not seem to be cautious of the wordings of the sentence. According to the assessment made on IEC materials, most of them used general statements instead of providing specific examples to educate the public, mystifying the epidemic instead, and creating fear. The following sentences on discrimination could be examples of such statements:

There must be some efforts to fight discrimination against people living with the AIDS virus.

Measures must be taken to avoid any form of discrimination against people living with the AIDS virus.

Information dissemination activities must be strengthened to fight discrimination against people living with the AIDS virus.

Different programs need to be designed to fight against discrimination.

As it could be clearly noted, there was no attempt to describe what the above statements try to say. To take the first statement as an example, there was no mention of the kinds of efforts needed to fight discrimination against people living with the AIDS virus. In the next example, there was no attempt to clarify the kinds of measures that were needed to be taken to avoid stigma and discrimination.

My young informants told me that a person who died of AIDS is mentioned as winning a DV lottery, a lottery which provides a chance for the winners to live permanently in the USA. Since winning a DV lottery has been considered by many as a good chance, relating the lottery with the AIDS death could be looked at as a way of

mocking at the epidemic. The mockery may be seen as a way of criticizing the common frightening messages of HIV/AIDS and the strong metaphors surrounding the epidemic. Individuals may use the defenses of denial or fatalism in the face of overwhelmingly frightening threats, of the kind represented by HIV/AIDS. Such defenses may be particularly common among people who are persistently facing difficult life situations over which they have little control.

In the above discussion I attempted to show how counselling and testing are strategies in which efforts are made to control the population. I also tried to indicate that these strategies did not take into account the socio-cultural contexts within which the HIV/AIDS prevention programs were undertaken. In the following section we will look at more HIV/AIDS prevention activities.

4.3.2. Participatory HIV/AIDS Prevention Activities and Power Relations

The scientific HIV/AIDS prevention programs in Addis Ababa try to involve beneficiaries of activities using participatory approaches. This goes with the general current trend in health education that shifts from the traditional approach to participation in health activities. The trend is based on the ideal that health education should be participatory but not descriptive (Gastaldo 1997:119). In relation to HIV/AIDS, there has been a widespread agreement that a major step in addressing the HIV epidemic is to engage local people so that they 'take ownership' of the problem by engaging in collective action. *"The focus in participation of clients goes hand in hand with the conceptual shift away from understanding 'sexual behaviour' as the product of individual decisions, in favour of the concept of 'sexuality' as a socially negotiated phenomenon"* (Campbell 2003:3).

At both the organizations selected for the study, the participation of beneficiaries was very much emphasized. According to members of these organizations, beneficiaries have been involved in identifying their problems. The importance of beneficiaries' involvement in finding solutions to their problems was highly

emphasized during interviews. This was what a social worker at one of the NGOs said:

We give a lot of emphasis to beneficiaries' participation in all of our activities. Beneficiaries are given the chance to air their views without inhibition. Their participation makes them feel that they are part of the process of HIV Prevention (Informant 50).

Awareness creation could be mentioned as one of the major activities of the HIV/AIDS prevention programs in general and the two organizations selected for this study in particular. Different activities were undertaken by the organizations aimed at raising the awareness of beneficiaries regarding the transmission and prevention of the AIDS virus. The four major communication channels used for awareness creation were drama, peer education, coffee ceremonies, and lectures and discussions. The main purpose of discussing these four activities below is to show how the beneficiaries of the two NGOs negotiated with the information provided to them through these activities. As it was stated at the beginning of this chapter, my main focus will be to look at power relations.

Drama

HIV/AIDS prevention programs in Addis Ababa have used drama as one of the approaches in communicating information to the public. MSF-Belgium had a drama program for patients at Wereda Health Centres in Addis Ababa. The drama was usually prepared by five to four women in each Wereda. The actresses rehearsed the drama at least for three weeks using the scripts provided by the organization. Members of the organization checked the work of the actresses during rehearsal. The drama program at the health centres was staged for half an hour in the morning mostly from 8:00 a.m. to 8:30 a.m. when patients wait for their treatment. Addressing patients at health centres was very important because it gave a good opportunity to meet an audience that might not get a chance to attend a drama

program elsewhere. I observed that most of the attendants of the drama program at the health centres were poor women, most of which were housewives.

An example of the dramas was the one staged at Yeka Woreda Health Center with the title '*Zemenegnoch*/ The New Generation'. The drama was presented mainly in a form of dialogue between three friends. Two of the characters described drinking and having multiple sexual relations as enjoyable. The third character advises the two to keep themselves away from the risk of HIV infection. The humorous dialogue about sexual relations in the drama as well as the costume of the characters seemed interesting for the audience. What made the drama activity participatory was the discussion afterwards. A health officer from the health centre came to the stage and asked attendants about their impressions regarding the drama. The theme of the drama was also discussed by the attendants. According to the interview with some of the attendants, the drama was good because it presented an interesting story. Others said they enjoyed the drama because the characters were unforgettable. For some the fact that the performance was short was a reason to like the drama.

According to my observation at the health centres, drama was found to be a very much-liked means of sensitising the audience about HIV/AIDS since it combines education and entertainment. Members of the NGO and the health centres noted that drama is a good means to address the issue of HIV/AIDS because it could present serious issues in a light manner. The coordinator of the drama program mentioned the following as the reasons why drama is the most preferred method of creating awareness about AIDS:

As it is well known, the issue of HIV/AIDS is a very depressing issue since it affected the lives of people in many ways. The story of AIDS is a story of death and suffering. Women suffer most. HIV/AIDS is about sexuality which is a private and sensitive issue considered as taboo because of the deep-rooted sexual norms in the society. It is wise to present a very bitter truth in an easy manner. This way the issue will be

more understood by the wide public. It is especially the best way to reach the youth (Informant 49).

Although the dramas ware very much liked by the audiences, my observations proved that their preparations have some difficulties. From the assessment on the scripts of some dramas, the emphasis was on the content. It seemed that no serious thought was given to the plausibility and the characterization of the drama. A good example was that the role of a man was played by a woman in some places. I am critical towards this presentation because it indicates that gender differences were not seriously taken into account by the NGO. According to the interviews with the actors of the drama, some men ridiculed female actors for taking the role of men. I had a chance to talk to the person who was involved with the follow up of the above drama at the NGO and this person's response was, "*We mostly focus on the message not on the technical aspect. We leave this to the players of the drama"* (Informant 49).

Some of the dramas at the health centres were found to stigmatize individuals and groups. For example, there were dramas that tried to reinforce negative stereotypes against women by portraying them as passive, naïve and as having low self-esteem. It is known that commercial sex workers are vulnerable to HIV/AIDS mostly due to the pressure from their clients. In a drama with the title '*Tesfa*/Hope' however, a woman was depicted as willing to have sex without condom thinking that a wealthy client of hers couldn't have the AIDS virus because he was rich. This same character says that there is no AIDS after 10 p.m., a phrase known to be used by clients to convince commercial sex workers not to use condoms.

In some of the dramas, persons living with the virus were portrayed as hopeless. The script writers of the dramas seemed to focus on teaching the audience from the 'mistakes' of those characters who lost their lives due to HIV/AIDS. Most of the HIV positive characters in the dramas were portrayed as promiscuous and reckless. The ending of some of the dramas depicted confessions from the AIDS patients telling that others should not repeat their 'mistakes'. Such dramas may create fear and may

have an effect of creating stigma against people living with the virus. I believe that decisions must be made on the objectives of the drama, what to portray so that the drama should not reinforce negative stereotypes, attitudes and ideas.

It was mentioned earlier that health professionals invited the attendants to discuss about the dramas. After the discussions with the professionals ended, the patients sometimes had lively discussions about the dramas. There were a number of occasions when attendants criticized the depiction of some characters as implausible. Although most of the dramas are liked for their humour and ways of presentation, the stereotypical presentation of certain groups of the society was objected by some attenders.

Peer Education

Peer education has been one of the most common activities of HIV/AIDS prevention education programs in Addis Ababa. According to members of the organizations, peer education is based on the assumption that people are most likely to change their behaviour through collective action. Hence, peer education acknowledges that sexuality is constrained by collectively negotiated peer identities, rather than simply by individual-level information and behavioural skills.

According to the information from members of the organizations, community members play a key role in the selection of their peer educators. This is to ensure that peer educators are seen to be representatives of the groups that they serve and have the respect that will assist them in playing their leadership roles. At MSF-Belgium, peer educators were selected from commercial sex workers. The peer educators were given the task of encouraging other commercial sex workers to participate in their programs. I attended a training program where peer educators were given basic knowledge about sexual health and HIV/ADIS for two weeks. The major aim of the program was to provide basic information about sexual health risks. According to the

members of the organizations, participants liked peer education programs. This was what one peer educator said:

'Shimgilina' is a traditional practice where people (mostly the elderly) sit together and discuss issues to solve problems. In our peer education programs too, participants discuss the problem of HIV/AIDS and look for solutions to the epidemic (Informant 56).

At the peer education sessions that I attended at MSF-Belgium, mostly six women participated. Because of the fact that women participated in the peer education in small groups, they had more chance to have detailed discussions on health matters and other issues related to their lives. Peer educators who attended peer education trainings led the discussions. Most attendants participated actively in the discussion. For example in one of the peer education sessions organized for commercial sex workers, I observed that women shared their experiences freely on skills useful for negotiating safer sex.

Although most of the time women were allowed to have open discussions, there were times when their participations were inhibited by peer educators. An example is a peer education session organized for six commercial sex workers at MSF-Belgium. During the session, the peer educator read a training manual prepared by the organizations for more than 20 minutes without any break. The manual consisted of different chapters on HIV/AIDS. There were some portions of the lesson that needed clarification and the teaching manual did not have specific instructions to guide the peer educator. I observed that the peer educator made sure that the training manual was strictly followed and did not allow participants to present ideas that were different from what was written in the manual. The document did not refer to '*common-sense knowledge*' of the participants but mostly adhered to the medical knowledge about the epidemic. At this session, two of the women mentioned the role

of traditional medicine in preventing AIDS but the peer educator strongly stressed that the manual should be strictly followed.

I observed that participants at the particular peer education session were not passively taking everything but found to be sharply criticizing the peer educator and questioning the relevance of some of the information to their own lives. A good portion of the training manual was allocated to condom use but some of the women complained that they have good knowledge about condom use but the problem was *'their inability to use condoms with clients'*. This is because peer groups like commercial sex workers are often the most vulnerable to poor sexual health and they have the least power to challenge factors undermining their sexual health.

I work all night at a bar. As you know, our work doesn't allow us to sleep at night. Usually I come here in the morning without sleeping even for a few minutes. It takes me more than half-an-hour to walk to come here. This program takes a lot of my time. I had to take care of my children and do household chores during the daytime. Most of the time I think of my house while sitting here (Informant 79).

This quotation shows that shifting the level of analysis from the individual to the peer group level is often not enough because there are a number of interfering factors that prevent the program from being successful. Some participants told me that most of the time they did not have interest to attend the peer education sessions because they had other more important things to do. Some highly criticized their peer educator for lack of teaching skills. It was easily noticeable that in some groups the relationship between the peer educators and the participants were not smooth. A peer educator pointed out that some of the participants in her group were *'jealous because she gets money and they don't'*. On the other hand, an informant said: "*the peer educator is only here for the 80 Birr monthly payment but she has no interest to do the job. There are more qualified individuals in the group than her. She just reads the book and doesn't allow us to have enough discussion*". During this specific peer education

session, the beneficiaries' loss of interest was easily noticeable. I observed that some participants looked out through the window while the manual was read.

It may be said that the participants of the peer education programs did not do much but just complained in the absence of the staff of NGO. I argue that the women should not be taken as passive recipients of everything since they objected the work of the NGO in a certain way. They expressed their dissatisfaction with the program by showing disinterest in the information and by criticizing the peer educator in her absence.

Another example about the dominant role played by peer educators is the discussion on abortion and HIV/AIDS. This discussion took place in a high school anti-AIDS club, a club supported by one of the NGOs in this study. At the session, the peer educator strongly argued that a girl should not be allowed to have an abortion in order to avoid HIV infection due to the use of contaminated instruments during abortion. The peer educator insisted that abortion should not be allowed even if a woman is not willing to give birth to a child. Despite a strong criticism from the rest of the students, the peer educator went on to justify his one-sided argument. Although he gave a chance to others to air their views, he asserted at the end that his point was the 'right' one. This is an example that whilst a volunteer-led organization is undoubtedly more democratic than a professional-led one, the volunteers themselves might not present themselves from a wide range of sources, but from a narrow, already aware sector that potentially had little or no contact with other men and women who might identify HIV as an issue of their lives. As I said earlier, during observations it was common to come across peer educators who forced their views on others.

Coffee Ceremony

The coffee ceremony is said to be the most liked activity by women beneficiaries at NGOs. According to the social workers organizing the program at one of the NGOs,

there was always big attendance during coffee ceremonies. They said that women who were reluctant to attend other activities were eager to come to the coffee ceremony. Moreover, women who were also not actively participating during other activities were much more involved in this one. At the coffee ceremonies, I observed that women were willing to discuss issues pertaining to their personal lives. Mostly the women tried to give advice to each other. In one of the coffee ceremonies, a heated discussion took place on women's sexual needs and some of the participants were open enough to site their own sexual experience. As it is known, the coffee ceremony is a common ceremony in Ethiopia attended almost at every household. Most of the women said they liked to discuss serious issues like the problem of HIV/AIDS while relaxing and drinking coffee.

I like the coffee ceremony more than any activity here because I like coffee and the ceremony. It gives me closeness to members of the group. It also puts me in a mood where I don't feel like attending an education program. This is because coffee ceremony is what we attend everyday at home (Informant 76).

The coffee ceremony is popular in Ethiopia because of its ceremonial context. Although it is believed to be an ancient tradition in Ethiopia; in its present form, it is a relatively new institution, and one which is still evolving. Some of the basic characteristics of the coffee ceremony derive simply from the method of making the drink. According to Pankhurst, in Ethiopia the coffee ceremony is on the ascendant (1997). Christians may perform the coffee ceremony every morning, sometimes after church. Moreover, coffee ceremony is performed at the arrival of a relative or guest and at important family occasions.

Seven women commercial sex workers were present at one of the coffee ceremonies that I attended. The group selected a woman among themselves to prepare the coffee while the rest of them sat close to each other. The woman washed a handful of raw coffee beans and roasted it on the tin (*Metad*), which was placed on the brazier. Then she strewed sweet-smelling grass on the floor. Next she brought in a black

earthenware narrow-necked pot (*Jebena)* for heating the water. Incense was lit creating a heavy mix of smells along with the roasted beans. Then a woman from the group volunteered to go outside and pound the coffee. The rest of the women started the discussion on condom use. What made the discussion interesting was the specific examples selected from their life experiences. Bread and popcorn were served as '*Yebuna Kurs* /coffee snack'. All the while those present conversed quietly, dipping into the snacks.

The coffee was boiled in the *Jebena* and poured in small handle-less cups (*sini*). The cups were then distributed, first to the oldest in the group, and then to the younger women. In the Ethiopian coffee ceremony every guest must have *abol, huletegna* and *bereka* or *sostegna* (one, two, three) cups, the same coffee boiled three times. The first round is known as *awol* or *abol.* While the strong, sweetish coffee is being enjoyed, water was added to the pot and a further brew was prepared, known as *hulategna.* The server once again added water, and the last brew, called *bereka,* was prepared.

According to my informants, the coffee ceremony allows women to sit and talk about any issue. Although both men and women attend coffee ceremonies, women are known to be the ones who are more involved. The occasion gives women a time to momentarily abandon their long day's work to exchange useful information. In Ethiopia drinking coffee is traditionally a lengthy process, which provides women an opportunity to relax. For example, most of the coffee ceremonies I attended at the NGOs took more than an hour.

Realizing the potential of a relaxed, seated audience of women, NGOs have experimented with using the coffee ceremony for group discussions on HIV/AIDS. According to Pankhurst (1997), more than providing relaxation, the coffee ceremony offers conviviality without giving rise to drunkenness. The fact that teaching through coffee ceremonies was liked by the audience might be a good indication that people are more drawn to education delivered with the use of already existing means and

structures. Hence, coffee ceremonies might play a good role in creating the relaxed mood for discussing sensitive and serious issues of HIV/AIDS, gender and sexuality.

Lecture and Discussion Program

During my fieldwork I was able to attend some HIV/AIDS awareness activities presented in a lecture form followed by discussions. The main purpose of the discussion after the lecture was said to be sharing, with beneficiaries, information about HIV/AIDS. Mostly the focus of this activity was on raising the awareness of the audience about the means of HIV transmission and ways of preventing the spread of the virus. Furthermore, the social and economic impact of the epidemic on Ethiopia had been on the agenda of most of the discussions. An example of such a program was the one held at Adey Ababa Cotton Factory by ISAPSO.

It was a bright morning when approximately two hundred workers were summoned in the factory compound to attend the program. Most of the attendants sat on the ground while a few seats were reserved for the speakers, guests and the management of the factory. The first speaker was an expert from the Ministry of Health who took around thirty-five minutes to talk about the problem of HIV/AIDS and the ways of its transmission. I observed that most of the individuals at the gathering were not attentively listening to the speech made by the person. Some were chatting with each other while the person was speaking. There were also three women who were knitting and talking to each other. After the program I was able to ask one of these women; her response to the speech was that *'it was boring because it didn't have new information'*. As I tried to explain earlier, local codes and even silences could be signalling resistances. Hence, the women's lack of interest in what the expert was talking can be considered as a way of rejecting the information.

After the expert, the next speaker was Fanaye, a woman who lived with the virus. Different from the situation during the previous speech, the beneficiaries looked very attentive. After the program a woman said: '*Fanaye's speech was the best one since*

it showed that AIDS is real and near to us'. This may indicate that beneficiaries are more interested in real life issues than the medical information provided by experts. The stories of people living with the virus make the problem of HIV/AIDS not the problem of the '*other*' but of everyone's. As it was said earlier, people need tangible evidence and information about the virus and AIDS. As the following quotation shows, beneficiaries also needed to obtain information that specifically interests them.

I think it is good that all the factory workers have a chance to attend a program on HIV/AIDS since the epidemic is a serious problem affecting our lives. A number of workers of this factory have died and there are also many who are sick. But I don't think all factory workers should attend programs together. Today all the workers from the manager of the factory to janitors attended the program together and that is not good. I think AIDS programs need to be provided in groups (Informant 72).

This person emphasized that the organizers should have given more emphasis to the difference in the factory workers. According to the information I got from the factory, the workers have varying status, some being university graduates and others illiterates. The reason why some looked not very much interested with the lectures could be related to the difference in the audience. What I found out during my observation was that most of the time the information flow was one way; the factory workers being the recipients of the information while the experts were the providers. A group of experts did most of the talking while the audience sat and listened to them. Compared to the time allocated for the experts, the time provided to the audience at the end of the program was very little. The time allocation itself indicates that the 'experts' in positions of authority were seen to be the ones who could speak 'the truth'.

4.4. Conclusion

Drawing on data from my interviews with residents of Lideta and my observation of HIV/AIDS prevention activities, I have attempted to describe how the scientific HIV/AIDS discourse have contributed to the management of social and individual bodies by introducing new knowledge, surveillance and disciplinary techniques to everyday life. As the discussions showed, HIV/AIDS prevention education has been conceived as an asset within health care because it provides information and suggests alternatives to individuals, families or groups to prevent HIV/AIDS and promote health. My intention in this chapter was to challenge this assumption, providing a critique of health education in HIV/AIDS prevention. I have attempted to show that the social dimensions of AIDS epidemic were marginalized in the biomedical discourse and that the social construction of AIDS is a complicated matter. One of my main arguments is that the impact of AIDS education may be seriously limited by circumstances far beyond the control of educators or program implementers.

The different means of communication discussed in the last section showed that beneficiaries' participation was presented as a partnership between professionals and users. As the earlier discussion shows, lectures and drama allowed lesser participation of beneficiaries while there was higher level of participation at coffee ceremony and peer education activities. However, in most of the activities discussed above, the leaders of the process are the professionals. It was observed that the discussion topics were identified by the professionals, implementing planned actions among groups and individuals within the community. "*The concepts of participation and partnerships serve as articles of faith in development projects around the world. Yet understanding of the process whereby participation or partnerships might achieve their allegedly beneficial effects is still in its infancy*" (Cambell 2003:1).

This chapter has tried to show with examples that dominant biomedical HIV/AIDS discourse has been resisted by informants. Heaphy stresses that while people with HIV/AIDS are, in some senses, subject to dominant medico-moral and medico-scientific discourses on HIV and AIDS, they do draw on counter-discourses in making personal sense of the virus and syndrome, and do not accept dominant meanings uncritically (Referred in Adkins 2002 :112). Similarly, my informants tried to make personal sense of HIV/AIDS by explaining the epidemic in relation to their own religion and tradition. In the following chapter, the intersection between religion, tradition and HIV/AIDS will be discussed in detail.

Chapter Five - The Intersection between Religion, Tradition and HIV/AIDS

5.1. Introduction

In Addis Ababa, religion and tradition play a significant role in constituting the HIV/AIDS discourse. As it was discussed in the second chapter, Ethiopia is a highly religious and traditional society. Hence, religious and traditional institutions play a vital role in influencing the people's modes of life including their sexual behaviour. As it was said earlier, the HIV/AIDS discourse should be seen as both an overall term to refer to all statements regarding the epidemic, the rules whereby those statements are formed and the processes whereby those statements are circulated and other statements are excluded. As we have seen in the previous chapter, the dominant HIV/AIDS discourse in Ethiopia is the scientific discourse. It was also discussed in the same chapter that some informants questioned the scientific information about HIV/AIDS. These informants valued the scientific information on HIV/AIDS using other forms of knowledge which didn't have much place in the dominant scientific HIV/AIDS discourse. There are 'subjugated knowledges', that tend to be buried and disguised beneath more dominant, often more 'scientific' or 'expert knowledges' (Foucault 1984). As it could be seen in the following discussion, religion and tradition highly intersect with the HIV/AIDS discourse in Addis Ababa.

5.2. 'HIV/AIDS Could Be Prevented by Religious Means'

'*Issu Yametawin Issu Yimelisew*/God brought it and Let Him take it back', is a common expression most of the informants at Lideta used while we were discussing about the prevention of the epidemic. Due to this conviction of them, most of the informants did not take AIDS as a disease that its transmission could be controlled by a natural means. Their views about the virus, its ways of transmission and the ways of prevention are all explained in light of their religious beliefs. Molvaer (1980:58) also asserts this point when he said: "*in everyday life Ethiopians frequently mention religious concepts. It would be difficult to converse normally and politely without*

referring explicitly to God, the saints, or the Church, although this may be as much a cultural as a religious manifestation".

As I mentioned above, my respondents at Lideta gave religious explanations to the epidemic, despite some differences in their education and standard of living. Unlike those working at the two NGOs who described HIV/AIDS scientifically, most respondents at Lideta understood the epidemic as caused by divine power. *'Yih Yegzir Kitat New/*This is God's Punishment', was their answer. Similarly, Aspen(1994:337), describing the Ethiopian society, noted that "*the history of the state and the people, and the religious traditions that have existed at state and local levels, have all contributed to an immense cultural stock from which people choose elements by which they compose their ontological meals*". During my interviews, I happened to discuss various issues with my informants since my main intention was to look at issues surrounding the AIDS epidemic. Not only their understandings of HIV/AIDS but also most of my informants' views to most life issues were based on religious explanations looking at life through a religious lens. The following quotation best explains how most Ethiopians view the dependence of the created world on the creator, and hence relating every happening to God's will:

> The name of God is nowhere in such constant use as in the mouths of the Abyssinians. They imagine a special interference in every act of their lives, and in everything that occurs to themselves. A thief will piously praise God for having assisted him a dangerous robbery; a man will say, 'God threw my enemy in my way, and I slew him;' the death of a dog, the breaking of a bottle, a slip in the mud, are sufficiently important to be attributed to the immediate will of the Divinity (Cited in Messay 1972: 91).

The above quotation might seem an exaggeration but it is not. Even the Ethiopian view of the Almighty is radically different from the African conception. In Africa south of the Sahara there has been a common belief in a Supreme Being who ultimately controls human destinies, but the almighty is so remote that he plays little

part in daily cults or in the mythic imagination of the people. It is said that this conception of an aloof Supreme Being is radically alien to the Ethiopians. For the Ethiopian, "*God is omnipresent, controlling everything in slightest detail*" (Messay 1999:195). One informant said: "*The first words that come out of my mouth each morning are 'God follow me and protect me from any danger'. I know there is nothing I can do without His will*" (Informant 10).

I may explain this unity of the natural and the supernatural taking myself as an example. Being an Ethiopian and spending my whole life in the same country, it is obvious that I could not escape from the influence of the traditional religious values and conceptions of the society. As an Orthodox Christian by birth, I was often confronted with the question of how I could fulfil my academic duties without making any damage to my religious self. Am I defying God while I am questioning my own religion? Am I not committing the gravest sin when I defined my religion as a mechanism for controlling the function of human life? These are just two of the many questions which kept popping up in my mind throughout my research period. It was quite a challenge for me to separate my academic exercise from my religious duty. I often tell myself, if I am troubled by this constant clash between my 'worldly' and 'religious' lives, I wouldn't wonder if my respondents explained life issues considering the supernatural as controlling the natural.

Ethiopians are known for their deep religiosity (Molvaer 1980). I would like to argue that no HIV/AIDS prevention program would yield results if it does not base itself on the role religion plays in the Ethiopian society. I reject an ideology or any notion of symbolic power which might explain social cohesion at the level of belief, values or tradition. In place of such concepts, I take Foucault's notion of the normalizing force of power as the imposition of '*regimes of truth*' through the operations of power upon the body (Referred in McNay 1994: 111). Hence, when I look at religious norms, I am interested in their normalizing effects since the normative is inevitably normalizing.

Religion is one of the most powerful, deeply felt, and influential forces in human society. Contemporary culture is born out of religious traditions and the conditions of our knowledge are therefore embedded in religious discourses. The so-called secular space is itself a hybrid of past religious traditions. Hence, to understand contemporary culture we need to recognize the religious influences upon thought and practice (Carrette 1999: 33). It is through social interaction that the individual learns religious meanings and develops a sense of personal and group identity. Every religion has an essential cognitive aspect and hence, religion shapes what the adherent knows about the world (McGuire 2002). Bourdieu also asserts that power relations are largely situated in agencies such as the church (2001:116).

When we look at the case of Ethiopia, the vast majority of believers are Christians and Muslims. There are also a few Felasha Jewish communities.. Although, both Christianity and Islam are widely practiced, as it was discussed in chapter two, Orthodox Christianity has been the most dominant and historically old religion in Ethiopia with a tremendous influence on the people's view of the world. The religious influence of Orthodox Christianity can be observed in the day-to-day activities of the people. As my informants asserted, following the religious rules and rituals is considered as appropriate and sometimes mandatory to fit into the social system.

Even if Ethiopia follows the main beliefs and rituals of Orthodox Christianity, it is easy to notice the strong native flavor of its religion. Before looking into how the issue of HIV/AIDS is related to the Orthodox religion, it is important to briefly look at the theological roots of the Ethiopian Orthodox Christianity. Even if the theological foundation of the Ethiopian Orthodox Christianity was discussed in chapter two, I felt it is important to raise here some of the points that may help to understand the intersection between religion and HIV/AIDS.

As it was mentioned earlier, the Ethiopian Orthodox Church is known by its name '*Tewahido/*oneness', a name given to the church based on its Biblical Cannon. In terms of doctrine, the Coptic Church was separated from the early Orthodox Church

in AD 451. This issue concerned the Person of Christ—obviously an important matter to Christians. Orthodox Christians believe to have two distinct natures, one divine and one human, whereas the Monophysites believed Christ has a divine nature in which the human nature is contained. The position of Chalcedon was termed '*diophysite*' meaning 'the two natures'. Those opposed to the Chalcedonian formula were called '*Monophysites*' meaning one nature, i.e. Jesus Christ had only one nature- a combined divine-human one. The Ethiopian Orthodox Church is categorized under the '*Monophysites*'. The '*Monophysites*' conceded that before the Incarnation there were indeed two natures (human and divine) but they maintained that in the Incarnation these two natures were merged into one new nature or state, simultaneously human and divine. They could not make sense of one person with two natures that were '*without confusion, without change, without division, without separation*' (Berhanu 2000; Asrat 1998).

The Ethiopian Orthodox Church for most of its history has been isolated from the mainstream of Christian history and growth in Europe. This was due to two factors. One is that its theology was rejected by both the Roman Catholic and the Eastern Orthodox Churches at the Council of Chalcedon in A.D 415. The second factor was its political and geographical separation from Europe by the Muslim conquests in North Africa in the 7th and 8th centuries. This has resulted in the development of unique practices and rituals and in possessing a Biblical canon that differs from both Catholic and Protestant churches. It is generally understood that when a church is threatened, it tends to harden its patterns in an effort to maintain its identity and seeks to emphasize its distinctive forms, rituals and dogma. This principle applies to all the Oriental churches and especially to the Ethiopian tradition (Berhanu 2000).

The most useful point in the above discussion is that the Monophysite doctrine of Orthodox Christianity, rejected metaphysical dualism favouring the single, divine nature of Christ. This shows the natural sympathy of the Ethiopians for the conception advocating the utter dependence of the created world. "*All things exist by and for God; they are not substances and have no end of their own*" (Messay

1999:193). If Ethiopians have such a conception regarding the existence of all things in the world, my informants' strong conviction that the epidemic is an order from God makes sense. Most informants at Lideta believed that everything is the expression and instrument of God's will. This was what a young man said:

HIV/AIDS is a punishment from God because human beings are sinning too much these days. Look at all the ungodly things that are taking place on this earth. It is the promiscuous and the homosexuals that the epidemic affects most and this is good evidence that this is a sickness ordered by God to punish deviants. Our sins have created a big wall between our creator and us. We are not wiped out of this world only because of God's mercy (Informant 31).

The idea of warring forces of good and evil has been recurrent in Christian ideologies. A dualistic worldview depicts all reality as consisting of two fundamental modes or opposing principles – one Good and the other Evil (Mcguire 2002:40). This identification provides explanations of all events- good and bad- that occur in their lives, and it gives meaning to everyday existence. Meanings are given to all human failure, social problems, personal difficulties, suffering and death. The believer constructs and perceives his/her world in dualistic terms: Good versus Evil, truth versus deceptions, purity versus pollution. Even trivial aspects of daily life become part of the order implied in this dualistic worldview.

In Ethiopia, the association of HIV/AIDS with sin could be seen in relation to this dualism. Dualism enables believers in Ethiopia to name the sources of their anxieties, fears, and problems about HIV/AIDS. Identifying certain difficulties as caused by evil forces also implies a clear-cut course of action. This identification can be considered as an important source of believers' sense of order and control. "*Believers locate their personal courses of action within a cosmic struggle, a continual battle between the forces of Good and the forces of Evil*" (Mcguire 2002:42).

A number of respondents at Lideta expressed their belief that the spread of HIV/AIDS in Ethiopia is a sign of God's punishment for the people's lack of purity of heart. Most believed that the country was spiritually bankrupt. As the quotations below indicate, the meaning of spirituality is not limited to its religious theological sense but embrace such concepts as truthfulness, freedom and justice. The following informants gave their comments with a facial expression full of anger and disappointment. This was what a housewife and an educated man at Lideta said consecutively:

God brought AIDS to punish the Ethiopian people because we have become selfish and untrustworthy. People used to give their lives for their country and their religion but this is not happening with this generation. It has become difficult to find people with self-pride and commitment. This time what is important is money. People try to use every means to get money even if it entails stealing or killing people. Backbiting, violence and crime are all common and these are the things that are not good in the eyes of the almighty. God's rules haven't been respected (Informant 12).

It is not just an accident that great tragedy is constantly striking Ethiopia. We are known for our famine, war and disease. The spirit of Ethiopia has declined since 1974. Unless the nation lives up to the mission ordained by God, misery will be our fate. If we don't act soon God will leave this country for good and HIV/AIDS is just a warning for that (Informant 3).

The quotations show that not only HIV/AIDS but also famine and other tragedies were considered to be the result of people's sins and their negligence of their religious duties. Most of my respondents mentioned the widely used Amharic proverbs '*Lesew Mot Anesew*/Death is too small a punishment for human beings' and '*Igzir Sikota Kesemay Dingay Yazembal*/When God is angry, He may pour down pebble with rain', to explain to me the limits of God's patience. In the Ethiopian society illness representations are transformed into culturally accepted and culturally meaningful

notions that equate pain with punishment from God. This understanding may ultimately have consequences for the way AIDS is acted upon.

According to my informants, the things that test God's patience are things like greed, lust and all the practices that defy God. Adultery was mentioned by most of my informants as one reason for God to punish the nation with HIV/AIDS. For a number of my informants at Lideta, the AIDS epidemic is a result of '*tigab*' (the sin of presumption and arrogance), manifested in sexual promiscuity among other wrong doings. "*In its physical sense, 'tigab' expresses satiety, repletness, in the moral sense arrogance, conceit, presumption*" (Messay 1999: 196). Defiance entails punishment where as submission entails reward. For most of my respondents at Lideta, Ethiopia is not a God fearing nation as it used to be. This is what a young woman at Lideta said:

There is no wonder HIV is the most serious health problem of the world. God's rules are not respected nowadays. We live at a time when God's power has been questioned. If we don't follow God's way, it is evident that we will face adversities and AIDS is just one of them (Informant 9).

The above quotation shows that the experimental attitude, which is an intent on discovering phenomena concealed deliberately by God, will only result in punishment. Not to confine oneself to what God has benevolently revealed is considered as transgression. The manipulation of nature is the opposite of submission. "*Unlike the Western mind, which values the propensity to impress God by achievements, the Ethiopian is rather of the opinion that humility is the only viable attitude towards God. What is expected from individuals is the correct fulfilment of the role assigned to them by God, and so to be worthy of their fate*" (Messay 1999:191). During interviews, religion came up repeatedly as a main reason for treating sexual matters secretly. A few of my informants went up to citing Biblical verses to support their points about the wrongs of sexual immorality. One informant citied the following verse from the Bible:

But now I have written to you not to keep company with anyone who names a brother, who is sexually immoral, or covetous, or an idolater, or a reviler, or a drunkard, or an extortioner - not even to be with such a person. ...But those who are outside God judges. Therefore put away from yourselves the evil person (I Corinthians 5:11-13).

The informants' efforts to explain their points with citations from the Bible shows that one's religion shapes what the adherent knows about the world and interprets events surrounding him. An interesting point is raised by McGuire (2002) concerning the issue of knowledge. He noted that there is a tendency in modern Western societies to treat religious beliefs as '*mere opinion*,' as opposed to empirical beliefs, which are treated as 'knowledge' (2002). This tendency was exhibited during the interviews I had with some of the staff of the two organizations while they were commenting on the influence of religion on their work. I strongly support McGuire's argument when he said that the distinction hides the fact that both types of belief are '*knowledge*' to the individual who holds them. McGuire gives a good example related to health and says: *'the individual who believes that evil spirits cause illness and the individual who believes that germs cause illness are both acting according to their 'knowledge'* (2002: 15-16). Similarly, this is what Deleuze argues about the different sources of knowledge:

> Knowledge is not science and cannot be separated from the various thresholds in which it is caught up, including even the experience of perception, the values of the imagination, the prevailing ideas or commonly held beliefs. Knowledge is the unity of stratum which is distributed throughout the different thresholds, the stratum itself existing only as the stacking-up of these thresholds beneath different orientations, of which science is only one (Deleuze 1988:51).

Unlike the point made by some of the informants working in the NGOs that science is the only form of knowledge, the quotation asserts that science is just one sources of knowledge among many others. Although religion is a form of power that has a

controlling effect, my informants have taken religion as a source of 'truth' and used it to understand phenomena surrounding them without an explicit imposition of the church or individuals. This indicates that power operates within everyday relations between people and institutions and it is not an imposition of the will of one individual on another, or one group on another. We can see power as a set of relations and strategies dispersed throughout a society and enacted at every moment of interaction (Foucault 1978). My informants at Lideta used their religious based knowledge to look at the AIDS epidemic and its prevention. For them, AIDS is caused not only because people have sinned but because they didn't do what they ought to do after sinning. A young woman at Lideta said the following:

God is a merciful father but we people don't exploit His character. It is human to sin but it is another thing not to repent afterwards. People go to church regularly but they do it as a kind of norm. One has to go to church to communicate with God and to ask for his forgiveness. I believe HIV/AIDS is a sign from God that we have too much sin for which we didn't ask God's forgiveness (Informant 8).

This quotation indicates the informant's belief that the AIDS situation could change. Although there was a strong conviction that HIV/AIDS is a punishment from God, a number of informants were optimistic about the possibility of preventing the spread of the virus. This view goes in line with Ethiopians' conception that nothing is definitively acquired and everything is reversible by God. To think otherwise is to forget God, *'the master'* of the world.

It is the belief of most of my informants at Lideta that God will forgive the nation and peace and order will take its place. For them, this is happening not only just because it is God's nature to forgive his people; it is also because Ethiopia is an elect nation and has always been protected by God from plagues and wars. The fact that Ethiopia is mentioned 45 times in the Bible was mentioned by some of my informants as a reason to the special protection the nation has been provided by God. There were some respondents who said that all the natural and man made problems Ethiopia has

faced will be solved soon. For these respondents, the country had to go through all these difficulties so that God's power could be seen when everything is changed back to normal.

Three of my informants referred to the Biblical sentence '*Ethiopia shall reach out her hand unto God*' (Psalm 68), written for King David around 1000 BC, citing it as a sign that supports their claim that the country has been elected by God. As Mark (2003:248) says: "*religious ideas have given a profundity and ideological clarity to what in many cases have been real experiences of economic destitution, social oppression, political corruption, and a desperate need for the hope or rising above the limitations of modern life*".

Beliefs, values and legends play a leading role in understanding the history and institutions of a country. In the case of Ethiopia, the commonly held belief that Ethiopia is a nation elected by God is supported by a famous legend, the legend of Queen Sheba. This is a widely told legend in Ethiopia and it may not be an exaggeration if I say that very many Ethiopian adults know this legend by heart. Even though it is difficult to say the same about the present time, this legend has been a source of pride and identity for the people of Ethiopia for so many decades. The legend reads like this:

Sheba, an Ethiopian queen, paid a visit to King Solomon of Israel. The queen was attracted by Solomon's celebrated wisdom while her beauty impressed him. In order to seduce her, King Solomon wove a stratagem: gambling on her promise not to take anything belonging to him. Solomon made Sheba eat a spicy supper, as a result of which she became thirsty during the night and drank the water he had purposely placed near her bed. Her pledge thus infringed, she had no other choice than to sleep with him. Sheba gave birth to a son who would become the king of Ethiopia under the name of Menelik I.

The myth suggests that Menelik I was heir to King Solomon not only naturally but in the eyes of God as well. The legend relates in no uncertain terms how God's favor swung from Israel to Ethiopia symbolizing Israel's disfavour and Ethiopia's promotion to the rank of the new elect of God. *"Thus, a religious instance was coupled with a secular component: Christianity was tied up with a given territory, emperorship and people"*(Messay 1999:76-77).

Like the myth of *Queen Sheba*, all over the world there are myths about all major aspects of human life. Myths are one form of religious belief and paradigms of human existence. Individuals draw on these interpretations to give meaning and direction to their own actions. Indeed, the very language in which beliefs are expressed structures believers' perceptions of the world. Values, norms, and attitudes derive from religious beliefs (McGuire 2002:16-17). Similarly, the '*Queen Sheba'* myth has an important place in how people make choices and interpret events in their everyday lives. As it was said earlier, for some informants at Lideta, Ethiopia has God's favour dating back to the Biblical times.

The sense of election pervaded the entire social fabric in Ethiopia through the focus of the value system on the notion of '*idil'* or fate. "*The call of destiny imparted a metaphysical meaning to individual ambitions and provided the fundamental norm of social order: each must be in the right place, that is the place allotted to him/her by the Almighty*" (Messay 1999:xxi). *'Idil/*fate' was a repeatedly mentioned word during my interviews at Lideta. Some informants at Lideta said, a person's being infected with the virus is related to his '*idil*' more specifically his '*Yarba Ken Idil*', with a literal translation 'his fate of forty days' referring to ones fate decided at baptism. According to the Ethiopian Orthodox Christianity, a boy is baptized in a church on the 40th day after birth and a girl at 80th day after birth. There seems to be a belief that the course of one's life, one's fate, is fully decided at baptism (Molvaer 1980:87). Since one's fate is said to be decided at baptism, not only being infected with an HIV virus considered one's '*idil*' but every incidence in ones life is considered as his/her fate.

The notion of relating bad happenings to *'idil'* is not peculiar to Ethiopia but it is common in other African countries too. For example, West African cosmologies show a duality of supernatural agency which suggests alternative principles of responsibility for misfortune, illness, etc. Each person chooses his/her fate before birth and has specific guardian spirits appointed. Having a bad fate is known only by evidence of the misfortune. Each person is responsible for good relations with ancestors and all that they entail for the social order (Wallman and Sachs 1988:31).

In Ethiopia not one's poverty and sickness are considered as the person's *'idil'* but his/her prosperity and health are also the results of his *'Yarba Ken Idil'*. For example the fact that a small child would be a good child or not would be based on her fate. She might be *'Yetebarekech'* or *'Yaltebarekech'* (blessed or not blessed by God), and there is nothing the child or his parents could do to alter her fate. Having a child who is 'not blessed' was described by a few informants using the common Amharic expression *'Firja New*/It is one's bad fate'. Similarly, contracting the AIDS virus was described by some as */firja/* bad fate'.

When we look at the case of HIV/AIDS, it is the belief of most of the informants that God will stop the pandemic the moment people respect His rules and act according to His regulations in the Bible. Even though the nation's fate is important, most of my interviewees at Lideta were hopeful that the pandemic would stop according to God's will. They asserted that since the punishment is God's wish, the solution also comes from Him. This is what a woman at Lideta said:

It is Medhaniyalem (the Holy Saviour) who will solve the problem of HIV/AIDS. It is beyond human power to deal with the issue. Had it been that human beings could solve the problem, all the researches that have already been undertaken could have identified the cause" (Informant.25).

Like this woman, most of my interviewees at Lideta were optimistic about the future. '*Egzer bekirb yitarekenal*/we will be provided with God's mercy soon' was what most have said, although the facial expressions of some of them were telling different. They said they believed that cure to the epidemic could be provided from God any day since God is controlling everything in slightest detail. Here we can see the influence of Orthodox Christianity. This is also common in other parts of Africa where misfortunes are believed to be caused by supernatural forces. According to Green (1994:234), in much traditional African thought, pathology in social relations leads to illness. Transgression of rules regarding sexual behaviour such as committing adultery is a common source of social strife. If we take Zambia for example, sex includes mystical ideas, it carries magical potency, and to avoid supernatural dangers, one must respect social boundaries and observe taboos. Ethiopia is no different from Zambia concerning the notion of dangers and their relations to supernatural powers. In Ethiopia there is a strong belief that danger looms whenever Ethiopia abandons its divine assignment. The danger includes punishment: disasters, such as invasion, famine, drought, and epidemic.

Appearance must be the expression of essence from the Western point of view. "*The more sublime the appearance, the greater is its adequacy to the essence. Quite the opposite for the Ethiopian: however sublime and refined the outward may be, it will usurp rather than express the inward. In fact, the more magnificent the countenance, the higher becomes the deception*" (Messay 1999: 191). This conception could be the source of Ethiopians' high perseverance to misery. Patience and endurance are among the highest virtues in the Ethiopian society. Related to this is the religious belief that sufferings in the world are sacred because they indicate ones' place in the next world. The capacity to persevere pain and suffering could be useful in the case of AIDS, since this capacity could enable people to withstand sufferings caused by the epidemic. Hope for change could also be a source of comfort during difficult times.

For most of my informants at Lideta, Nature cannot become object of manipulation. Therefore, their purpose in life is to live according to their destiny, their '*idil*', by

respecting the rules of God. I disagree with what Messay said about resistance when he asserted that the knowledge of Ethiopians about the reversibility of phenomena would bring a protracted will to resistance (1999). I argue that the above view regarding the reversibility of phenomena restrains their capacity to resist, leaving everything to God. If individuals do not make their own destiny, they cannot have the freedom to change their lives. Power is not a mere phenomenon of the world; it binds the created world to the Creator and determines its fate. Power being in the hands of the divine God, there is nothing human beings can do to alter their situation.

'*Gize*/time' is a powerful word for common people in Ethiopia. There are many proverbs around it like 'Lehulum gize alew /Everything has its own time', *'Gize Yesetewin Gize Yenesawal* /time makes one prosper and the same will take away everything'. The Ethiopian notion of '*gize'* expresses temporaries of phenomena indicating the possibility of reversals. 'Yenegen man yawkal/ No one knows what tomorrow brings' is a common expression of most of my informants.

Due to their religion and the ways of thinking based on their religious views, my informants showed a tendency of leaving everything to God, not acting in a way they could. I argue that this attitude has a negative effect in bringing about changes, especially changes that has to do with affecting people's sexual behaviours. In a country like Ethiopia where people's views of life are expressed in folklores, the highly used proverb '*Kemetagel Metadel* /better to be born lucky than to fight for everything in life' is a good indication that luck than deed is important. Although I agree with Messay (1999) that religion in Ethiopia is not a source of fatalistic worldview, it in some ways discourages the people from acting; instead they leave everything to be taken care of by God.

Donald Levin (1972:66) says: *"The Ethiopian has no drive to conquer or to become master over nature"*. This same issue can be raised in relation to the country's development problems. In his article 'Vision 2020: Whither Ethiopia', Mesfin (2003:15) supports the point made by Levin, when he noted: *'The Ethiopian's*

principle that guides their existence is 'why should I worry when I cannot ward off what providence has predetermined?'. He raises the question:

> How can the people of any given country succeed in life unless they struggle and act to ensure that the country and the sovereignty is theirs as a matter of right? For almost two thousand years we have been doing nothing more than blaming everything on the different regimes and supplicating God, the angels, and all the saints for solutions to our problems (Mesfin 2003:15).

Mesfin strongly criticizes the deep rooted notion that nature cannot be manipulated. In the quotation, this notion has been mentioned as a major obstacle for change and development in Ethiopia. Similarly, we could relate this notion to the prevention of HIV/AIDS. The following quotation from an interview with a middle aged woman at Lideta is an example to the commonly held attitude towards an individual suffering from AIDS. The woman described an AIDS patient as follows:

He is a person on whom the sky has fallen down. He is a person who can't do anything about his condition but pray that his days of suffering could be shorter. He has nowhere to escape. He should ask his creator what wrong he has done to deserve what he has got (Informant 20).

This woman considered an AIDS patient as an unfortunate person. This could be related to the informant's religious belief that nature cannot be manipulated and nothing could be done. The way Ethiopians consider people with disabilities and sickness is also related to this. Such individuals are considered as unfortunate, and hence are looked upon with pity. A good example could be the way people with leprosy are treated in Ethiopia. Leprosy is considered as being caused by evil spirits who creep into the body and produce the disease. Due to fear and stigma surrounding the disease, leprosy patients live in secluded places not mixing with the rest of the population (Malborg and Carlsson 1994). I would argue that the sigmatization of AIDS patients as well as those with leprosy has to be looked in connection to power

relations. Similarly, Parker and Aggleton (2003: 13-14) assert that stigma in relation to HIV/AIDS needs to conceptualized as social processes that can only be understood in relation to broader notions of power and domination. In the case of the above quotation, the woman used religion to categorize the AIDS patient the way she did.

Religion for Foucault was always part of a set of force relations and discursive practices which order human life. Foucault's work thus presents a reading of religion outside theological traditions and belief- a reading that positions religion inside a political struggle of knowledge-power. In this way Foucault provides a radical framework to question the politics of all theological and religious thinking (1999:32). If we look at the Ethiopian situation in line with Foucault's assertion, individuals' actions are controlled by religion. For the Ethiopian, "*what the West calls law, regularity in nature, is simply the permanent display of rise and fall, life and death through which the Master of the world attests himself*"' (Messay 1999:187). This is just a justification for religion to control its own functioning leaving everything to a divine power.

Religion might be seen as a societal institution of normative coercion (Turner 1992; Foucault 1999). According to Turner, this institution exercises a moral authority over the individual by explaining individual 'problems' and providing solutions for them. In this sense we could say that religion exercises a hegemonic authority because its coercive character is often disguised and masked by its normative involvement in the troubles and problems of individuals. Hence it is readily accepted as legitimate. This means it is coercive, normative and also voluntary (Peterson and Bunton 1997: xii).

AIDS was considered by a number of my informants Lideta as the punishment for manipulating nature and not obeying the orders of God. According to these informants, the victim of AIDS has been considered as one punished by God because he/she was tempted by his/her flesh and was involved in a sexual act which is considered not normal, normal being a sexual act confined to marriage.

Homosexuality was mentioned by some of the informants as an example of immoral sexuality against God's will. This was what one informant said:

AIDS has been destroying the world because people have engaged in ungodly acts like sex between individuals of the same sex. What could make God furious than a man sleeping with a man and a woman sleeping with a woman? (Informant 15).

Here we could see how Christianity controlled the sexuality of individuals, by labelling sexualities as normal and abnormal. Pleasure is not totally forbidden but controlled since sex in marriage is considered as normal but sex out of marriage abnormal. Christianity alerts individuals their weaknesses, the fact that their flesh could be tempted. This is what Foucault said:

> I believe that Christianity found the means to establish a type of power that controlled individuals by their sexuality, conceived as something of which one had to be suspicious, as something which always introduced possibilities of temptation and fall in the individual.... So it did not prohibit and refuse (sexuality), but put in place a mechanism of power and control that was, at the same time, a mechanism of knowledge, of knowledge of individuals, of knowledge over individuals, but also of knowledge by individuals over themselves and with respect to themselves (Foucalut 1999:126).

In line with the conviction about God's mercy, when asked about what they would do if they themselves or their family members have the virus, a number of the informants said they would go to church and seek solutions from there. Quite a large number of my informants said they believed that people suffering from AIDS could get cure from God with faith and repentance. This also goes with their conception that everything is reversible. It is the belief of most of my respondents that instead of seeking for God's mercy individually, Ethiopians should seek God's mercy as people of one nation.

*I feel it is important that we seek God's mercy soon. We need to repent. We need to pray day and night so that God turns his face to us. If we don't get God's mercy soon, this epidemic (*AIDS*) will destroy the country* (Informant 12).

Fasting and conducting intense prayers as one big group or a nation were mentioned by many as the major means to reconcile with God so that the nation in general regains God's mercy. Some mentioned the need to plead to God calling Him, '*Igzi O!*'(O, God!!!!) '*Igzi O!*' could be described as a mass cry for God's mercy during times of adversities. In the Ethiopian Orthodox church, '*Igzi O*!' is quite a common form of prayer during times of drought appealing to God for his forgiveness and His will to bring back rain. As a form of prayer '*Igzi O*' is believed to bring back God's mercy to His people and according to my respondents, such pleadings take place in churches now a days to ask God to stop the AIDS epidemic since God is believed to be interfering in human affairs very directly. A number of my informants asserted that Christians should say 'Igzi O!' regularly to get God's immediate response during times of adversity. As Molvear (1980:67) puts it, for Ethiopians, "*humility and knowing one's place are much praised virtues, and pride and arrogance are great moral failings*". This means it is humility that reverses a disaster like drought and epidemic and intense prayers like '*Igzi O!*' are considered as ways of showing people's submission to God's will.

In addition to prayers and fasts, my respondents expressed the spiritual power of 'T*sebel*/the holy water'. According to the belief in the Orthodox Christian religion, the holy water is considered as a source of healing for any kind of ailment and it is believed to be one of the ways in which God shows His mercy to His people especially the sick. Not only the holy water but '*Imnet*', the soil in the compound of some churches is believed to have a healing power since its source is a sacred place, the home of the saints. Both '*Tsebel* and '*Imnet*' have their theological bases in the Bible, related to Christ's healing of the sick. '*Tsebel*' could be water from a stream or the tap but the water from the tap has to be prayed upon by priests to have a healing

power. For believers of the religion, it is a taboo to call '*Tsebel*' by the name water since that is considered as desecrating '*Tsebel*' by equating it with ordinary water.

There are two ways of using the holy water for healing. Patients could drink the holy water or bath in it. Mostly, a patient is expected to drink the '*Tsebel*' or bath in it for specified number of days. Mostly it is priests who limit the dates but believers commonly know the required number of days for the '*Tsebel*'. It is in the mornings that the holy water has to be drunk or bathed in. Although exceptions could be allowed based on the level of sickness, the person is expected to drink the holy water or bath in it without taking any food. A patient might stay in the church and wash in the '*Tsebel*' each day early in the mornings. For this purpose, there are houses in some of the churches so that anyone seeking the service could come and stay. My informants told me that since the number of people who would like to attend this service is so high, it is not easy to find places to stay and they mentioned AIDS as a major reason for '*Tsebel*' places to be packed with sick people.

Some informants at Lideta told me that a lot of people living with the virus attend church programs where prayer services are conducted. A Documentary film with the title 'Hidden Cry' was showed on the national TV on the 18th of February 2004, presenting the fact that people with HIV virus come to get emotional comfort of churches and to wash themselves in the holy water. My informants at Lideta had similar stories to tell. This was what a woman said:

You may not believe what I am saying when I told you that 'Tsebel' (holy water) is the only remedy to the epidemic. A relative of mine had AIDS. He went to a hospital for almost a year but his health condition deteriorated very much. Six months ago he started to go to church to have 'Tsebel' and he is now much better. He was carried around when he went to church first but now he walks. Let alone getting better, there are some people who confessed at churches that they got cured from AIDS because of 'Tsebel' (Informant 22).

The woman tried to convince me to believe her story, supporting her points with specific examples. She asked her daughter to show me two articles written on a religious newspaper called *'Semea Tsidk'* which had the stories of women who got cured from AIDS with the help of *'Tsebel'*. This woman's story shows that religion plays a big role in providing meanings to people who are overwhelmed by the ambiguity and complexity of life. According to some respondents, attending religious ceremonies helped them to get away from the routines and ups and downs of day-to-day life. The believer's worldview is founded on the expectation that everything is ordered; therefore, order and patterns in the world are subsequently perceived. *'The 'positive' side of this spiritual order can be seen in the believer's constant discovery of 'holy coincidence,' 'providence,' and other evidences of the pattern of God's work in everyday life'* (McGuire 2002: 42-43).

During my fieldwork, I found out that women were highly involved in religious activities. In Ethiopia women are said to be more '*church kissers'* than their male counterparts. '*Betekiristian Sami/* church kisser' is the most common way of referring to a person who regularly goes to church. The name must have been taken from the ritual that people kiss the gate and the building of the church every time they come to church. Going to church and attending religious rituals were mentioned by many informants as ways of receiving God's forgiveness. A woman who lost her brother due to AIDS said she spent hours at a church each day praying to God to give her strength to overcome the pain of loosing her only brother. She said she felt that her burdens were lifted off her shoulder when she went to church. One gets the name '*Betekiristian Sami/* a church kisser' not only because one goes to church regularly but also because she/he attends all the religious rituals properly. According to informants at Lideta, HIV/AIDS was one of the major agenda in their prayers to God. This was what a woman said:

I feel a kind of relief when I see the church compound from a distance. I feel more content when I get into the compound. I felt so happy when I pray and tell my God all

the things I want Him to take care in my life. One of the regular questions I ask Him is to keep all my family from this sickness of the devil (Informant 14).

What the lady refers to as '*this sickness of the devil*' is the AIDS epidemic. Most informants at Lideta said they go to church at least once or twice a week. Had they had the time, they said they would have loved to go to church each day. Since I am a resident of Addis Ababa, I have observed that more women than men attend church ceremonies. Studies also proved the same. According to Pankhurst (1992), Christianity plays an influential part in the beliefs and actions of women, who find support and explanations of their world in Christian terms. Women are more likely than men to regularly present offerings to the church and to make vows.

During interviews I found out that quite a large number of people attend places where spirit beliefs are exercised. Not only Christianity and Islam but spirit belief also has deep roots in the Ethiopian society. According to some informants, people go to '*Weqabis*' (persons with spirit power) and ask for solutions to their problems. Some told me that it is common that AIDS patients visit people with spirits to get cure. Except one of them, my informants did not say much about their own involvement in spirit belief may be because such beliefs are non-legitimate beliefs which are also considered as 'backward'. But some told me stories of other women who regularly went to spirited men (*Weqabis*) to solve their problems, especially problems related to their health. Individual's inclination towards spirit treatment for sickness is understandable since spirit treatment is an emotional experience, offering comfort and promises about a brightening future.

Harald Aspen (1994:345), in his study on spirit beliefs of the Amhara people in Ethiopia, noted that a high number of cases presented for spirit treatment were on health-related problems. He says sickness for the Amharas demands a whole spectrum of treatments. Some of the possibilities include; holy water, amulets, blood sacrifices, coffee rituals, and modern medication. It is not at all uncommon in Ethiopia to get people who go to churches and in parallel attend spirit rituals. The

syncretism of Christianity and spirit belief might seem odd since the two belief systems are said to be in opposition to each other. Syncretism is not a threat to the hegemony of the Ethiopian Orthodox Christianity but rather confirmation of its hegemonic status. New and seemingly non-Christian elements are not presented as opposed to Christianity but conceptually at least, within its general framework (Aspen 1994: 337). Tubiana also supports the same view when he said "*the adoption of foreign belief and practices, amalgamated with locally known Ethiopian beliefs and practices is not at all surprising in Ethiopia*" (1991:30).

As in church, women are also said to have more involvement in spirit belief. Women predominated in the alternative religious sphere which caters more specifically to them. Pankhrust noted that spirit beliefs give women a voice, the time and space to clamour in society which tends to demand their silence. "*The dominant Christian religion gives power to men rather than women, yet it appeared more meaningful to women, who found support particularly in the virgin Mary*" (1992: 170-171). Pankhurst's argument goes in line with the point that women's involvement in religious activities could be looked at in relation to their positions in society. I agree with Pankhurst's argument even though there is a marked difference between my study area Addis Ababa and rural Amhara region which Pankhurst had based her study on.

Although most of them expressed hope, some informants of mine at Lideta believed that everything is out of order and there is no solution to the problem of HIV/AIDS. Those individuals who view this society as badly out of order hope for dramatic change. The ultimate religious 'solution' is the end of the world. The idea of an apocalypse - a dramatic end of the world- is not a new religious theme. Many religious groups have anticipated the imminent end of the social order they define as ungodly Some have expected a total physical cataclysm in which the world would end; others have awaited an end in which the existing social order would cease and be replaced by a perfect new order (McGuire 2002). It is not uncommon in Ethiopia that when new and strange things happen, it is a sign that the end of the world has come

near. A woman said: "*This world will come to an end soon. As it is written in the Bible, we are witnessing so many signs. All this disasters are signs and AIDS is one of the biggest*" (Informant 16).

The feeling of hopeless regarding the epidemic in Ethiopia could be looked at in relation to the economic situation of the country. Unemployment, war and other social problems tended to create a sense of distrust on the government and other agencies pressing people to lean on religion to all their problems. Not trusting the natural and all that is human could be a likely reason to trust the supernatural. There were two informants who said that the multiple social problems in Ethiopia could be reasons for the people's too much indulgence into religion. As it was discussed earlier, religion has played a big role in defining the 'truth' about the AIDS pandemic, putting at the same time its power of control on the population. Another factor important in shaping informants' conceptions of the AIDS epidemic is tradition.

5.3. 'AIDS Could Be Prevented by Sticking to Tradition'

A number of informants at Lideta were adamant that the tradition of the country should be preserved in order to prevent the nation from crisis and turmoil. This should not be surprising when it is looked at in relation to the religiosity of the people of Ethiopia. As it was discussed in the previous section, my interviewees believed that God is the maker of the destiny of people, a conception which gives almost no place to the law of nature. Medical discovery, which is totally human, could not have much value since it is incomparable with religious solutions to diseases.

In general, many informants at Lideta tended to be ambivalent towards the value of modern medicine and the current prevention programs on HIV/AIDS. This suggests that these individuals were discriminating in the way in which they assess the HIV/AIDS prevention information that is new to them. Foucault argues that the move from one episteme to another creates a discursive break or discontinuity. He suggests

that these breaks between episteme are sudden, rather than, as they have generally been characterized, an evolution or reaction to previous periods (Foucault 1979:31). Here Foucault is trying to react against the notion of evolution and progress whereby it is asserted that knowledge improves until it reaches the highpoint of the present day. It is known that modernization brings with it new understandings and ideas to justify how life might be lived differently from traditional ways. Some informants at Lideta criticized the change that comes with modernity. This was what a woman said:

This epidemic came to Ethiopia with modernization. Had we kept our tradition, we wouldn't have suffered from the result of HIV/AIDS. I believe AIDS is mainly the result of breaking traditional sexual rules (Informant 9).

In relation to the high importance of traditional values in the Ethiopian society, Messay (1999) stresses the leading role of beliefs and values in the understanding of the history and institutions of Ethiopia. In his book, he asserts that the adoption of Western institutions and values is the prime cause of the decline of inherited values and beliefs. Although he seems somewhat bold in his analysis of the situation, his arguments are quite convincing. Messay chose to analyse the reasons for Ethiopian survival, which were the country's legends, values and institutions. By survival he does not mean only a long history with no record of foreign domination but also the fact that the country preserved almost intact its social and cultural traditions despite a history fraught with turmoil (1999). He strongly argues that "*Ethiopia lost everything: its pride, its confidence, even its identity – all the forces of life which had so far sustained its will to survive by the severe damage inflicted by modernization on the foundations of Ethiopian resistance*". Here Messay is not against modernization but asserts that only the revival of the forces of Ethiopian survival can promote the drive towards modernization. He lists modernizing assets of traditional Ethiopia as social mobility, the rule of power game, the existence of supra-ethnic ideology, the ascendancy of the warrior class and the tendency towards syncretism (1999: xxii).

Messay's argument might give a good insight into how one should look into the problem of HIV/AIDS in Ethiopia. During the interviews I had with informants at Lideta, I was surprised by the frequency of the responses which related the epidemic with modernity and Western influence. It was the conviction of some informants that HIV/AIDS could be prevented if people stick to their traditions avoiding outside interference in any form. Moreover they tended to relate the pandemic with other socio-economic and political problems of the country. This is an indication that the issue has to be looked at in a broader perspective. "*Indeed, the recent ordeals and failures of Ethiopia have created a profound longing for traditional roots, whether in the form of nationalism or ethno-nationalism*" (Messay 1999: xxiii). As one informant said:

Our country may not easily solve the problem of HIV/AIDS because we almost have no say in finding the solution to the problem. Western experts design the HIV/AIDS prevention programs. The drugs come from the West. The books we use to teach about AIDS come from the West. The solutions to all our problems come from the West. This has to change and we must be the ones to seek solutions to our problems (Informant 2).

Not only in relation to HIV/AIDS, but also in our discussions on gender, sexuality and other related issues, my informants seemed to have a strong conviction that tradition should be preserved. Modernity is sometimes equated with a rejection of the moral and religious values underpinning the whole structure. As it was discussed in the previous section, humility is considered as a way of submission to God. Hence worldly pleasure, which is most of the time equated with modernity and westernisation has been considered against deprivation. Worldly pleasure was looked at as a road to disobedience.

A good example of the contradiction of modernity and tradition could be looked at in how the issue of condom use was taken up by some of the informants. A few of them had a strong objection against the promotion of condom use naming condom use us

'untraditional' and 'foreign'. According to a study on HIV/AIDS in Africa, the focus of much of the literature, and many statements of political and religious leaders is that AIDS is really a symptom of the erosion of traditional values, especially those of the family and sexual monogamy (Wallman and Sachs 1988:45).

Although there is criticism against condom use labelling it as untraditional, there were those respondents who said, contrary to the above view, that condom use should be promoted since abstinence is difficult to maintain. These individuals criticized those who go for abstinence and suggested that the cause for the spread of HIV/AIDS is the denial of that fact that it is difficult to abstain from sex. They said tradition and religion could be blamed for equating premarital sex with sin. Those who stick to tradition and religion for explaining sexual matters were criticized by some of my informants as 'backward' and 'uncivilized'. This only proves that even hegemonic discourses are not closed systems but are open for other conceptualisations, the revision of accepted truths (Hekman 1990).

Although criticized, the discourse that promotes one to one sexual relationship before marriage has got a wide circulation in the prevention discourse of HIV/AIDS in Addis Ababa. This indicates that even if institutions like the church play a big role in the shaping of individuals, the relations between individuals and institutions are not only of oppression and constraint but resistance is possible in power relations. As Dozon asserts: "*AIDS epidemic in Africa depends on an accumulation of factors, or in other words a process where tradition and innovation, in mutual tension and conflict, facilitate the rapid spread of HIV*"(1999:690).

In Ethiopia, 'modern', 'Western' or 'new' factors are valued positively or negatively in relation to traditional cultural forms. I found out that there are resistances not only to scientific knowledge but knowledge coming from outside and different to traditional forms of knowledge. As it was discussed in chapter one, these resistances could also be noticed in people's reactions towards some HIV/AIDS prevention activities that are considered 'new'. I was able to observe among my informants, a

tendency to look at culture as sacrosanct and static. There has also been a tendency of equating modernization with westernisation.

The widely used proverb *'Kemayawkut Melak yemiyawkut Seytan yishalal/* A devil you know is better than a saint you don't know' is a good example showing the level of how my informants at Lideta questioned new ideas. Similarly, I was able to notice that some informants found it difficult to question the traditional practices and values related to sexuality and this has a direct bearing on their response to HIV/AIDS. Although in each historical period, the set of rules and conceptual tools for thinking about what counts as factual change, it seems that people are resistant to change sticking to traditional values and practices. *"All phenomena, be they internally generated or borrowed from outside, were preserved as though they found in Ethiopia a kind of asylum"* (Messay 1999: xvii). One such phenomenon is, pagan and Judaic elements that still pervade in Ethiopian Christianity.

My informants' insistence on asserting the importance of keeping traditional values has to be looked in relation to changes of the current world. These changes are felt as sudden changes for Ethiopia, a nation that kept its traditional values for many centuries with little contact with the outside world. As Goddard (2000) puts it, change is a prominent, or perhaps the major, characteristic of modern times. Increasingly, change is related to the special relations that govern interaction of localities and regions. The technological revolution brought about by the dramatic expansion of new information technologies has promoted an acceleration of flows of information, goods and persons. With global relations there is a simultaneous process of globalisation of cultural elements. Moreover, the global space is constructed and mediated by the relations of economic inequality and power. Our perception of the global space and our position in it will differ according to our location in the world (Goddard 2000). So globalisation has quite different implications if we are considering the process from the perspective of Northern Europe or of Sub-Saharan Africa.

In line with the above point, it was the view of a few of my informants that Ethiopia is at a disadvantage in the current global system since the world is for the rich and the powerful countries like the USA. These informants related the issue of HIV/AIDS with the global economic, social and cultural situation using metaphoric expressions like '*We are out of the game*' and 'we *are destined to wither away due to the AIDS epidemic since we have no place in this world of the rich'*. This is what a young man at Lideta said:

We are known in the world for our poverty and misery. It was in famine and drought that we are known in the world. Now we have added one more name, HIV/AIDS. Our neighbouring African countries are much better than us and I don't think this country will prevent the spread of HIV/AIDS with all these poverty and political instability (Informant 31).

This quotation asserts the point that the AIDS situation in Ethiopia could only be considered in conjunction with the totality of problems and tensions which affect African societies in general and Ethiopia in particular. It is known that developing countries are facing difficulties in competing in the economic system of the current world. Globalisation encompasses but simultaneously creates margins, edges. Martha Nusbaum (2003) also underlines the fact that the international economic system creates severe, disproportionate burdens for poor nations. A globalized world is one in which Western categorizations of sexuality increasingly interact and interpenetrate with those operating in other sexual cultures and AIDS provides a reminder of the uneven development of societies (Weeks 2003).

Most of my informants were very much against sex videos, magazines and sex information on the Internet coming from the West to Ethiopia. It is obvious that in each historical period, the set of rules and conceptual tools for thinking about what counts as factual changes (Foucault 1981). These changed rules produce new knowledge that will be confronted with resistance. In Ethiopia, traditionalists aspire in vain to a restoration of stability. New voices articulate the aspiration for

recognition of new identities and new ways of being. Since there was not much the country could do to control information coming from outside especially from the West, the informants described the situation as a 'cultural invasion' with no retreat. This is what a mother of three young children at Lideta said:

Now we are living in a time where we can't protect our children from the evils of this world. Drugs and sex videos are everywhere and no wonder HIV/AIDS has been spreading at an alarming speed. It is a time where being a good parent is not at all enough to raise children since young boys and girls could be exposed to so many bad things and we as parents could not do anything but pray to God that our children are not showing inclinations towards those bad things. If they are interested, there is no way we could stop them (Informant 12).

This woman expressed her frustrations not only in words but also in her facial expression and body language. Her words in the quotation express a parent's worries in this 'information world' where children could be exposed to any type of information. Weeks (2003) describes this as a product of the disruption of settled patterns of sexual life under the impact of profound social change on a global scale. She emphasizes the need to explore the impact of transitional social processes, examining various economic and cultural dynamics. Hence, one should not be surprised by the fact that the notion of 'progress' was questioned by the local people in Ethiopia.

It was the opinion of two of my informants that Ethiopians are very skeptical about taking new information. According to them this relates to the fact that the country had less contact with the outside world for centuries. One of my informants added that since it has been a deeply rooted notion to cherish the country's tradition and to be proud of protecting the nation against Western interference, Ethiopians are resistant to change in relation to, viewing and evaluating any new idea through their traditional glasses.

The resistance to modern science was expressed in the way people lean on traditional medicine and religious ways of cure. Quite a number of informants at Lideta said they would believe that traditional medicine could cure people suffering from AIDS. The name given to modern medicine which is '*Yeferenj Medhanit*/the medicine of the white man', is itself indicative of the way people look at modern medicine. To the contrary traditional medicine is named '*Yehabesha Medhanit*/the medicine of the Abyssinians or the natives', implying that modern medicine is considered as the 'other' compared to traditional medicine.

Ethiopia is a country where traditional medicine and ways of healing were being practiced for centuries. Modern medicine and science were considered as coming from outside and hence different from traditional values and practices. Regarding the dissimilarities between traditional and modern medicine Imu (1986:127) says there are fundamental difference between the concepts of life, health and diseases."*These concepts are the foundations upon which the underlying philosophies of the various medical systems rest*".

Various survey results indicated that the majority of people in Ethiopia use modern health services than traditional ones. A study with the title '*Gender and Cross-Cultural Dynamics in Ethiopia*', a study that included 84% of the population and eleven ethnic groups of the country, the majority of the respondents for the study claimed to have modern health services in their communities. According to the study, a great majority of both males (80%) and females (83%) said they resorted to 'Modern Health Services'. Similarly, 86% of respondents from urban and 78% from rural communities stated that they had modern health services, while 36% of urban and 64% of rural Ethiopians visit the so-called traditional medicine men and women (Habtamu et al. 2004:101). According to another study on HIV/AIDS and other sexually transmitted diseases in Bahir Dar, informants named biomedical health service as the most appropriate for obtaining treatment while traditional medicine was mentioned next. Although many informants in the study preferred traditional medicine, particularly for the treatment of some sexually transmitted diseases, a small

minority of the respondents believed in the efficacy of traditional medicine for several illnesses. The researcher doubted this result stating "*traditional medicine is probably more popular than the study results indicate due to a general reluctance to admitting its use"* (Ayalew 2000: 141).

The reluctance to admit the use of traditional medicine may be related to the notion that traditional knowledge has been considered as inferior to scientific knowledge. Similarly Fairclough claims that 'alternative' knowledge about health is not given the status as conventional medical science. He added that a great deal of effort is expanded on ensuring that alternative medicine is considered amateurish and inferior, thus maintaining for medical science the authority of the 'true' and the 'scientific' (Referred in Mills 2004: 16-17). As McNay (1994:53) asserts, traditional histories of science privilege the discourse of pure reason – 'rigorous science'...- to the exclusion of less systematic and more empirically based types of knowledge. According to her, the less systematic types of knowledge are seen as irrelevant and unreliable to developments in formal knowledge. McNay (1994:53) adds that traditional knowledge also follows its epistemic rule and hence traditional medical knowledge is based on this specific rule. Here, my intention is not to justify the validity of traditional medicine in HIV/AIDS prevention but to show how the production of knowledge is bound up with historically specific regimes of power; every society produces its own truths which have a normalizing and regulatory function. This indicates that discourses are always in constant conflict with other discourses and other social practices which inform them over questions of truth and authority.

Although most of my informants use modern health services, quite a number of them suggested that traditional medicine could give cure for those aliments which science was not able to find cure, and AIDS was on top of their list. The notion of distrusting modern medicine might be looked in line with the religious thinking of the people. In the Western thinking, scientific and technological innovations are considered as the concrete expression of the will of mankind to become possessor and master of nature. For the Ethiopian who thinks that the solution for AIDS comes only from God,

modern medicine, being an innovation of modern times, might appear as transgression. This only disproves the commonly held notion that scientific knowledge is the only source of 'truth'. Foucault also asserts that 'truth, like knowledge, is not an abstract entity. Instead, 'truth' is of the world, it is produced there by virtue of multiple constraints (Foucault 1979:46).

In the Ethiopian society, the herbalist is like the general physician in traditional medicine. He is expected to be knowledgeable in all aspects of healing. There are many herbalists in Addis Ababa who claim that they give medicine that cures AIDS or treats AIDS patients and my interviews at Lideta showed that these herbalists are highly trusted by their beneficiaries specially in their treatments of sexually transmitted diseases and other ailments which they referred as 'beyond' the curing power of modern medicine. This was what one informant said:

Although it is said that HIV/AIDS is incurable, there are many who got cured by traditional medicine. It is possible that traditional medicine can eliminate AIDS altogether if the disease is detected at its earlier stage. For example the traditional healer Ato Mammo is known to have cured many people with AIDS (Informant 13).

Mr. Mammo is a much known herbalist in Addis Ababa. A few informants explained that the medicine from herbalists like Mr. Mammo were effective because they used natural plants. It is known that herbalists mainly use plants which they gather fresh. When such required herbs are seasonal plants they are collected at the appropriate times of the year and preserved. Herbalists devote much time and personal attention to the patient, thus enabling them to penetrate deep into the psychological state of the patient and the nature of his/her particular disease.

According to a study on traditional medicine in Africa, there is enormous variation existing in the use of herbs among different tribes and even among herbalists in the same locality. The bark and the roots are the most common plant part employed, occasionally leaves, flowers and fruits are used in the preparation of remedies. The

drug is usually drunk for most internal diseases or applied topically for external infections. It is common to incorporate drugs with food and drink (Imu 1986:51). The African medical agents consist of two groups: those used for rituals, sacrifices and other religious acts as part of the process for the treatment of disease; and the plants, that are supposed to have an organic effect directly on the patient (Imu 1986:69).

The preparation of the plant drugs is dictated by the nature of the illness and the plant part used. The plant could be pounded or simply pressed and the juice applied directly on the affected part, particularly for the treatment of wounds, abscesses and skin infections. According to Green's study on traditional medicine in four countries in Africa, healers in all the four countries conceded that there are conditions for which traditional treatment is superior to Western biomedical treatment (Green 1994:13). This is a good evidence to contradict the widely held view that poor people in Ethiopia tend to resort to traditional treatments mainly for lack of easy access to biomedical treatment. The main reason for these people to resort to traditional medicine than the Western biomedicine in the case of diseases like AIDS might be summed up in the following quotation by Ricardo Arguilo Martinez on the importance of medicinal plants and traditional healing in the lives of Africans:

> Unlike modern Scientific Medicine, it is the creating of the common people, the end product of knowledge of herbal cures and magico-religious assumptions which they share. It is the wisdom of the forefathers handed down from generation to generation through which the layman perceives and interprets experiences related to illness (Cited in Imu 1986:69).

During my fieldwork, I have also found information that there is a tendency to mix traditional medicine and the modern one and use them together. One informant at Lideta said "*it is good to mix traditional and modern medicine instead of totally relying on the modern one. If one fails the other might work*" (Informant 16). This informant mentioned a relative who lived with the AIDS virus and who got good result while taking anti-retroviral drug and traditional medicine simultaneously. Not

only in Ethiopia, but studies in other countries of Africa also proved that it is quite common to mix modern medicine with the traditional one. In South Africa for example, traditional healers may mix modern and traditional medicines in their treatments of sexually transmitted diseases (Green 1994:236). This mixing of traditional and modern medicine could be an indication to the fact that people do not have total trust in modern medicine.

Since HIV/AIDS is not only a medical problem but a social one too, it requires knowledge to handle it from different perspectives. The rule of the HIV/AIDS prevention discourse that bases itself on the medical definition of the disease seems to neglect the socio-cultural factors that are related to the epidemic. Looking at the place of culture in HIV/AIDS prevention in Africa, Jungar and Oinas said: *"Medicine, as no other human enterprise, cannot represent a level of knowledge that can raise itself above 'culture' and thus address the HIV epidemic 'objectively'* " (2004: 98).

5.4. Conclusion

The discussion in this chapter tried to show that religion and tradition have a strong influence in shaping individuals' perception about the AIDS epidemic. Religion intersected with the discourses on sexuality and HIV/AIDS, and the informants frequently draw upon religious resources during conversations Although the scientific HIV/AIDS discourse has been dominant in Ethiopia, individuals give explanation to the AIDS epidemic based on their own religion and tradition. As it was said, Ethiopians are known for religiosity. The influence of Orthodox Christianity has been tremendous since the religion has dominance in Ethiopia for centuries. We have seen that the doctrine of the Orthodox Christianity has a direct influence on how people understand and also respond to the AIDS epidemic. The conflict between modernity and tradition is also clearly seen in the way informants looked at the solution to the epidemic.

Chapter Six - Construction of Risk in the HIV/AIDS Discourse

6.1. Introduction

> 'መታቀብ: መታመን: መጠቀም' '*Metakeb, Metamen, Metekem*/Abstinence, faithfulness, and condom use'

'Metakeb, Metamen, Metekem' are the Amharic words known in Ethiopia as the three 'Ms' for avoiding risk of HIV infection. HIV/AIDS prevention programs in Ethiopia mainly concentrate on disseminating information on how to avoid the risk of HIV infection. As mentioned repeatedly, HIV/AIDS prevention programs have been providing special attention to 'risk groups'. The focus has mostly been on commercial sex workers, the youth, and other groups that have been considered to be likely to involve in multiple sexual relations.

Risk is a dominant concept in HIV/AIDS discourse worldwide. Lupton (1999:13-14) categorized risk related to sexual activities as lifestyle and interpersonal risks. Since AIDS is mainly a sexually transmitted disease, the risk of HIV infection may be identified as related to lifestyle and interpersonal behaviour/practices. Lupton also asserts that the identification of risks takes place in specific socio-cultural and historical contexts (1999:13). Hence a number of factors contribute to the risk of HIV infection and these factors include gender and sexuality. In this chapter I shall try to show how men's and women's risk of HIV infection is influenced by the positions they occupy in the gender and sexuality discourses.

In Ethiopia marriage has been considered as the best means of avoiding risk of HIV infection as it promotes one-to-one sexual relationship. I believe it is important to give sufficient consideration to power relations and cultural expectations in influencing married women's and men's possibilities for avoiding risk. Hence, the major aim of this chapter will be to create a counter-discourse to the dominant risk discourse and its narrow perspective on risk groups by focusing mainly on a group

which is normally considered as 'not at risk' by the dominant HIV/AIDS discourse in Addis Ababa.

The first section of this chapter briefly looks at the construction of risk in the dominant HIV/AIDS discourse in Addis Ababa. The main objective of this chapter is to look at the relationship between power relations and risk of HIV infection. Hence, the major focus of the second section of the chapter will be on the counter discourse to the dominant risk discourse of HIV/AIDS. This section analyzes the institutionalization of gender and sexuality in marriage and related issues like divorce and reproduction.

6.2. Construction of Risk in the Dominant HIV/AIDS Discourse

In the HIV/AIDS prevention discourse certain societal groups are considered to be highly exposed to the risk of HIV infection. Although there has been a lot of efforts in Ethiopia to inform the public that AIDS could affect anyone, groups like prostitutes, truck drivers, soldiers and unmarried youth have been considered to be facing a higher risk of HIV infection because of the general assumption that they involve in multiple sexual relations. Even if blood contact and mother to child HIV transmission are considered to be among the main routes of HIV infection in Ethiopia, the focus of prevention programs has mostly been on the sexual transmission of the AIDS virus. Similarly a number of studies have been carried out on 'risk groups' like commercial sex workers, truck drivers, and unmarried youth (for these studies see Kloos 2001 and Pankhurst et, al., 2005).

During my fieldwork I have observed activities of two NGOs which specifically addressed groups which were considered highly vulnerable to HIV infection. Both organizations provided prevention education and health services to commercial sex workers. Young school girls and boys were also targeted by the NGOs. From among their various activities, it seemed that the organizations had laid greater emphasis on

distributing condoms. This was what a woman beneficiary at one of the NGOs said about condom distribution:

It is good that this organization provides us with condoms but for most of us the problem is not access to condoms. What is the use of having hundreds of condoms if you are unable to use them? Men don't want to use condoms (Informant 76).

This woman and a number of other beneficiaries of the organizations emphasized the point that women's access to condoms is not that important if men refuse to use them. In most of the peer education programs that I attended commercial sex workers asked questions that were related to their power positions in sexual relationships. One of the repeatedly raised questions of these women was '*How could we be able to use condom when our clients use force to have sex with us?'* Although there is no doubt that condom distribution is important, I am critical about prevention education programs which tend to leave the responsibility of avoiding risk of HIV infection to men and women without considering the web of factors that put them at risk of infection. The special focus of prevention programs on providing information regardless of how that information could be utilized may be seen in relation to the humanist notion of considering the individual as in control of his/her destiny (Hekman 1990).

A group of women who have been severely affected by coercive sexual encounters have been commercial sex workers (Mulumebet 2000). Similarly, some of the commercial sex workers that I talked to at one of the NGOs told me about their personal experiences in which they were raped by clients. According to them, it is quite common to experience rape as many of their customers preferred to have sex without a condom. They mentioned that bar owners who were mostly women, never tried to rescue them when they cried for help since these women did not want to lose their customers. One informant described her boss as *'inhuman who wouldn't mind if her workers die of AIDS as long as she gets her money'*. This woman was highly critical of men who prefer to have sex without condom when they are well aware of

the risk of HIV infection. With a smile on her face she narrated the following oral poem that one of her clients told her when she asked him to use condom:

ከነዱ ዲኤክስ:
ከሞቱ በኤድስ::

Kenedu DX (If you drive, drive DX /Toyota DX)
Kemotu beAIDS. (If you die, die of AIDS)

The Toyota DX was mentioned in the poem because a few years back the car was considered as a good quality car in Addis Ababa associated with class prestige. The woman described the man who narrated the poem for her as '*Tesfa Yekorete*/A frustrated man who had no hope in life'. She added that most of her clients are men who would not mind risking their lives for a brief moment of sexual gratification. She related these men's risk taking behaviour to poverty, unemployment and the resulting frustrations. She said it was common for her to listen to her clients narrate what she called 'overused' sayings like '*Having sex with condom is like eating a candy without removing its cover'.*

Young men and women have also been considered vulnerable to HIV infection. Some of the prevention activities I observed stressed that economic problem had been a major reason for young women's vulnerability. As some informants at Lideta stated, young schoolgirls involve in risky sexual relationship to get money for their education. Others also mentioned cases in which young girls go out with different men to bring income that would support their families. '*It is no secret that some young girls in my neighborhood come out on the street in the evenings and sleep with different men in order to get money',* said an informant. The same woman added the following:

I have to sell boiled potatoes in the evenings so that I could get some money to cover my school expenses. I have to support my mother too as her income is so little. Selling

potatoes on the street in the evenings is so risky since there are drunken men and street boys who rape women. Nothing has happened to me so far but I know a girl who was raped while she was out to sell boiled eggs (Informant 20).

This report may indicate the relationship between poverty and women's vulnerability to the HIV infection. Owing to this vulnerability prevention programs in Addis Ababa have designed specific activities addressing poor women. Although it is important that special emphasis has been given to protect certain groups from the risk of HIV infection, I argue that the designation of the label 'at risk' might serve to reinforce the marginalized or powerless status of individuals. Singling out certain groups as highly 'at risk' of infection could also be dangerous as it may indirectly imply that the group is responsible for the spread of HIV/AIDS. According to a study in two regions of Ethiopia blame is common in reaction to HIV infection. For instance, unmarried youth are generally blamed for being sexually irresponsible because they frequently visit bars and do not use condoms (MHRC 2004). In a similar vein Lupton (1999:114) says:

> The 'at risk' label tends either to position members of these social groups as particularly vulnerable, passive, powerless or weak, or as particularly dangerous to themselves and others. In both cases, special attention is directed at these social groups, positioning them in a network of surveillance, monitoring and intervention.

When we look at it from a different angle, the labeling of certain groups as 'at risk' of HIV infection could also have its own influence in masking the problem of AIDS. This is because certain groups might be alluded into 'a false sense of security'. Risk is a phenomenon that is highly influenced by social factors and power relations that underlie the social meanings that inform risk. In Ethiopia marriage has been considered as the best means of avoiding the risk of HIV infection. As the following section attempts to show, there is a need to look at women's position in sexual

relationships within marriage to have a better understanding of men's and women's risk.

6.3. Counter Discourse to the Dominant Risk Discourse of HIV/AIDS

As mentioned earlier, risk is a phenomenon that is highly influenced by social factors and power relations. In this section I shall try to analyze the relationship between men's and women's risk of HIV infection and their power positions in sexual relations and use this as a counter-discourse to the dominant risk discourse. Here the focus will be mainly on marriage, reproduction, infidelity and divorce. The reason why marriage is considered important in the analysis of risk of HIV infection is because sexuality is defined in a context of marital relations in Ethiopia.

6.3.1 Marriage and Risk

The best remedy to avoid HIV/AIDS is to get married because sex out of wedlock is risky (Informant 10).

This woman's opinion about avoiding risk of HIV infection was supported by most of my informants at Lideta. Moreover, during several of the HIV prevention activities observed, marriage was recommended as a way of slowing down the spread of the AIDS epidemic. Religious institutions also promote one-to-one relationships strictly within marriage. In this regard, some of my informants at Lideta highly stressed the need for observing the holy order 'one woman one man' in marriage at the time of HIV/AIDS.

Though men's and women's positions in sexual relationships are important, in Ethiopia sexual activity within marriage has not been thoroughly studied as sex remains a taboo subject (Rachel 2001, NCTPE 2003:134). In the case of the AIDS epidemic, I believe it is mandatory to look at sexual relations within the marriage

institution since most of the issues related to one's vulnerability to HIV/AIDS have relations to men's and women's position within marriage.

In Ethiopia, sexuality is defined in terms of heterosexuality and in the context of marital relations. Marriage is seen as a very important stage in the developmental cycle of men and women because getting married confers status and therefore power. Thus it is expected that upon attaining the appropriate age, one should be married to show that one is a proper man/woman. As mentioned earlier, in relation to risk of HIV infection, marriage is considered as a means of preserving one's safety. '*Keadega Yitebikegnal/It keeps me away from danger'* responded a married woman at Lidata describing marriage as a means of avoiding risk. Another woman said the following:

A married man doesn't have time to waste outside his home. His attention is focused on his family. He might be tempted to look around but he would come to his senses the moment he thinks of his wife and his children waiting for him at home. That keeps him away from risk of HIV infection (Informant 16).

This response describes marriage as a means of protection from risk. As Bujra (2000:71) noted: *"there is a clear hierarchy of risk in many people's minds with those deemed 'inside' (at home, not moving out) to be safe, whereas those 'outside' represent a series of levels of danger".* It seems that women, by contrast, have always stayed at home, paradoxically giving them a false sense of security.

Although most of the married women I talked to said they did not suspect that they would be at risk of infection, after a long conversation, some of them gave hints on their worries that they could also be at risk. Some women even went as far as blaming men for *'bringing AIDS home'*. There were also men who mentioned that it is difficult to totally trust a wife even if the partner stays at home all the time. When asked if they shared their worries with their marriage partners, most of these men and women said '*no*'. What is interesting is that more men than women said they could express

their worries to their marriage partners if they felt that they couldn't trust them. Most of the women emphatically stated that it was very difficult to discuss issues of trust with their husbands. Some of the women even asked back '*How can I tell my husband that I don't trust him?*'.

This opinion indicates that men and women have different power positions in sexual relationships. Not trusting a marriage partner and hiding the issue may indicate that elaborate games are played out in the conjugal bed with each partner pretending to trust the other, because the consequences of not doing so will in themselves induce mistrust. Both men and women informants regretted the way that AIDS had transformed trust into doubt. '*Wond Minu Yitamenal*?/Men can't be trusted' was the response of some female informants. But inconsistently perhaps, these same men and women put their faith in trust saying that '*Egzer Yetebikenal*'/God will protect us'.

There were some informants at Lideta who went to the extreme and suggested that it is better to stay lonely than involve in any kind sexual relationship including a relationship within marriage to avoid risk of HIV infection. This point may indicate that the epidemic has eroded the trust between the sexes. It is also a reminder that the notion of faithfulness deserves a closer scrutiny in relation to the issue of risk in HIV infection.

If men and women are afraid that their marriage partners might infect them, it indicates that the traditional form of sexual union, that is, within the marriage form, does not seem to guarantee safety from HIV infection. The following section attempts to probe deeper into the relationship between risk of infection and the power positions men and women hold in marriage in Ethiopia.

Men's and Women's Power Positions within Marriage

I was a very good student at school and I had a dream of becoming successful in life. My hope of becoming someone was dashed when I was forced to get married to a

man whom I had never seen before. Now that I have three kids to take care of, there is no way I could go to school again (Informant 15).

This woman also told me that she tried hard to escape the arranged marriage but with no avail. She mentioned that she wished to fulfill her dream of going to school again, by not having kids. Since it was her husband who decided on sexual matters within the marriage, she said she was forced to have children. A number of my female informants at Lideta had similar experiences in which they were forced to marry and have kids, when their wishes were otherwise. Most of these women came to Addis Ababa leaving their marriage bonds in the rural Ethiopia. The women's actions of running away from home will be discussed in more detail in the section that deals with resistance.

Most of my interviewees at Lideta said it is men who are given the mandate to demand sex while the woman is duty bound to fulfill the desires of her husband. To support her point a woman said *'Liyayat Alagebat'* /A man doesn't marry a woman just to look at her and admire her'. It is the opinion of a number of women that a man might seek an outside lover if he cannot have sex with his wife. This is related to the notion that will be discussed in the following chapter that men's sexuality is uncontrollable. The attitude that a woman should serve the sexual needs of her partner no matter what has a negative implication as it does not give women the negotiating power to avoid risky sexual encounters.

In line with this consideration, women tend to be socialized into a concept of sexuality which is often extremely directed - as a young woman; a wife; a lover; a mother. At Lideta, my female respondents themselves told me that a girl should possess all the qualities of a good woman in order to attract a man who would marry her. According to most of these respondents, a girl should not only have good looks but also good character to be identified as marriageable. In support of this point, the following well- known oral poem was recited by a woman:

መልካም ጠባይ ያላት የወለዱ እንደሆን፡
ታመጣለች አማች ብረት መዝጊያ የሚሆን።።

If your daughter possesses good character,
She will bring you an in-law who is as strong as a metal door.

The oral poem indicates that parents look for a strong in-law but this strength does not only refer to his physical looks. The poem implies that parents look for in-laws who are financially secure and who are also capable of playing a protective role in relation to the girl's family. In marriage arrangements in Ethiopia parents try to maximize the economic advantages of their children and indirectly their own. Here we could see that marriage is linked to economic security and hence power. My informants told me that parents prefer to enter into conjugal ties with those from districts furthest from their own to have more connections. For the same reason, some of my informants said they were married when they were in rural areas to men of different districts..

Some of my informants at Lideta asserted that women should get married at an early age to bear children while most preferred to provide the common reasons *'Bahilachin new*/It is our tradition' and *'Yegzer Fekad New*/It is God's will'. The Bible was also mentioned by a number of informants as a reason for men and women to get married. As Blackwood (2000:224) noted, sexual meanings are produced through any number of factors, including religion. These factors provide the context for the development of sexual relationships, desires, and longings. In the case of my informants, the Biblical verse '*Gabicha Kibur New*/marriage is sacred' was mentioned by some as a justification for their strong support for marriage. '*According to church doctrine, marriage is not an invention of human society; it was instituted by God the Creator'*, one informant explained. According to this informant, sex between husband and wife has a double purpose, of procreative and unitive functions. She added that marriage is to draw man and woman closer together for their spiritual growth and for procreation.

I always wanted to pursue my education but since there was no one to support me after my mother died, I had to get married. It was my aunt who arranged the whole thing. Although I know very well about AIDS, I didn't ask my husband to take HIV test. I never had sexual relationship before I got married but I can't say the same thing about my husband (Informant 4).

This woman added that she did not ask her husband to take HIV test before the marriage because that was 'too embarrassing' for her. Similarly, some of my respondents at Lideta said they were unable to postpone marriage because they had no income to live on. As my data show, AIDS in Ethiopia cannot be separated from extreme poverty and unemployment. My informants expressed their worry that the number of women who rely on sex and other forms of street work for all of their income is growing to a considerable extent increasing the risk of women's infection. According to them, women's economic dependence on men further curbs women's sexual license. This indicates that when gender influences one aspect of life such as men's and women's positions in the economy; it also influences other aspects of life, including sexuality.

Although a number of my informants mentioned religious and economic reasons for getting married, tradition plays a vital role in marriage in Ethiopia. *'Set Tolo Magbat Alebat/*A woman has to get married soon', was what most informants at Lideta said. A name with a very strong negative meaning is given to a woman who did not marry. This name is *'Komma Ker' (*literally translated as 'one who is not moving anywhere' but with figurative meaning 'unwanted'). The name is also used as an insult. A national survey reported that, unless there are compelling reasons such as abject poverty, very low status etc., almost all women in Ethiopia are married by the time they reach the age of 20 and all men by the time they are 25. The Ethiopian Church seems to view 15 years (the age difference between Adam and Eve) as the optimal age for marriage (NCTPE 2003: 125-126). The average age difference between couples in Ethiopia is about 8 years but much larger differences, 15 years and more,

can be found among polygamous communities. This big age difference between a couple in Ethiopia is indicative of men's stronger bargaining power in sexual relations. And, the lesser women's bargaining power in sexual relationships, the lower their power to avoid the risk of HIV infection.

Early marriage is common almost in all the regions of Ethiopia. My informants told me that marriage could be at a very early age, between 4 to 5 years, or even as early as when the girl is still in her mother's womb. The marriage ceremony could follow soon but often the bride does not go to her bridegroom's home until she is 10 to 13 years old. In some cases, the child stays with her in-laws. The girl is often forced to have sexual relations even when her body is not mature enough. This causes problems at delivery and damage to the uterus sometimes leading to death*.

A number of my informants told me that oftentimes the young couple did not meet before they were married. The new wife went to live in the household of her husband and was under the strict supervision of her mother-in-law. Marriage presented an especially frightening prospect for girls since they are married out of their village. Among most of the highland agricultural population (Amhara, Tigray, Oromo), marriage is usually arranged by parents or relatives. Where early marriage is frequent, informants told me that the child, in particular the girl, is in no position to understand what is going on, let alone to participate in decision making. If the wife has no say in selecting her marriage partner, it is not difficult to realize that she is less likely to know him and still less about his sexual behaviour. She might hence join in marriage a man with risky sexual behaviour that might expose her to HIV infection.

Most of my female informants at Lideta were victims of early marriage. These women had to struggle to tell me the horrifying experience they had during their

* My informants strongly criticized the practice of early marriage because of its consequences like fistula, a disease that results from the rupture of a woman's bladder due to prolonged labour. Since they do not have access to medical treatment, a large number of women die during childbirth or suffer from fistula and other diseases. An expert in one of the NGOs also mentioned that Ethiopia is topping the world list when it comes to the death of mothers.

childhood days. Some were so adversely affected by the practice that they had to flee to the city to run away from it. This is what one of the women said:

When I was 13, I was married off to a person I hadn't seen before. I only knew about the marriage when my parents started to prepare for the wedding. My long suffering started on the night of the wedding when my childhood husband forced me to have sex with him. I can't describe the horrible experience I had each evening. My only option was to run away from him. I am glad that I did run away but even after 11 years I still hate sexual intercourse. I think this hatred is the result of what I had to go through during my childhood days (Informant 27).

From the strong critical comments this woman gave on men, I was able to sense that not only her opinion regarding the sexual act but her general attitude towards the opposite sex might have been colored by what she had experienced as a child. We could also guess that women with such experiences might develop feelings of hopelessness and helplessness which might result in their having less negotiating power with sexual partners and hence less resistance to risky sexual encounters.

My fieldwork showed that there was a fair degree of awareness of the harmful consequences of an early marriage among my respondents. A survey result also showed that 86.8 percent of the Addis Ababa population is aware of the harmful consequences of an early marriage. It is indicated that 70.5 percent of the rural and 83.5 percent of the urban population is well aware of the harmfulness of an early marriage. However, the same survey states that early marriage is still widely practiced in Ethiopia and there is no appreciable difference between male and female level of awareness (NCTPE 2003:144).

The above figures may indicate that awareness is not enough to alter the situation since such practices are the result of varying underlying socio-cultural factors. As such, it is obvious that there are explanations to keep up the practice despite the harm it does to men and women. It is a great source of pride for parents to be approached

for the hand of their daughters. As mentioned earlier, the economic factor also plays an important role in early marriages. When a family has a child, male in particular, they start looking for a family of an equal or better economic status with which they could connect through marriage.

Some informants told me that an early marriage limits threats like loss of virginity, premarital pregnancy, and loss of face and maximizes advantages. The girl child, the wife-to-be, is seen by her own family, as a source of potential advantages to be controlled and disposed of as they see fit. I am critical about the view that female sexuality can be destructive and dangerous if it is not controlled, repressed and regulated. This is a power used to suppress the sexuality of women.

Some informants told me that young girls need the protection of their husbands, as they are too young and inexperienced to know the difficulties of life. This argument shows that early marriage is one of the most effective ways of ensuring control over a young girl's productive and reproductive labor by inculcating the norms of obedience and subservience to the older 'father-figure' husband at an early age. This is also directly related to a control of the girl's bargaining power in sexual relationship which increases her risk of HIV infection.

I got married when I was 35. I can't tell you how miserable I was the last six years before I got married. Some of my relatives were asking me why I was still single when I was a good person and also beautiful. Although she didn't say much not to hurt my feelings, I could feel that my mother was so worried. I was praying day and night to get a man. The pressure was so strong that I didn't care about whom I would marry. I just wanted to get someone to marry so that I could make my family happy and relieved (Informant 14).

In Ethiopia, inability to get married is perceived to be problematic. There is a common expression in Amharic '*Abebawa Sayregif Set Lij Tagba* /A girl should get married early before her flower falls'. This expression itself is indicative of how

society values early marriage and puts pressure on girls in different ways for its practice. Unmarried women decide to get married to whoever comes their way in order to escape the societal pressure and stigma. Moreover, parents start to feel ashamed when daughters stay unmarried because of the same pressure from relatives and the community at large.

Society exerts pressure on women to involve in early marriage in different ways. Some informants at Lideta pointed out that a woman may remain single because of destiny. Hence, a woman who did not get married at an earlier age is considered as *'Idile Bis/* unfortunate or unlucky'. This opinion was shared by a number of my informants, both men and women. Most of them were not able to give any specific reason as to why they believed that women, unlike men, should get married at an early age. For them this was a form of order set by tradition and their stock response was: '*Bahlachin New/*It is our tradition'. According to Schwartz and Rutter: "*traditional norms of marriage and sexuality have maintained social order by keeping people in familiar and 'appropriate' categories*"(1998:19). In her Amharic poem, Wudalat (2004:13) also portrays this order set by tradition in Ethiopia:

> I am not allowed to propose
> My desire and aspiration refused
> Decided by customs and cultures
> That a girl has no right to choose
> To marry a man of her wish
> But people advise me against
> As if they do not know the customs
> That forbid girls to go by their desires
> They sense there is something amiss
> And urge me to marry before late it becomes
> Pretentious they are, they know nobody cares
> For the desire and consent of girls. (Translation taken from Zerihun 2005:10)

As it will be discussed in detail in chapter seven, the Ethiopian society upholds premarital chastity for both girls and boys but female sexuality is largely constructed in relation to a perceived male sexuality and pleasure, and is intimately linked to reproduction. During my fieldwork I found that there is a deeply entrenched perception in Ethiopia that sex is bad unless it relates to reproduction in marriage. It is my contention that this perception affects women's bargaining power in sexual relationship and hence increases their risk of HIV infection. What the following discussion tries to show is that traditional practices deprive women completely of any bargaining power in sexual encounters. A case in point is marriage by abduction. Consider the experience of a girl in this connection:

It was one bad afternoon that this horrible accident happened to me. As usual I went out to fetch water. After I walked for about 15 minutes, I heard some people talking. Before I moved my head to see who these people were, my hands and legs were grabbed forcefully. I was unable to move. It took me some minutes to realize that I had actually been abducted. The abductors took me to a house and I was raped. It was the next day that my family came to know what had actually happened to me and I was rescued. I was lucky to be rescued because most women are forced to marry their abductors. My father was different from his age group and refused the offer given by the abductor. Although I was lucky that I was not forced to live with the criminal, my life has been affected by this experience so much (Informant 19).

This informant did not have words to describe her overwhelming feeling of powerlessness after the abduction. Her face was covered with tears while she was describing her experience. This woman said that she always had a feeling of shame for what had happened to her. She added that it was only to a few people in Addis Ababa that she told this childhood experience of hers because she felt very ashamed of it. This may indicate the power of traditional practices like abduction and the way they suppress resistance, by harming women and making them feel guilty at the same time.

There has been a high frequency of occurrences of marriage by abduction* in most of the regions of Ethiopia and it is practiced even in the capital, Addis Ababa. Different informants at Lideta narrated abduction incidents almost in the same way. According to their narration, the abductor forms a group of intimate friends and relatives for the act. The movements of the girl are studied and a plan made for the abduction. The group grabs the girl and carries her off while she goes to school or to fetch water for example. If she shows any resistance, she is forcefully dragged or carried on the shoulder of the abductor, who might beat her to subdue her. The girl is then taken to a hideout prepared by the abductor.

Sexual intercourse (rape) occurs almost immediately, said my informants. This is considered important in terms of burning the bridges and presenting a *'fait accompli'* to the girl's family, as in most communities, a girl who has lost her virginity is not marriageable. Elders are then sent to the girl's family immediately to ask for their consent and blessings for the marriage. Mostly these elders put pressure on the girl and her family not to take their case to police or court. Maltreatment of the girl including beating and suffocation sometimes causes disability or even death. It is also reported by the informants that some of the girls develop severe psychological problems and some even commit suicide. As rape occurs after abduction, a girl faces the risk of sexually transmittable diseases including HIV/AIDS (Konjit 2000:15). Some of my informants said that one of the reasons for the spread of HIV/AIDS in rural parts of Ethiopia is abduction.

Although only a few of my informants at Lideta had actually experienced abduction, most of them said they had a very good knowledge of the practice since they had witnessed it happening to close family members. Some informants told me that their sisters were abducted while many more said they saw it happening to their friends, relatives and neighbors.

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* Marriage by abduction could take place for two reasons. Men decide to abduct and marry a girl mostly when they feel that they might not get consent from the family of the girl for marriage. There are also cases where a poor man abducts and marries a young girl because he could not afford to cover the expense of a wedding ceremony. In this case the man abducts the girl with her consent and this is called elopment.

Not a single person among my informants was in favour of abduction. The traditional practice was referred by some as 'barbaric' and 'backward'. All informants asserted that abduction is a harmful traditional practice that should be stopped without delay. They also suggested that women should play their role in that. Two of the women narrated the story of Amina, a woman who became a victim of a series of domestic violence before she brought her case to a court of justice with the help of the Ethiopian Women's Lawyers' Association (EWLA).

Amina Kasim was forced to marry her abductor while she was 14 years. Her abductor repeatedly beat her in her 14 years of marriage and he finally cut off both of her ears at the presence of her 8 years old child (*Reporter* 3 July 2005:50). The two informants cited Amina's life as an example of one of the worst cases of abduction. Amina's case had come to be known to the public due to its media coverage. My informants added that domestic violence is a common practice in Ethiopia which mainly affects women victims of early marriage and abduction. According to them, some women are forced to stay in relationships where they face the risk of contracting the HIV virus because they are afraid of violent practices like severe beating.

In some communities in Ethiopia, the act of abduction is considered a sign of assertiveness and bravery and an expression of the male ego (NCTPE 2003:159). This is one of the themes in a popular play, *Telfo Bekise* ("Marriage by Abduction") by the prominent Ethiopian playwright and poet Mengistu Lemma. In this comic play, the abductor and his friends had a long and heated argument on whether to keep the abducted girl or to let her free. Interesting points were raised in this argument, points that vividly depict the relationship between bravery, manhood and abduction in Ethiopia. The father of the abducted girl was very furious by the news of his daughter's abduction and he even threatened to kill the abductors. In this comic play, young educated men abduct a young girl saying '*We are proving that we are men today'* (1969). As Molvear (1997:280) says, the author uses the play to criticize

'modern educated young men, who are all talk and unwilling to act radically for social change'.

Young brides in Ethiopia are subjected to sexual encounter by force. As mentioned earlier, the Ethiopian society upholds pre-marital chastity for both girls and boys mainly for religious reasons. Except in a few ethnic groups in the South, premarital sex is strictly prohibited. Virginity is a sign of purity and honor among the *Oromo, Amhara, Tigray*, and most of the large ethnic groups in Southern Nations, Nationalities and Peoples' region. In many regions of rural Ethiopia a girl who is not a virgin on her nuptial night would not only be beaten by her husband and humiliated in a number of other ways but would also risk being sent back to her family (NCTPE 2003: 132-133).

For most girls in rural Ethiopia, the wedding night is a night of dreaded anticipation. The cultural norm is to resist the intimacy and, in some ethnic groups, elaborate measures are taken to weaken the girl. On the night, the groom enters the bridal hut/room while in most cases the singing and dancing continues outside. He tries to force her, sometimes beating her in the process, until he deflowers her. The exploit is then communicated to the jubilant crowd outside. Thus, the first sexual experience for a girl could be called an 'institutionalized rape' (NCTPE 2003: 132-133). Holding a whip during the marriage ceremony as a symbol of the groom's dominance is common in many ethnic groups. The bridegroom holds a whip during the marriage ceremony in *Arsi* as a symbol of masculinity and the right to beat his wife if she refuses intercourse.

In this situation where the woman is forced to have sex, there is no way that she could avoid risk of HIV infection. As most rural areas do not have medical centers near by let alone HIV Testing Centers, it is unlikely that a women will have a chance to make her would-be husband tested for HIV. Even in areas were there are testing centers, people would find it difficult to ask for HIV test as such a demand could easily be related to the issue of trust. As it was discussed in detail in the forth chapter that dealt

with HIV/AIDS prevention programs, the fact that sexuality is a taboo subject also makes HIV testing difficult.

Although most of my informants were well aware of the risk of HIV infection due to early marriages and arranged marriages in the countryside, they were unable to suggest ways of minimizing risk. Some of these informants pointed out that they would support the idea that marriages take place in the traditional way in cases where they are arranged by parents. Almost all of these informants were unable to give explanations to their viewpoints but said *'This is how it is and it should continue like this'*. When I probed further, the common answer given by these respondents was '*Bahilachin Newa*!/This is our tradition of course!'. Some gave this answer with a look of amusement on their faces surprised by the very fact that the issue was brought up for discussion. This indicates that dominant discourses of gender and sexuality have been imposed by deeply entrenched societal customs, values that may not be necessarily supported by specific reasons for their existence. As the following discussion shows, not only commercial sex workers but married women could also have limited bargaining power when it comes to sexual encounters.

One of the topics of discussion during my fieldwork was the issue of expressing one's sexual needs. Most of the married women at Lideta said they wouldn't dare to discuss their sexual needs with their husbands. According to them, a woman who dares to discuss sexual matters with her husband might be considered *'balege/*indecent'. For these informants, it is simply 'n*ewir*' /taboo*'* and also untraditional for a woman to ask a man to have sex but she could show her interest in different ways. One of these ways was trying to express her interest in the way she dresses. Three of my young female informants had a different opinion and said that women could express their sexual feelings openly but added that '*It would be weird if women ask men for marriage'*.

According to most women at Lideta, a woman should not express her interest in a man. The women added that if a woman initiated a relationship and succeeded in

marrying a man, the man would not show respect to the woman. He would become too proud and could tell her that she '*begged him to marry him'*. The result of a national survey in Ethiopia also shows that the overwhelming majority (78%) of the participants did not accept the idea of a woman asking a man for marriage (Habtamu et al. 2004:22&80).

This means that parents and mostly boys are the ones to make the selection and the marriage proposal in Ethiopia. Sixty three percent of Orthodox Church followers in Ethiopia preferred to abide by the choice made by elders and relatives (Habtamu et al. 2004:22 and 80). As this number only represented what people preferred rather than what really happened, I suspect that the practice could be more wide spread than what the figure showed. The point is that even the survey results indicate that women's bargaining power in sexual matters within marriage is limited.

In a similar vein, some informants at Lideta said it is better if a woman should try to look less knowledgeable when it comes to sexual matters. The reason provided for this was that the husband might feel uncomfortable suspecting that his wife's interest in the matter indicates her high sexual appetite, which is considered 'dangerous' for a woman. The informants added that the man also might suspect that the woman had an extramarital affair and that the affair could be the source of information. Moreover, some of my informants said that a man is expected to be knowledgeable in the area of sexuality. This different view regarding men's and women's knowledgeability on sexual matters can be related to the active/passive metaphor. "*Women do not pursue; they await pursuit"* (Haste 1993:78). In the words of an informant:

A woman has always to be ready to please her husband in every way and that mainly includes sex. If a man is not happy with his sexual relations at home, he might go out and look for alternatives. He might even go to a prostitute. In order to keep her marriage safe, a woman is required to do whatever she can to please her husband (Informant 1).

This requirement is forcefully articulated in a discourse that aligns women's sexuality with men's desires. Thus, 'good' women save themselves for and desire only their husbands. Other options may be imaginable, since men are known to have other sexual contacts but the harsh consequences for women in most cases foreclose any thought of going beyond the permissible. On the other hand, 'bad' women like prostitutes are expected to fulfill men's sexual desires. From what the women respondents at Lideta said, it is clear that gender discourses are critical to the production of men's and women's sexualities in Ethiopia. Such discourses work to produce very different possibilities for men's or women's understanding of their desires and their access to other sexual partners.

In some of the HIV/AIDS prevention activities of the two NGO's and the Women's Association that I observed, the use of condoms was highly promoted. As it was discussed in chapter five, the Ethiopian society is a religious society which gives high regard to religious rules and traditions. Both the major religions in Ethiopia, the Orthodox Christianity and Islam, prohibit the use of condom due to the religious conviction that it encourages multiple sexual relationships. For most informants at Lideta who considered themselves religious, the use of condom was out of question since it is against their religious belief. Some of these women displayed embarrassment and shock even at the naming of the item 'condom' and preferred to call it *'Ya Neger /*That thing'. I also found that even some of the informants who thought condoms should be used, believed that they were defying religious rules. In this condition, it is easy to realize that men and women would be in a difficult position to avoid risk of HIV infection since using condoms might mean not adhering to religious principles.

Similarly, the majority of the women at Lideta told me that it is highly embarrassing for a woman to ask her husband to use condom since condom use raises the issue of trust and the reaction from the husband is expected to be very much negative. As we know, condom is a device encapsulating safer sex and adopted to reduce risk - particularly in situations where there is no trust. At the same time, condoms are

themselves seen as risky and dangerous, whilst their use, rather than inducing trust in partners, actually symbolizes and augments distrust. This is because marriage is said to be based on trust and the question of condom use will put the trust into question. One of the women whom I asked about this issue said *'Balen Kondom Kemiteyik Bimot Yishalegnal/*I prefer to die rather than to ask my husband to use condom'.

Not only do women have problems asking their husbands to use condom, some female informants told me that it is likely that husbands could force their wives to have sex. For these women, it is totally unthinkable for a woman to refuse to have sex with her husband for fear of reprisals. A refusal is bound to end with a beating. Although none of them mentioned that they had such an experience, it was easy to notice from the way they commented on the issue that they felt it could happen to anyone. When asked if a woman resists the use of force one informant said, '*Wend New Yefelegewin Madreg Yichilal/* He is a man. He can do whatever he likes'.

The issue of the use of force in sexual relationships is quite important since a person who is coerced to have sex will be in an unlikely position to avoid risk of HIV infection. As it was discussed earlier, the notion of considering sex as a man's domain is highly prevalent in Ethiopia. This provides men the right to have sex even by force. Another area that shows men's and women's different power positions in sexual relations is reproduction. The following section discusses the relationship between marriage, reproduction and risk of HIV infection.

6.3.2. Reproduction and Risk

የዛሬ አመት የዛሬ አመት (Yezare Amete Yezare Amete)
የማሙሽ እናት (Yemamush enate)

By this time next year, mother of a son.

A wife is seen as a source of children by her husband and kin. On her very wedding day, a young girl is told that a year later, she is expected to give birth to a baby boy. There is also a widely used saying '*Lij Belijinet*/One has to give birth to a child while still a child'. Some of my informants referred to the pain of young women during the anxiety-ridden waiting for her first child. They said women had to take the burden of repeated pregnancies and the anxious expectation of the male child if the first is female. The Bible was mentioned by some informants to explain the fact that marriage without children is incomplete. Two women at Lideta quoted a Biblical verse: '*fertile and multiply and fill the world*' *Genesis 1:28.*

The main objective of marriage, according to most of the respondents at Lideta is having children. For these men and women, marriage without children is '*Yaltebareke* /Not blessed'. Moreover, children are said to play the role of 'cementing' marriage by bringing joy to the home. According to a national study, the two top responses given to the question that asked about the major objectives of marriage were to bear and to rear children (Habtamu 2004:81) The common Amharic saying *'Weldo Mesam Zerto Mekam Kehulu Yibeltal*/To kiss your new born baby and to enjoy a harvest mean more than anything' also supports this point. Usually a childless woman is regarded as a failure, and is pestered by in-laws for not bearing children. McFadden (1992:169) also notes that in most African societies, sexuality and fertility are still treated as synonymous, and a woman's sexuality is closely related to her reproductive roles as a mother and wife/lover.

Some of my female respondents at Lideta told me stories of women who had to run away from their homes due to the frustration of not having children. They also mentioned that women could end up in prostitution as they try as far as possible to run away from their villages and come to cities to avoid the humiliation of being labeled '*fruitless'*. This is because the common Amharic expression used to describe a woman who could not have a child is *'Fere Yelatim* /A woman who has no fruit' or '*fere alsetatim/* A woman who is not given fruit by God'.

Two of my respondents narrated in great detail how much pain they had to bear for not being able to have children. One of the women told me how the family of her ex-husband had almost lost hope after two years of her marriage. She said she was so stressed out that she had nothing else to think about but her inability to conceive. She told me with a big smile how relieved she was when she found out that she had conceived. According to Rachel (2000:9), in Ethiopia "*No matter how rich, successful or poor a woman is her worst fear is, the stigma of being left a 'spinster' or a 'barren'*".

In Ethiopia, reproduction relates to divorce. According to my informants, inability to conceive relates to risk of HIV infection as a divorcee may involve in multiple sexual relations until he/she gets children. Several examples were given by these informants in which 'barren' women in the countryside came to cities exposing themselves to risky sexual encounters and HIV infection. A commercial sex worker that I talked to at one of the NGOs had a similar experience. This woman came to Addis Ababa leaving her husband and family because she was unable to give birth to a child. She was exposed to the risk of HIV infection as some of her clients forced her to have sex without condom. Another informant, an elderly woman of 68 years, vividly remembered the humiliation she had to bear for being unable to have a child. She was married to a middle aged man while she was only 15. She tells her story in the following way:

After three years of my marriage, I started to lose hope of having a child. I was so unhappy that I didn't know what I should do. I prayed and prayed but it seemed that God didn't want to listen to my prayers. My husband was a very kind man and he never tried to hurt my feelings. But one morning he told me that he and his family had a plan to bring another wife for him because he wanted to have children. I felt so humiliated and that same day I ran to my parents' home crying all the way (Informant 5).

As the story of this woman shows, infertility could be a good reason for divorce. Two of my respondents had a similar experience where one of them had to divorce her husband because the man decided to marry another woman as she was unable to have a child during the first four years of her marriage. Luckily, this woman got children from her second marriage after fleeing to Addis Ababa from the village of her birthplace. She told me that her first husband died recently without having a child but it was she who was blamed for not conceiving a child due to a widely held notion that women are the causes of infertility within marriage. After 19 years, she had a fresh memory of the demoralizing comments she had to take from relatives of her husband for not conceiving. She remembered her sister-in-law telling her brother that there was no need for him to work hard as there would be no one to inherit his property. It is easily realizable that such humiliating comments could push women into directions that they have not ever planned to follow.

As most of my informants had their childhood days in rural parts of Ethiopia, they had similar stories to tell about the decisive place procreation has in sustaining marriage. Living in urban Addis Ababa at the time of our discussions, these respondents could compare the life of rural women with that of women in urban areas. According to them, the societal pressure demanding married women to bear children is stronger in rural than in urban areas.

I must mention an interesting point in relation to reproduction. This point relates to a couples' possibility of having a child out of wedlock. When one of the married couples is unable to conceive, there are ways to solve the problem but these ways have double standard for a man and a woman. According to an informant:

If a woman has a health problem and could not have a child, the man should go out and give birth to a child through another woman. He could bring the child so that his wife could raise him or he could keep the child with the mother. If the husband is the one who could not give birth to a child, there is nothing to do. The wife cannot have a child through another man. She should stay with her husband (Informant 22).

This woman's opinion was shared by almost all my informants at Lideta. Except one young man and two women, there was no respondent who could imagine the possibility of a married woman having a child through another man rather than her husband while still living with the husband. As the above report shows, a man unable to have his own child has an option to rescue his marriage as his wife is expected to stay with him but if it is the woman who is unable to conceive, it is very likely that she loses her marriage right.

According to the majority of the informants, if the husband could not have a child, his wife should stay with her husband no matter what, sacrificing her dream to have her own child in order to keep her marriage. According to them, the man is allowed to leave his wife by divorcing her if she is unable to bear children. But if the man decides to live with his wife, he could bring his own child so that the wife could raise the child. The common expression used by most of the informants was '*Isu Kewich Woldo Yamta, Isua Gin Atichilim*/He can have a child through another woman but she can't'. Here we see that having children is related to divorce, predisposing men and women to multiple sexual relations.

This avenue through which some men are seeking to deal with the need to have children have grave implications for their reproductive health predisposing them to having multiple partners and exposing them to HIV infection. Since mostly couples do not undergo medical checkup to find out who is unable to conceive, and due to the belief that it is usually women who have problems, men develop relations with different women to get children when they are the ones who could not have children. It is easy to realize the risk of HIV infection for such a man, his wife and the other women when he tries to have a child by having a number of sexual relationships outside his marriage. Another related issue that requires attention is infidelity within marriage since unprotected multiple sexual liaisons are considered to be major factors that expose people to HIV/AIDS.

6.3.3. Infidelity and Risk

In Ethiopia, marriage arrangements and types of marriage vary greatly. As it was discussed earlier, arranged marriages are quite common in rural parts of Ethiopia. But in cities like Addis Ababa marriage by personal choice is the predominant practice. Although one- to-one relationship in marriage is considered the general norm in Ethiopia, there are cases in which multiple sexual relations in marriage are supported by culture. Exchange marriage is still practiced in certain areas*. Marriage of inheritance (levirate i.e. widow inheritance)† is practiced in some Oromo areas and by some ethnic groups. Surrogate marriage i.e. marriage of usually a younger sister in replacement of her dead sister, is practiced in some areas. Here it is not at all difficult to realize that such practices predispose men and women to multiple sexual practices.

The Ethiopian Family Code (2000) recognizes civil, customary and religious marriages.‡ Most households in Ethiopia are monogamous but polygamy is also practiced all over the country. Christian churches discourage polygamy but it is not unusual to find polygamy among Christians. Polygamy is also practiced among the Muslim in Ethiopia. There are substantial regional variations in the prevalence of polygamy with the highest percentage in Gambella (29 percent), the lowest in Amhara (2 percent) and Addis Ababa (2.4 percent) (NCTPE 2003).

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* In certain ethnic groups in Ethiopia, a man has to have a sister to give in exchange to a girl he is going to marry from another family.

† In some ethnic groups in Ethiopia a widow will be made to marry the brother of her dead husband.

‡ The legitimacy of most of marriages in Ethiopia is sanctioned at the community level by customary law. Elders from both the bride and the bridegroom sides witness the conditions of marriage which are called *Semanya,* These conditions are generally put in writing. The civil marriage is conducted by the municipality where the couples would be registered as legally married. Religious marriages are conducted by religious institutions. To take as an example, the Orthodox Christian religious marriage, the ceremony of holy matrimony will take place at church. Holy Matrimony is a sacrament in which the priest prays and blesses the bride and the groom who make their marital vow in church. In the matrimonial ceremony the priest recites the prayer of matrimony *(Teklil).* Although there are cases in which couples marry at church without holy communion but it is the decree of the church that young Christian couples should fulfill their legal marriage in Holy Communion (Kefyalew 1998 37-48).

There were a few women at Lideta who said it is necessary to forgive a husband who had a sexual relationship outside his marriage as long as he did it secretly and safely. The reason they mentioned for tolerating such an act was that men's sexual appetite is strong and uncontrollable. The problem with such a perception is that it encourages men to indulge in multiple sexual liaisons. According to my respondents, a man found to have extra-marital sexual relationship might be warned or cautioned but a woman who had a similar relationship has to be severely punished. Her action is taken as an abomination and a defilement of womanhood and a bad example for her children. Beating is a common punishment for a woman found to be involved in an extra-marital affair but it is also very likely that she loses her marriage right.

As mentioned earlier, this double standard is mainly the result of the widely accepted view that men have a greater sexual interest than women; hence they should be allowed to have more freedom than women. Most of the women I talked to were against the infidelity of men but a number of them believed that it is difficult to control men's sexuality. This point highly relates to the attitude that women should do everything to please men sexually. This is what a woman said:

Women are always ready to fulfill men's sexual demands not because they are happy to do so all the time. A close relative of mine is a very sick woman but her husband always comes home drunk and forces her to have sex with him. This woman is willing to do whatever her husband asks because he threatens her to leave her for another woman if she refuses to meet his demand (Informant 16).

The woman quoted above told me that her relative did not tell this to anyone but her, because they are very close to each other. Although she thinks that her friend should not be forced to have sex while sick, she believes that in marriage priority should be given to men's sexual demands. Similarly, a number of male and female informants supported the notion that a man has to play the major role in sexual relationships. This is but an indication of the pervasiveness of the norm of female passivity in sexuality. My material shows that cultural practices in Ethiopia promote the system of

keeping concubines, indulgence in multiple sexual liaisons and the double standard of morality which condones male promiscuity. All these practices increase men's and women's vulnerability to HIV infection since it is not common to protect oneself by using condoms.

In Ethiopia, an issue that could be considered as subversion to the norms of traditional marriages is the issue of concubines. Though the dominant view, which is largely informed by religious morals and ethics insists that sex should be for reproduction, profit has come to play an increasing role in determining why, when and how sex is performed. As a study on early 19th century Ethiopia stated, despite the church's insistence on monogamy, concubinage among the higher aristocracy was habitual (Pankhurst 1990:265). Adultery is still common in present day Ethiopia as a study indicated that, although the percentage for women is less, both men and women in Ethiopia involve in extramarital relations (Habtamu et al.: 2004).

Although most informants insisted that sex should be confined to marriage, they admitted that sexual relationship outside marriage is a common practice in Addis Ababa. In relation to this point, one sex blamed the other for being promiscuous. Men respondents said women should be called responsible for tempting men with their beauty by luring them into sex. Women on the other hand had a different opinion on the matter blaming men for not managing to control their emotions.

There are more than 80 ethnic groups in Ethiopia, but there are marked differences in the way extra-marital affairs are taken in different cultures. A peculiar example here comes from a tribe in southern Ethiopia. For the members of this tribe, extra-marital affair is not discrete. For instance if one is to have sexual contact with ones brother's wife, he leaves his stick or javelin out on the verandah so that if the husband comes home and happens to see the sign, he does not enter the house but rather goes away.

Although this kind of open extra-marital sexual relations are very uncommon in the rest of Ethiopia, informants told me that adultery could be tolerated if practiced in

discretion. An important question to ask would be: Why is extramarital sexual relationship common in the Ethiopian society despite the fact that the dominant sexuality discourse which is highly influenced by religion and despite the fact that the Ethiopian Orthodox Church strictly demands sexual relationship within marriage? In contrast to his Christian belief that adultery is taboo, Levine describes the Amhara peasant as *'feeling justified in having sexual relations outside marriage'*. Trying to explain this conflict between norm and practice, Levine says: "*...the legitimate tone of the non-Christian behaviour suggests that it might well be considered as an alternative norm, a carry-over from the ancient culture which legitimized polygamy*" (1965:83).

This contradiction might be looked at as a resistance to the religious sexuality discourse that suppresses the sexuality of men and women. One informant told me that there are cases in which the family of a woman involved in extramarital affair defends the woman using a common expression *'Yekonjo Wegu New!/*What is so unique about a beautiful woman involving with different men!'.

In my collection of oral literature, a number of jokes and oral poems dealt with the issue of extra-marital relations. The proliferation of literature on the issue of extra-marital relations is an indication of the attention given to the practice in the country. Here is one example:

The wife of a farmer had a sexual relationship with a man in the neighborhood. This woman was used to entertaining her lover whenever her husband was away. But one day her husband suddenly showed up while she was with the other man. She had to hide her lover first but she also had to think of how she could help her lover escape without being seen by her husband. As she was a very clever woman, she planned a way to solve her problem. She put her lover in a sack and told her husband to carry it to her friend's house. Her husband was told by his wife that the sack contained grain that she borrowed from her friend.

Here I do not need to discuss the way the woman in the joke has been portrayed as that has been dealt with in the next chapter where I discuss the depiction of women's sexuality in oral literature as 'uncontrollable'. My focus here is on the attention given to extra-marital relations. The fact that the woman in the joke did not panic but devised a way to solve the problem may indicate that she was clever enough to solve her problems in a calm manner.

The prevalence of extra-marital relations in Ethiopia could be directly related to the spread of the AID epidemic. As mentioned earlier in this chapter, some of my informants opened up to me and told me that they could be at risk of HIV infection, since they did not totally trust their husbands. These women were not willing to discuss the specific reasons as to why they didn't trust their partners, but expressed their worries in indirect ways by saying '*Bezih Gize Man Yitamenal*/Who can be trusted in these days! This may show a general mistrust of men but it could also indicate women's distrust in their own husbands because it was a comment given to the question addressing their own lives. The final statement these women gave just before concluding our discussions on trust was '*Egziyabher Yitebikenal*/God will keep us safe'.

As some informants mentioned, it is a common practice that a woman reports her husband's infidelity to her close relatives. Problems in the marriages are for most part handled by a *'Shimagele'*, a committee of family elders assigned to play the mediating role in solving disputes at all levels'*. This committee consists mostly of men from both the husband's and the wife's sides, and it is the opinion of some of my informants that these men most of the time favour the husband. They said it is common that the *Shimagiles* would put pressure on the woman and settle the case mostly in the interest of the man.

* In Amharic the word Shimagele means an elderly man. The committee set up to play the mediating role in solving disputes is called Shimagele. Each individual in the group is also named Shimagele.

"A man found to be involved in an extramarital affair would often ask his wife's forgiveness and he would for the most part be forgiven", said an informant. The wife is often advised to endure her problem and to take solace in her children. The *Shimagiles* would say *'Lelijochish Sitiy Yikir Beyiw*/Forgive him for the sake of your children'. In a national study on eleven ethnic groups in Ethiopia, the respondents were asked to whom they turned for advice when faced with serious problems. Both males and females responded that they went to older men (52.2%) as their first choice and then to their marriage partner (20.9%). There was no significant difference between men and women on the choice of the source for advice. It is to be noted that older women were the least sought after persons for advice (Habtamu et al. 2004:29). This survey shows that elderly women do not play the role of a *Shimagile*.

As Rachel (2000:14) notes, in Ethiopia religious leaders are also usually sought for guidance when a family is in trouble, especially concerning moral issues. The issue of adultery is one of these moral issues that is usually dealt with in discretion. Although the national consent of marriageable age for a girl is 16, the Ethiopian Orthodox Church priests still encourage earlier marriages as morally right and oblige women to maintain their marriages no matter how big atrocities the husband perpetrates on them (Rachel 2000:14). As religion has a strong influence in Ethiopia, such stands by religious leaders encourage women to be passive minimizing their power to resist risky sexual encounters that may expose them to the risk of HIV infection.

Not only early marriages arranged marriages and adultery but also some other traditional practices affect the lives of women by exposing them to the risk of HIV infection. One example is the practice of *Jala* in Alaba, where the best men sleep with the bride before the groom. The other practice is sharing of a wife in Borena and Kereyou (MHRC 2004:52). In practices like this, we could say that women are taken as sex objects where their needs are not at all considered important. The likelihood of being infected with the AIDS virus is high in practices like *Jala* because women are in no position to refuse unprotected sexual contact. Another issue that shows the relationship between risk and women's power position is divorce. As the following

discussion shows divorce could be one factor that predisposes men and women to risk of HIV infection.

6.3.4. Divorce and Risk

Divorce is quite common especially in rural parts of Ethiopia despite the Holy Scripture's confirmation that adultery and death are the only acceptable reasons for divorce. This is paradoxical considering the religiosity of the rural communities in Ethiopia. Similarly, a number of my informants at Lideta told me that they went through divorce. Compared to Addis Ababa, they said divorce is more common in the rural areas where they came from. As Pankhurst (1992) noted, the most remarkable feature of Amhara households is frequency of divorce and its correlation with the high incidence of serial marriages in what is a strongly Christian community. Pankhurst added that in Amhara culture marriage is most often perceived in economic terms, and emotions are often not taken into consideration since individuals usually do not know each other. Divorce on the other hand, she says, tends to be explained in more complex terms of incompatibility -emotional and economic. As I have discussed earlier in this chapter, another reason for divorce in Ethiopia is inability to conceive a child.

Among my informants, there were two women who got married four times. As Pankhurst's study indicated, among the *Amhara*, divorce and remarriage three times to four times is quite frequent with some women marrying up to twelve times (1992). One informant told me that she saw a program on Ethiopian TV where a woman said she got married 16 times*. As a study indicated, while the separation/divorce rate for girls less than 15 years of age at first marriage is 47 percent, it is only 18 percent among those aged 20-21 (NCTPE 2003:145). The fact that 47 percent of the female divorcees are less than 15 years clearly reveals that early marriages had a stronger

* Although divorce is common in Ethiopia, it is not easy to dissolve marriages. From the three types of marriages discussed earlier (civil, customary and religious), it is relatively easier to dissolve a customary marriage. In the religious marriages of the Orthodox Christian Church divorce is not allowed for couples who got married with matrimonial prayer and Holy Communion. According to the church doctrine, adultery and death are the only acceptable reasons for divorce.

correlation with divorce. Similarly, the stories of the women at Lideta showed that women divorce their husbands mostly because the marriage partners do not know each other before wedding. As an early marriage is arranged by parents without the consent of the wife and in most cases the husband, it is likely that the couples may not get along.

The majority of the informants saw early marriage as a traditional practice that has strong influence on the spread of HIV/AIDS in Ethiopia. They said the practice increases divorce rates in Ethiopia and exposes men and women to risky multiple sexual relationships. As an example for this, they mentioned the point that most divorcee rural women opt for commercial sex work. A study on women living with the HIV virus in Addis Ababa also proved that traditional practices like abduction and early marriage increase women's vulnerability to HIV/AIDS since women tend to be exposed to unprotected sex after running away from such practices (Salem 2003). Although traditional practices like early marriage have deep-rooted bases, Ethiopian women do not passively accept these practices. Resistances to some of these practices will be discussed in detail in the last section of the next chapter.

6.4. Conclusion

As mentioned earlier, almost all my informants at Lideta knew the three 'Ms' by heart since their instant response to the question on ways of avoiding risk was *'Metakeb, Metamen, Metekem/* abstinence, faithfulness and condom use*'*. When asked about the practicality of these three methods however, most of these informants were found to be skeptical. Some even commented that they did not make use of most of the prevention information on HIV/AIDS to avoid risk.

In this chapter an attempt has been made to analyze the interface between gender, sexuality and HIV/AIDS by specifically looking at the issue of risk. As we have seen in the discussion, besides gender and sexuality, a web of factors lead to risk and some of these factors include religion, tradition, economy and the law. Again I affirm that it

is by looking at the multiple factors that construct risk in HIV/AIDS discourse that we have a better understanding of the reasons why men and women have been differently affected by the AIDS epidemic. There is the necessity to create a counter-discourse to the narrow focus on the dominant discursive construction of 'risk groups' in order to address the more common situation of women.

As mentioned earlier, providing information on how to avoid to risk of HIV infection cannot be sufficient to retard the spread of HIV/AIDS in Addis Ababa. I am critical about the activities of HIV/AIDS prevention programs as they overlook the different interfering factors that would not allow the individual to be in control of his/her situation. In the case of HIV/AIDS in Addis Ababa, I contend that we need to revisit the dimensions of men's and women's stereo typical identity and self-definition that are constructed by discourses such as gender, sexuality, religion, tradition and modernism. HIV/AIDS prevention programs have to give appropriate attention to the relationship between risk of HIV infection and men's and women's power relations in sexual relationships.

Chapter Seven-Construction of Perpetrators and Victims in the HIV/AIDS Discourse

7.1. Introduction

In the following Amharic couplet of a minstrel, a man tells his female partner to protect herself from HIV infection so as not to put him at risk of contracting AIDS. The couplet reads:

ተይኝ አላልኩም ወይ አንዱን ባንዱ ላይ እያሉ መኝታ፡
ታመጪብኛለሽ ያን ደደብ በሽታ፡፡

Have I not warned you not to go out with different men,
I am afraid that you would bring that 'idiot' disease to me.

The couplet indicates that the woman might be a 'cause' for her partner's infection, her own health also being at risk. This woman is depicted as a threat to the safety of her partner because of her promiscuous nature. Contrary to this kind of presentation, women have often been depicted as 'hopeless victims' in the dominant HIV/AIDS discourse in Addis Ababa. Women, especially poor women, have been portrayed as victims of AIDS mainly due to their lower economic status in society. As it could be seen in the above oral poem, men are depicted as 'victims' of HIV/AIDS due to their relations with certain groups of women. Men are however, also depicted as promiscuous and as the perpetrators in the spread of the AIDS virus. In Ethiopia, there is ample statistical evidence that indicates that women are more affected by HIV/AIDS than men (MOH 2004), but the relationship between gender and HIV/AIDS remains one of the unexplored issues in the study of the epidemic in Ethiopia (Rachel 2001, Sehin 2000).

I have divided the chapter into two major sections. In the first section, I will look at the construction of first the Perpetrator and then the Victim positions in the HIV/AIDS discourse. The second section of the chapter discusses resistances that can

be identified in my study. In the first part the main focus is to analyze the intersection between gender, sexuality and HIV/AIDS in Addis Ababa. During my fieldwork, I witnessed that narratives of men's and women's lives make evident the multiple strands that interweave to make up individual identities. Though the main focus of this chapter is the intersection between gender, sexuality and HIV/AIDS, I will also show how other discourses such as religion and tradition mediate men's and women's multiple inscriptions and their differential relationship to the AIDS epidemic in Addis Ababa.

As mentioned earlier, the second part of this chapter tries to explore the informants counter discourses or resistances. Resistance is possible because relations of power do not depend upon the direct control of subjects through coercive means but rather upon creating a sphere for their regulated autonomy. As Alsop et.,al (2002: 83) also note there are always many and contradictory discourses about different subject matters, which are linked with power in different ways. In the second section I will discuss mainly women's resistances to the perpetrator and victim positions, but let us first look at how the perpetrator and victim positions in the HIV/AIDS discourse in Addis Ababa are constructed and negotiated.

7.2. Intersection between Gender, Sexuality and HIV/AIDS Discourses: The Perpetrator Position

For a number of my informants at Lideta particular groups of women have been considered responsible for the spread of the virus. Although most of them said that the women engage in multiple sexual relationships without having any choice, from their tone of voice and their facial expression I understood that some informants claimed that these women are responsible for the spread of the AIDS epidemic. As they negotiate their interpretation of events, the informants labelled women, especially commercial sex workers as perpetrators of the AIDS epidemic.

The wide spread of prostitution is nothing but a sign of God's wrath. God brought AIDS on to us because He wanted to punish those sexually immoral people in our

society. The sad thing is that the epidemic doesn't separate the immoral from the good ones. This is what makes me believe that AIDS is a punishment on all humans. Otherwise God would have punished only the ones who have sinned (Informant 38).

This is a quote from an interview with an elderly woman whose only daughter is a commercial sex worker. We may wonder how a woman could criticize her own daughter this way – as being punished by God for behaving like a sexually immoral person. We can however observe that she views AIDS as God's way of punishing all human beings, since it does not discriminate between the 'immoral' and the 'moral' ones. Even the 'moral' ones can be infected. In the woman's statement the main agent is God since both the amount of prostitution and HIV/AIDS as a punishment are exercised by him. Her daughter as a prostitute is however also indirectly named as a perpetrator.

Men were by many informants seen as naturally less able to exercise self-control in sexual encounters and hence need the services of sex workers. Men hence become the victims of HIV/AIDS. This may imply that these informants share a widely-held belief that it is through the body of a prostitute who acts on males that AIDS is spreading in the society at an alarming rate. Here we can see that commercial sex workers become scapegoats for the spread of the virus. The assumptions underlying this blame are deeply embedded in the definition of women as carriers of sexual disease, as well as in the moralistic belief that certain forms of sex are bad. Hence, the way the perpetrator discourse of HIV/AIDS was negotiated by my informants has everything to do with the discourses of gender and sexuality in Addis Ababa.

In a number of HIV/AIDS prevention activities I observed AIDS was explained in relation to contagion and vulnerability. For example, a woman at Lideta called HIV/AIDS "Merz/poison' referring to the virus's contaminating power. Contagion implies an alien biological form entering the body; it may occur in conjunction with vulnerability. Both contagion and vulnerability seem value-neutral, but in fact they may be seen as self-induced, the consequence of carelessness or over indulgence, which brings in a moral element. As Sontag (1990) says those who suffer from AIDS

are already the 'pariahs' in western societies. Similarly, among some of my informants, there was an assumption that men and women become 'perpetrators' of the AIDS epidemic due to failure to control that always problematic 'energy'-sexuality. Sexuality in general seems to be at stake here and not only prostitution. This is what an elderly woman at Lideta said regarding young men and women's sexuality:

God has put fire between the legs of young men and women. He did this to test their love and dedication to Him. One has to suppress one's sexual demands as this is what makes us humans different from animals. Now a days men and women find it almost impossible to control their sexual feelings. This is the reason why they die of AIDS every day falling like the leaves of a tree (Informant 1).

To this informant the main problem is the inability of young men and women to control their sexual urges. The dominant HIV/AIDS discourse in Addis Ababa, as administered by the government and NGO's, also presents sex as something that must be administered, but they in addition see it as a policy matter that requires an open discussion. Contrary to this, for reasons related to religion, most of my informants like the one quoted above associated sex with self-control and the perfecting of the self. As it was discussed in the fifth chapter that dealt with religion, the intemperate talk about AIDS as God's punishment expresses a moral panic. I will shortly return to the problem of creating an open discussion on issues of sexuality in Ethiopia.

While observing some of the activities of the two NGOs, I noticed that HIV/AIDS control advocates were not keen to listen to what people had to say but merely provide information. The reason for this is, in my opinion, that HIV transmission was regarded primarily as a public health issue and a disease resulting from low sexual moral. In targeting prostitutes as perpetrators, and truck drives and others as 'risk groups', I would say that the NGO's were not able to address the women's main questions and challenges.

Recently AIDS prevention campaigns in Addis Ababa have started focusing on preventing women from transmitting HIV to the child during pregnancy or the process of birth. This represents a different version of the female body as a source of possible infection and danger. What I would like to draw attention to is that one of the major consequences of the AIDS pandemic for female sexuality, and to a limited extent for male sexuality, is that sexuality is being redefined in even more guilt-ridden and rigid terms. Fear and terror have become an essential part of sex. Arnfred's (2004:59) analysis from other African countries seems to support my argument:

> ...issues of sexuality in Africa are conceptualized in contemporary (often donor-driven) investigations and debates, centering on illness and violence (HIV/AIDS, Female Genital Mutilation) and often victimizing as well as blaming women. Sexuality - and female sexuality in particular - seems to be linked to violence and/or death.

During my fieldwork I did however find that not only women but also men were considered as perpetrators in the spread of the HIV virus. '*Wond Ayitamenim/ Men cannot be trusted'.* was a common expression used by my female informants to describe what they named 'the irresponsible nature of men'. This indicates a tendency to lump all men together in some singular notion of men's sexual irresponsibility. What is very interesting is that even though men can be seen as agents that are also responsible for the spread of the epidemic, they are not seen as able to prevent it. This is what a woman said with regard to this point:

God created women in such a way that they could control their sexual feelings. This is not the case with men. I don't trust men when it comes to sex. Some married men go to prostitutes to satisfy their sexual appetite. Men's sexual demand is so high that they have to go and have sex with other women since they can't even wait for a few months while their wives are pregnant. Thanks to God we are not like them (Informant 9).

Underpinning this view are deeply rooted cultural assumptions about the sexual nature of men which make prostitution necessary and result in its widespread acceptance. One of the commonly held assumptions is that men cannot help themselves since their sexual urges are too high for them to control. During the interviews with my informants at Lideta, I noticed that there was a sense of mistrust towards the opposite sex, females blaming men and males blaming women. My female respondents said women are trustworthy and committed while they described males as unreliable and treacherous. The same adjectives were mentioned by men while describing females. This indicates that men and women blame each other for the spread of AIDS. In this way they place their own group in an 'innocent' and 'passive' position, as the ones that are acted upon. For the women it might be possible to understand their occupation of the victim position as the position traditionally prescribed for them: weaker and less powerful than men. Yet, how should we understand the inclination amongst men to insist on a victim position? Can men tolerate this position as victims because they are placed in it as a result of their virility? That is, their strong sexual urges, and hence their masculinity is what makes them victims of the prostitutes.

While women's sexuality is said to be in demand of control my data show that men are allowed to exercise more freedom in relation to their sexuality. Of course, men have also been named as perpetrators in the HIV/AIDS discourse but explanations have often been provided for their actions since men are considered to have greater (legitimate) sexual needs than women. Contrary to what is expected of a woman's character, my informants at Lideta stressed that a man should be aggressive and assertive. The word '*Setaset/* Womanish' is a commonly used curse insulting a man who is less aggressive and less assertive.

Explanations of natural and essential sex differences make assumptions about what is necessary with regard to character traits. These explanations assume that certain character traits are natural for men and to oppose these would be disastrous. As the explanations are tied to essence, neither sex is equipped to perform the other, and attempting role reversal would mean loss of essence and -especially for males - loss

of status (Haste 1993:66). In similar vein, an Ethiopian man should not show any of the characters of a woman. Levin explains:

> The Ethiopian cult of masculinity differs from the Latin cult of machismo. The former does not emphasize sexual prowess, nor is it complemented by the idealization of women for distinctively feminine qualities. The general Ethiopian pattern is to associate the highest values exclusively with masculinity and to conceive of the virtues of masculinity almost exclusively in terms of aggressive capacity (Cited in Bethlehem 2000:9).

This is a good illustration of the point that the social context is important in constructing men's and women's subjectivity in Ethiopia. As Haste (1993:9-10) notes: "*the social context provides a repertoire, a resource, of concepts and ideas, and sets the terms of reference for what is acceptable, comprehensible and legitimate.*" I believe that the individual draws upon this repertoire in making sense of, and in negotiating concepts and meanings in the interaction with others.

Although a number of informants expressed their opinion about the opposite sex in relation to AIDS, it was mostly in indirect ways that such issues were expressed since sexuality is generally a taboo subject in the society. In the predominantly illiterate Ethiopian society, people's attitude towards sensitive issues like gender, sexuality and HIV/AIDS are mainly depicted in the oral literature. Jokes and stories are therefore important sources of knowledge on these sensitive topics.

Most of the jokes and prose fictions on gender and sexuality that I collected for this project are about women. Although a number of the jokes presented men as having high sexual appetite and depicted them negatively, when we compare the presentation of men and women in the jokes, women are in general portrayed more negatively than men. Although the focus of most of the jokes I have collected seemed to openly present sexual matters that are considered taboo in society, the differences in the depiction of men and women need some consideration. Let us now take a closer look at some of the most commonly used jokes.

There was a poor young woman who sells eggs on the streets of Addis Ababa. One day while she was walking to the place where she sells eggs, beautiful cars were passing by her. Looking at these cars, she wished that she had one of them. She started contemplating about owning a car. She told herself that she would sell her eggs in order to have money to buy a car. And she started imagining herself in her own beautiful car. She could also see poor people she knew bowing their heads as a sign of respect for her. When she tried to act out how people would bow to her, the basket of egg which she was carrying on her head fell down and all the eggs were smashed. The poor woman went home crying.

A young man asked his girlfriend the following question just after proposing to marry her. The question he asked was how many boyfriends she had before him. The girl didn't reply. When she kept quiet for so many minutes, the man thought that she was embarrassed to respond to him due to the sensitivity of the question. In an attempt to help her, he told her that she shouldn't be embarrassed since he asked just to know. The girl said that she was not embarrassed but she needed a good amount of time to count all her ex-boyfriends since they were too many.

In the first joke the young woman is depicted as a naïve person who spoils her life because of her farfetched dream to be wealthy. The girl in the second joke is a person who has no shame to give a long list of names of her ex-boyfriends to a man who just proposed to marry her. Another very common issue in my collection of jokes is the story of the cheating wife. These jokes present women's sexuality as uncontrollable. The following joke is a case in point:

A husband and a wife had a discussion on how the wife should tell her husband whenever she wants to have sex. They decided that the woman should bake a special kind of bread for dinner whenever she wants to have sex with her husband. A problem came up soon after this plan had started to work. The wife baked the bread each and every day and the husband started to become tired of her sexual demand. One day when he came from work he was so tired that he prayed that his wife hadn't made the same type of bread for dinner. Just before he entered the house, he asked his

daughter playing outside the gate what her mother had prepared for dinner. The daughter told him that she prepared the usual type of bread. Since he had no energy in him to satisfy the sexual demand of his wife, the man left his house and never came back.

The joke serves to poke fun at a 'deviant' woman who is unable to control her sexuality. The reason that the story works as a joke is that the situation seems surprising and unusual. It might also be read as a story of a woman as the one controlling sexuality and giving the man access when it suites her. The man is assumed to always want sex since she is supposed to signal when she also wants it. When the woman turns out to be the sexually insatiable, the situation gets turned upside down. The man cannot perform and has to escape. The moral to men might be to be careful about what you ask for - you might get it.

As the above examples illustrate, women are presented in jokes as both passive and active, and as both pitiful and dangerous. They are both seen as irrational, lustful and unfaithful. The picture created of women is hence very complex. In two of the jocks, we see that men are presented as victims of lustful and untrustworthy women. The difference in the portrayal of men and women in the jokes could be seen as manifestation of their positions in society.

In his study of the oral narratives of the *Jimma Oromo* of Ethiopia, Abraham (2004:8) cites examples of narratives that testify to the uncontrollable nature of women's sexuality. One of his examples is the story of *Makka Ware* the first ruler of the Jimmas, a woman who had to give up her ruling power after she fell into the trap of men who plotted to overthrow her. Because of her lustful nature, *Makka Ware* missed an important meeting just to have sex with a man. The community decides to take her power from her since she was unable to control her emotions. The historical narrative ends by stating that *Makka Ware* was removed from power and the community made a law that defined women as incomplete creatures who are not fit for leadership position. The narrative justified the end of *Makka's* rule as well as women's participation in politics in general.

In both the above stories women are described as victims of their bodily urges in much the same way as we saw that the present public HIV/AIDS discourse of Addis Ababa depicts men. The major difference is however that the consequences of the inability of controlling their urges have. For women this serves as a reason to remove them from position of power and influence, whilst the same behaviour does not have any consequence for men. It is supposed to be natural in men but not in women. Men are not seen as able to control their sexual urges but this is not taken to mean that they cannot be trusted to hold positions of power and influence.

The oral narrative about *Makka Ware* is a historical oral narrative, and hence it is held in high regard since historical narratives are generally believed to be true accounts of the great deeds and wisdom of the Jimmas' forefathers. There are however also fictitious stories and humorous tales that depict Jimma Oromo women as deceitful and unfaithful. As Abraham (2004:20) asserts, the ideological definition of women as 'inferior' creatures enables the dominant male elite to justify and maintain the subordinate status of women among the Jimmas.

As the above examples of oral narratives illustrate, women's lustfulness is deemed more problematic than men's. This makes women unpredictable and prone to victimize men. The uncontrollable sexuality does however seem to install a capacity of agency in women, so they are not only passive victims. Women's 'weakness' did not seem to come from their lack of physical strength but was rather a result of their lack of moral strength in relation to their sexuality. This lack of moral strength could on the other hand be viewed as a reinstatement of the lack of agency among women. This negative portrayal of women in the oral literature cited above is in my opinion a reflection of the way women's sexuality is understood in the Ethiopian society today.

The commonly used Amharic proverb 'ሴትና ቄስ ቀስ /Women and priests have to behave in a calm manner' also supports the view that women must be in control. The placing of women and priests in a parallel position can be understood as a statement about the expectations towards the two groups way of handling of temper and

emotions in general. It can also be read as a way of constructing women's sexuality in a suppressive manner.

In Ethiopia, not only jokes and proverbs but graffiti also depicts the sexuality of women as uncontrollable. Graffiti is said to be subversive writing as it presents issues like sexuality, issues considered to be taboo (Nielenberg 1994). In the following graffiti taken from a toilet at the Addis Ababa University a man warns a woman about AIDS implying that she needs to control her sexuality:

"Sex is making me crazy"- Almaz

"What is wrong with women these days? Almaz! Be careful, AIDS will kill you" - Kebede

Kebede does not only criticize Almaz but all women implying that women's sexuality in general has become uncontrollable. In the graffiti's collected at the Addis Ababa University, women's sexual bodies are in addition depicted as unclean and unpleasant. My informants at the two NGOs said that there is a widespread view that women are inherently sexually unclean and that women therefore cause sexually transmitted diseases. As AIDS is also a sexually transmitted disease, it means that AIDS is taken as women's disease, reinforcing the tendency to position women as the perpetrators in the HIV/AIDS discourse. The tendency to consider AIDS as women's disease might also give men a false sense of 'safety' since AIDS does not spare anyone.

As the discussion so far has tried to explore, the most important question would be: What creates this common assumption that women's sexuality needs control while men's does not? Sexualities are informed by and embedded in conceptions of gender that structure the different possibilities for women and men. What is important in the context of my argument is that women's uncontrollable sexuality, as opposed to men's, is constructed as being accountable for the spread of the AIDS virus in Ethiopia, particularly through prostitutes. Let us now turn to other practices and discourses that are made relevant in my study. Female genital mutilation is of particular importance in relation to HIV/AIDS and the perpetrator position.

Female Genital Mutilation (FGM)

In Ethiopia there are a number of traditional practices that mainly are aimed at controlling women's sexuality. Through a closer look at the practice of female genital mutilation (FGM) the intersection between discourses of gender, sexuality and HIV/AIDS will be further analysed. In the present argument FGM will also serve to problematize the perpetrator position by adding further complications.

The traditional practices that involve the removal (cutting) of well functioning female genitalia go under different names. In Ethiopia, Female Genital Mutilation has often been referred to as '*Yeset Girzet*/female circumcision'. Different types of female genital mutilation are practiced in all regions in Ethiopia except Gambella (NCTPE 2003). Although the practice for FGM is said to be on the decrease, it is still widely practiced. It is mostly elderly women, traditional birth attendants, or other traditional practitioners that perform the mutilation and it is commonly done under unhygienic conditions. A relative holds the young child; often the mother, and the circumciser cuts the parts (without any anaesthesia) with a knife, razor blade, sharpened stone or nails. One of the harmful effects of female genital mutilation is the possibility of HIV/AIDS transmission due to tearing of the skin during intercourse and childbirth (NCTPE 2003). HIV can also be transmitted through blood due to the use of the same knife or blade used by grown-ups for other purposes or mutilating many young children with the same knife or blade.

In Ethiopia, FGM could be inferred to have preceded the conversion to Christianity of the emperors in the 4th century and started earlier with, at the latest, the introduction of Judaic practices, probably at the same time as male circumcision (NCTPE 2003:70). Despite the fact that neither the Bible nor the Koran prescribes FGM among their religious requirements, FGM is considered to be a religious obligation by some of my respondents at Lideta. Christians and Muslims alike practice FGM.

The most predominant type of FGM in Ethiopia is referred to as Clitoridectomy (62 percent), the excision or removal of the clitoral hood with or without excision of part

or the entire clitoris. The other common type of FGM in Ethiopia is excision (19 percent). This involves the removal of the clitoris together with partial or total excision of the labia minora. The least practiced type of FGM in Ethiopia is infibulation (3 percent). This is the removal of part or all of the external genitalia and stitching/narrowing of the vaginal opening leaving a small hole for urine and menstrual flow (NCTPE 2003:84).

Almost all my female respondents at Lideta said they were circumcised while they were infants. When asked whether they circumcised their own daughters, almost half of them said they did not. I do however question the reliability of this answer because during our conversation, I sensed that some of them were telling me what they thought I would have wanted to hear regarding this topic. Now a days, there is a wide public media coverage of the harmfulness of FGM and I suspect that these women preferred not to tell that they did circumcise their daughters, so as not to be associated with a practice which was described as highly harmful. A recent survey shows for example that 70.2 percent of women have been circumcised in Addis Ababa (NCTPE 2003:87).

Almost all of my informants at Lideta said that they were against female genital mutilation. Among those that had performed FGM on their children, quite a number of them said they had awareness of the harmfulness of FGM at the time of their children's circumcision. This shows that it is not at all easy to explain how dominant discourses and categories get reproduced despite the fact that very few people are prepared to acknowledge that they support or believe in them. Moreover, it indicates that there is no easy fit between the discourses and the subject positions we take up. Not only may different discourses be contradictory, each discourse may also be internally contradictory leaving it to the individual subjects to negotiate their different positions.

My discussions with informants at Lideta show that FGM was viewed as a means of preserving the femininity of women's bodies and a form of empowerment that allows women to control their sexual desires. One respondent argued for instance that FGM

is necessary for the preservation of female virginity- until the night when she is penetrated by a husband. This strict control reflects a social system in which female chastity was highly praised. In Ethiopia, female circumcision was believed to control a girl's sexual appetite, prevent masturbation, and ensure her virginity until marriage (Prouty, 1986;34). Women who were not circumcised were considered 'uncontrollably sexy', and it was commonly believed that an uncircumcised woman would be unfaithful to her husband (Prouty 1986).

Removal of the female genitalia is also informed by a belief system that defines the female genitalia as unclean and the female as sexually promiscuous. The clitoris and the outer-genitalia are hence removed in order to impose chastity and sexual control in or out of marriage. We can here see how the construction of FGM intersects with the discourses of gender and sexuality.

Informants at Lideta said that engaging in sexual intercourse as an unmarried female is frowned upon. For some of these women, male virginity is not an issue; instead males are encouraged to experiment with sex, and to lose their virginity as soon as they become young adolescents. This implies that the sex act is invariably posed as empowering to the male and degrading to the woman. In Ethiopia, a woman is expected to be less active during sexual intercourse and female genital mutilation is considered to have an effect in minimizing women's sexual pleasure. As my informants at Lideta said, a woman who is mutilated is considered to be less aggressive than one who is not mutilated. All in all, the major reason for mutilating women's genitals is to make women passive both sexually and emotionally. Mutilation could therefore be seen as an answer to the challenge posed by the story mentioned earlier about the sexually and emotionally unstable *Makka Ware*.

Communities have a range of mechanisms to enforce the practice of FGM even though they are publicly condemned. One of the discursive contradictions is a construction of FGM as a harmful and an old fashioned traditional cultural practice, and at the same time constructing it as necessary. Why is it considered to be necessary? Some of the women at Lideta said they had to do it on their children to

avoid shame and ostracization. They told me that an uncircumcised woman is believed not to find a husband. The other most often mentioned reason for practicing FGM is respect for tradition. As we know, relations of power are held in place with specific forms of 'rationalities' and the above mentioned serve as illustrations of this.

FGM is a highly complex issue that ties into traditional gender relations, superstition and religion. According to a national survey on harmful cultural practices, those who do not adhere to FGM face a number of consequences. Among the major consequences, some are related to superstition such as invoking curses or considering non-adherents as cursed. Other consequences are exclusion from traditional voluntary associations that serve as social institutions such as *idir* or other voluntary associations; refusing marriage relationships; openly criticizing or directly or indirectly insulting the non-adherents, opposing the anti-FGM campaign, backbiting, and religious ostracisation. (NCTPE 2003:118). Hirut (2000: 216) affirms that female genital mutilation is inextricably linked to the socio-cultural, economic and political realities of the Ethiopian society. She adds: "*This is why an analysis of any such cultural practices must consider historical and ideological parameters if it is to go beyond a simple description and superficial (monocausal) analysis*". The FGM discourse is very contradictory leaving the women in a position to negotiate the destiny of their female children in a very difficult terrain.

Though minimal, there are some efforts to stop FGM throughout the country. According to one study, discussions have been conducted in some parts of Ethiopia to stop the practice and there are also reported cases where young women have refused to be circumcised (MHRC: 2004). These efforts are however, insignificant compared to the high prevalence of the practice. The DHS Survey shows that the level of awareness of the negative consequences of FGM in Ethiopia is generally low (59.7 percent do not think it is problematic), indicating that there is a long way to go to eradicate the practice (CSA and ORC Macro 2000). McFadden reminds us: *"Until we come to terms with the reality of sexual construction and its variedness for different peoples, mounting campaigns which simply tell people to stop FGM will only be marginally effective"* (McFadden 1992:175).

So far I have tried to analyze how both men and women in Addis Ababa have been constructed as perpetrators in relation to HIV/AIDS, my main focus has however been on the women. The intersections between the discourses of gender, sexuality and HIV/AIDS have also been discussed. I have made a more detailed 'detour' into the discourse of female genital mutilation in order to give sense to the socio-cultural, economic and historical contexts that have to be negotiated by the individual woman. The analysis has been conducted in a way that highlights the contradictions in the Ethiopian discourses regarding gender, sexuality and HIV/AIDS. In the following section I will analyze the construction of the victim position in the HIV/AIDS discourse.

7.3. Intersections between Gender, Sexuality and HIV/AIDS Discourses: The Victim Position

"Poor women in Ethiopia engage in multiple sexual relationships due to poverty".

"Ethiopian women are victims of harmful cultural practices".

These are but two of the commonly used descriptions of women in the dominant HIV/AIDS prevention discourse in Ethiopia. I contend that we need to recognize the diversities of women's realities by presenting them from a situated perspective.

An elderly woman in Lideta told me:

This is a very difficult time. Young women go out with different men and put their lives at risk to earn money. Husbands bring the disease home to their wives. It is women who are highly affected by the epidemic just because they are women and they have no power (Informant 5).

This elderly woman views young women as victims of poor economic circumstances (that force them into prostitution) and she views wives as victims of their husbands careless actions. In both cases, women are, in the end, seen as victims of their gender,

with the resulting lack of power. The woman's opinion was shared by a number of other informants. This could be understood as a tendency towards considering women as a homogeneous group, putting women in one group and labelling them as 'victims' of the epidemic without taking into account their different subjectivities and their different positions.

According to two of my male respondents at Lideta, women cannot be trusted when it comes to sex and it was the view of these men that women easily leave their partners if they are offered money and gifts. Although one tried to relate this to poverty he emphasized the point that women are very interested in material things and hence are inclined to try to get money in return for sex. This man's opinion was not however, shared by the majority of my male and female respondents. They tried to explain women's vulnerability to HIV/AIDS in a different way. A woman said the following:

'It is better to die of HIV/AIDS than poverty', has become a common expression now a days. The explanation some women give is that HIV/AIDS waits for years before it kills you but an empty stomach will only tolerate you for a few days. Women involve in multiple sexual relations while they are quite aware of the risk of HIV infection. It may not seem true but women put their lives at risk for survival (Informant 17).

Women put their lives at risk for survival. How can this be understood? Some women make an active choice to work as a prostitute in order to be able to put food in their children's mouths. A desperate choice made in circumstances that do not allow for many other options. Trying to protect herself by using a condom might not be of much use when confronted with a client that does not have any intention of using a condom. They would be forced to put their lives at risk by having unprotected sex in order to get food and hence to survive for a while longer.

Another story presented in some of the dramas that I had attended show women as easy victims of men especially rich old men. This storyline reminds us of the one suggested by the man presented earlier. A Drama prepared by an NGO and staged at a Health Center serves a good example. The drama was about three school girls who

started to have sexual relationship with rich old men for money. The drama depicts that these girls opted for sex work because their parents were poor. The girls are presented as naive and irrational and they do not seem to care about the risk of getting an HIV infection. I have observed many similar constructions of poor uneducated women by the educated women and men working at the two NGOs. The following is a common description provided by members of the NGOs as these words of a social worker illustrate:

Most of our beneficiaries are commercial sex workers. These women had so many difficulties in life. Due to their life style, they are victims of HIV/AIDS. They can't leave their profession because they are poor and they don't have skills to find job. Most of them don't know how they could protect themselves from HIV. Hence, we provide them with relevant information (Informant 50).

The quotation indicates the 'we/they' dichotomy where the women beneficiaries are described as 'they', the others Similarly, some members of the NGOs described poor women coming to their organization for support as tradition bound and victimized needing their support to protect themselves from the AIDS epidemic. They did not describe them as partners in the fight against AIDS but as victims seeking rescue. This approach, in my view denies women the opportunity to construct their own subjectivity. Moreover, it does not welcome the possibility of understanding gender differences.

Although the general tendency of prevention programs was to raise awareness about the vulnerability of women to the HIV infection, I have noticed that there was a tendency amongst the NGOs to define the help women needed by solely addressing their economic problems. Although these efforts are commendable, I do not believe that they will bring much change in the women's lives if we do not give equal, or even more emphasis to the cultural meanings of gender. The tendency to label women as victims of HIV/AIDS because of their economic insecurity is underestimating the efforts of many women who are trying very hard to overcome their economic problems. A large number of women in Ethiopia try to come out of poverty by

engaging in different types of work including petty trading. As we said there are multiple discourses of masculinity and femininity in Ethiopia and hence there are different subjectivities constructed by these discourses. Each of these discourses work to normalize different sorts of behaviour and thereby produce power in different ways.

Women often have unsafe sex for reasons that have less to do with money per se than with cultural ideals for heterosexual relationship and gender roles (Mehata and Sodhi 2004:29). Hence, the presentation of women's poverty seems to overlook the web of factors that may push young girls to involve in sexual relationship and that would make them vulnerable to HIV/AIDS. It is for this reason that I am critical towards the overemphasis placed upon women's economic deprivation in the prevention work. Although the NGOs I visited undertake various activities to raise the awareness of men regarding the transmission of the epidemic, their focus lies on women and especially on those segments of the population like poor women. Although the effect of poverty on women's lives should not at all be underplayed, the tendency to consider poor women as easy pray of rich men has to be looked in relation to the wider global context. As Mohanty has argued, the emergence of the position of 'Third World Women' has the effect of constructing a homogenized 'other' to the subject position of Western women. Mohanty goes on and affirms that the representation of such women as *"...ignorant, poor, uneducated, tradition bound, domesticated and victimized' allows a contrasting conception of Western women as 'educated, modern, having control over their bodies and sexualities and the freedom to make their own decisions'."* (Referred in Alsop et.el. 2002:86-87).

It is on the other hand true that women beneficiaries stressed their economic problems and that they demanded support from the NGOs. Hence, the NGOs focused on the women's account, considering it as most important. This stance might however be made problematic. As Hollway reminds us: *"Once an account is given, it assumes the status of the expression of the person's experience in relation to a particular topic. What is not considered is the status of the account in relation to the infinite number of things that were not said"* (Hollway 1994:40). I believe that it is useful to see the

beneficiaries' accounts as one production among infinite possibilities. It is important to look at these personal accounts by being sensitive to contradictions and avoidances and by exploring similarities and differences between them. What an informant told me during tea break at a peer education session could be one example of these multiple possibilities:

It is good that we discuss our problems openly but we don't repeat what we say here at home. They tell us to say no to men when we think a sexual contact has a risk of HIV infection. This is the right thing to do but where is a woman going to live after refusing to have sex with her husband? (Informant 76).

This woman underlines that some of the information and advice she is given by the NGOs is not possible for her to use in practice. As Rachel (2001:10) also notes, married women in Ethiopia remain vulnerable to HIV/AIDS regardless of their financial situation, since they do not have negotiating power in their marriage to convince their husbands to use condoms, even when they suspect they are at risk. Similarly, during coffee ceremonies and peer education sessions arranged by the NGOs, I heard female participants mentioning cultural factors that impede women from protecting themselves from the AIDS epidemic. Such facts impel us to direct our focus to other aspects of the women's lives in addition to the purely economic issues.

The presentation of women as a homogeneous group fails to appreciate the specific gender dynamics of the particular society. Since discourses and discursive practices provide subject positions, and since individuals take up a variety of subject positions within different discourses, the gender relations in a specific society and the specific negotiations individuals engage in must be empirically explored and not assumed. The way men and women negotiate the gender and sexuality discourses in Addis Ababa influences their subject position vis a vis the victim position.

If I see my daughters with men, I will stone them to death. I mean it (Informant 1).

Though it was only one woman at Lideta who went so far as being determined to stone her own children to death, many parents said they would take serious measures if they found out that their daughters were having sexual relationships with men. Three women talked about throwing their daughters out of the house if they were found to have sexual relationship while still going to school. In addition to prevent their daughters from catching the virus, this might also indicate the prevailing feeling in Ethiopia that girls might be contaminated by masculinity. The reciprocal is however also true: boys need protection from the dangerous influences of the feminine in order to maintain their masculine selves. The women assumed that the separation of the sexes prevented each from being polluted by qualities of the other.

I also interviewed some parents who strongly believed that unmarried girls should not even be friends with boys. Here the reason given was not contamination of masculinity in general but of HIV/AIDS in particular. Any prior sexual relationship before marriage was unacceptable for them because as one of the woman said *"this is very risky during the time of HIV/AIDS."* Her fear is neither only explicitly related to sex before marriage in general. She stated:

As a single mother I always tried to take good care of my children, providing everything they need. I have a conviction that these girls don't need boys. What they should do is concentrate on their studies. I strongly criticize parents who just leave their children to do whatever they want with their lives. We need to tightly control our children especially today because of the spread of AIDS (Informant 22).

For this parent sex in our times should take place within the framework of a lasting relationship. Most of the parents I interviewed had no knowledge of their young children's sexual lives however. Some of them said they suspected that their daughters and sons had boyfriends and girlfriends because of the telephone calls they received and made while at home. Some said they suspected that their children had dates, simply from the way they dressed and prepared for different occasions.

One informant said '*wondima wond new/* Of course, a man is a man!' and underlined that women should not be compared with men because they are sexually different. For this woman, it is girls who should not be seen with boys but not vice versa. Although the woman had only two daughters, I asked how she would feel about boys having girl friends. According to her, men have stronger sexual needs than women and hence it is appropriate to tolerate them. This is the similar argument that we discussed previously in this chapter. A number of other women that I interviewed on the same issue also suggested that it was more important to control girls than boys. The reason given was that a school girl's life could be destroyed by an unwanted pregnancy while the boy who impregnated her could easily get away with what he did. According to these respondents women face more problems in life than men particularly because of their reproductive role.

Although this argument holds water, the problem relates to the double standard set for men and women. Most of the women said women's sexuality should be controlled but not men's. It seems as if problems related to sexual matters are the sole responsibility of women or could it be that the women are regarded as the only ones capable of, or expected to, controlling it. In the case of HIV/AIDS, the presentation of women as victims of the epidemic could also be seen in the light of this argument. Women are victims of HIV/AIDS because of their bodily disposition for pregnancy but they are regarded as responsible for not engaging in sexual relations. Here we can see how gender discourses construct men and women's sexualities differently.

Other and more complicated examples are illustrated by stories told by my female informants. They told about the contradictory discourses they had to negotiate where young girls on the one hand are expected to avoid sex and at the same time are pressurized by their male partners to involve in sexual relationships. One of the girls at Lideta said that young women are expected to stay virgins by their parents and the society at large and at the same time those who stayed virgins were positioned by peers us 'uncivilized' and 'conservative'. According to this girl it was difficult for many young women to withstand the peer pressure and avoid sexual intercourse. She added that many young girls she knew succumbed to men's sexual demands and had

to quit school and face unwanted pregnancies. Mens and women's difficulties in protecting themselves from HIV/AIDS should hence be discussed in relation to the subject positions created for them in the current Ethiopian gender and sexuality discourses. The knowledge of how to protect oneself does not seem enough to ensure that people act accordingly. Peer pressure is here viewed as responsible for creating victims amongst youngsters, both girls and boys. A young man described the dilemma like this:

When I was in high school, I was under a lot of pressure by some of my friends to start to have sex. I even had a nickname 'Dingilu' (the virgin). As I was unable to withstand the pressure, I had to do it. I had to look for a girlfriend to do it to prove to my friends that I was a man. I did it and it was a big relief to get rid of that nickname. When I look back, this was one of my gravest mistakes in life since I had sex without any protection. I could have contracted AIDS and lost my life for no reason (Informant 29).

Another contradictory issue in relation to the subject of 'victimhood' is the way HIV/AIDS prevention programs in Addis Ababa urged women to take control in sexual encounters, whilst at the same time ignoring the process which makes this difficult and, in some cases, dangerous. While the normative female sexuality is constructed as 'passive', it is elsewhere threatened by the allocation of responsibility for negotiating sexual practices, showing the contradiction within the dominant AIDS discourse.

I found that some of the activities of the NGOs seemed to place the responsibility of avoiding infection solely on the women. For example commercial sex workers were told only to have sex when using condoms. As it was repeatedly mentioned, this advice does not give due consideration to the power relationship between the women and their clients. The NGOs did not take into account the fact that although the women want to protect themselves from infection, there could be numerous occasions when they would be forced to take part in risky sexual encounters. While attending peer education sessions at one of the NGOs, I had a chance to observe women

repeatedly asking questions on how they could protect themselves from HIV/AIDS if they were unable to convince their male partners to take precautions. This problem could be related to a more general problem in HIV/AIDS prevention in Ethiopia. Some of my interviewees at the NGOs complained that the HIV/AIDS policy, as well as the strategic framework to prevent the epidemic, does not mention specific plans as to how women could be given special attention.

Religion

Although the dominant scientific HIV/AIDS prevention discourse did not sufficiently provide practical means to protect women from HIV/AIDS, the women supplied their own answers to the problem. Some of the respondents tried for instance to explain women's victim position in the HIV/AIDS discourse by indicating how it intersects with religion. The following verse was cited during an interview at Lideta:

But as for you, speak the things which are proper for sound doctrine: That the older men be sober, reverent, temperate, sound in faith, in love, in patience; The older women likewise, that they be reverent in behaviour, not slanderers, not given to much wine, teachers of good things- That they admonish the younger women to love their husbands, to love their children, To be discreet, chaste, homemakers, good, obedient to their own husbands, that the word of God may not be blasphemed. Likewise, exhort the young men to be sober minded (Titus Chpt. 2 Verse 1-6).

Citing this verse from her Bible, my young female informant at Lideta tried to justify the fact that women and men are assigned different positions in society. She asserted that serving men does not in any way indicate the subordination of women by men but rather complementary, mutual responsibility. The young lady further stated that a man has the responsibility of taking care of his woman and providing for her needs. For her this is the only way that men and women should live together supporting each other and fulfilling God's wishes.

For a number of my informants at Lideta, women's position in society is explained in relation to religion. According to them God created men and women differently and

also placed them in different positions in society. Hence, the place of women is undisputed for its religious bases. Some explained these differences referring to the Genesis and the fact that Eve was created after Adam so that she could be partners with him and support him. According to my informants respecting religious rules is the most important thing in one's life.

The religious discourse supplies us with another important twist for understanding of the intersection of gender, sexuality and HIV/AIDS. Following from this position is that a woman is in no position to challenge her husband, at least not as long as he is keeping up his part of the bargain by taking care of her and providing for her needs. As Bethlehem (2000:40-41) asserts, the two dominant religions in Ethiopia, Orthodox Christianity and Islam both adhere to the subordination of women in the family One unfortunate example of the Church's influence on women occurs when women are advised not to use condoms by the priest because he considered it to be against God's wishes (Flemmen forthcoming). The woman in question did not contract HIV as a result but she had several unfortunate pregnancies. Peterson and Bunton (1997:xiv) explain: "*institutions like religion are coercive in that they discipline individuals and exercise forms of surveillance over everyday life in such a way that actions are both produced and constrained by them*".

We can say that religion as an institution exercises a moral authority over the individual by explaining individual problems and providing solutions for them. Hence, its coercive character is often masked by its normative involvement in the problems of individuals. In one study it was noted that in Ethiopia, women living with the AIDS virus tend to seek refuge in religion for emotional comfort (referred in Pankhurst 2005:51). We may say that the women gain a position of strength by bringing themselves and their actions into alignment with God (Mills 2004:76). The role of Religion as a refuge is quite important in relation to the fear of HIV/AIDS in Ethiopia as the following excerpt from a poem titled *'Tareqen/*Have Mercy on Us' by an Ethiopian female writer illustrates:

God the Almighty! Have mercy on us
Enable us to stay in good health
Protect us from the deceitful disease
Let our children grow and mature
Let people have peace and awareness
Save us from the devastation
God the Almighty please have mercy on us. (65) (Cited in Zerihun 2005:12)

According to a number of my informants at Lideta, the male sexuality and persons of the male gender are created by God as active, aggressive and powerful, while female sexuality and persons of the female gender are passive, powerless, receptive and submissive.

Biology

This division is supported by an appeal to 'essence', the fundamental quality of maleness and femaleness - an appeal to innate physical or psychological abilities deemed functional to the sex-appropriate task. The essentialist distinction sets up an opposition that makes men dominant and agentic while women are dominated and passive. My critique of essentialism is not intended to deny the fact that women are more susceptible to HIV/AIDS than men due to biological reasons. During unprotected vaginal intercourse a woman's risk of becoming infected is up to four times higher than that of a man. The vagina's greater area of susceptible tissue (compared to the male urethra) and microtrauma during intercourse make women more physiologically vulnerable to contract HIV. Researches also show that an untreated STI in either partner can increase the risk of HIV transmission as much as 10 times. Women's symptoms are often latent or difficult to see and many women who have been diagnosed with STIs have no access to medical treatment. Even if they have symptoms thousands of women may also bear the pain and discomfort of STDs because they are too ashamed to visit a doctor (Sehin 2000).

As women's relations to STDs indicate, biological vulnerability is too often reinforced by socially constructed constraints on women's ability to protect themselves, increasing the likelihood of the women to become victims. Women with

STDs choose not to visit doctors not because they do not want to get cured but because gender and sexuality discourses as social constructs, create these women's subjectivity in such a way that they prefer enduring the pain of illness to exposing their ailment to the public.

The victim position seems to be more suitable for women as far as the gender relations in general are described by more informants. Although there were considerable differences in the way respondents thought about the issue, quite a number of the men and women at Lideta preferred women to be quiet and less aggressive than men. A woman should not be '*Wendawond*/Mannish' referring to women behaving like men because essentially womanly qualities may be destroyed by taking on male roles or male attributes. Becoming more 'like a man' in the field of leadership may make one less 'like a woman' - potentially a positive situation but an assertive and outspoken women will be called *'Aynawta'* (literally translated as *'one who plucks an eye from its ball')*. This is a commonly used Amharic expression to insult a woman for being thick-skinned and shameless by being too assertive and outspoken. Similarly there were a few women I interviewed who believed that a woman should be *'angetwan yedefach'* (literary translated as 'someone who bows her head'), meaning that she should be shy and not at all assertive. The reason one of the informants gave was the following:

It is our tradition that a woman should be shy and soft. She should not be 'Wondawond' (Mannish). Nobody wants to marry a girl who is aggressive and outspoken. As you know marriage is so important for a girl because it is God's will. A girl should behave properly so that she gets someone to marry her (Informant 20).

As the woman's opinion on desirable female character indicates, the major axes of sexuality and religion intersect with gender in ways which can be said to enforce their position of the victim in the HIV/AIDS discourse. The quotation indicates that a woman's assertiveness may be perceived as vulnerable and have a polluting effect of one's other female essences. Gender and sexuality discourses contribute significantly

to how societies establish the 'truth' of the subjects, and the norms for the relations that subjects should have with themselves and others (Danaher etal.2000).

The above detailed discussion of the positions of men and women in society and how they move into and out of the perpetrator and victim positions was an attempt to analyze how the discourses of gender, sexuality and HIV/AIDS intersect with religion and biology. I have stressed the fact that there is a need to avoid objectifying accounts of women where women are portrayed as passive victims, and where no agency is possible to envision. In criticizing the victimization of women in HIV/AIDS discourses, I am not denying that the position of women in Ethiopia makes them more likely to be victimized than the men. As Schwartz and Rutter (1998:34) put it: *"sexuality is one of the most diverse, pervasive, and enigmatic of human experiences."*

7.4. Resistances to Victimhood

The HIV/AIDS discourse that positioned women as victims as well as the related gender and sexuality discourses and practices were contested by my informants. As discussed earlier, most informants at Lideta confirmed the authority men hold within the home and their dominance in sexual relationships, but this does not mean that women have no options regarding their sexuality. Although we do not find many instances of public and collective resistance, women privately and individually oppose dominance. Resistance to power through new discourses and practices will therefore produce 'new truths'. As the following discussions show, women resist vicitmhood by challenging dominant HIV/AIDS, gender and sexuality discourses and practices.

7.4.1. Resistances to Risk of HIV Infection

Different forms of resistances to risk of HIV infection were revealed during my discussions with my informants. Most of the women were very much aware of the ways of HIV transmission and prevention. More than having awareness, the women

reported that they took different measures to keep themselves as well us their family members away from the risk of HIV infection. Some of these measures will be discussed below.

Avoiding Risky Sexual Encounters

During my fieldwork I also found out that some women had started to ask for HIV test results before getting married. Even though this was encouraged by AIDS prevention programs, respondents told me that it was not a common practice. Some said married women have also started to ask their husbands to take HIV test when they suspected that the husbands were not faithful to them. The sad story according to these informants is that most of the time the husband would be sexually involved with his wife and another woman at the same time, and the likelihood of infecting his wife is high if the other woman is HIV positive.

Some of my informants at Lideta cited examples in which women had refused to marry because the men refused to undergo HIV test before marriage. Two young women told me about their own experience where they had to resist risky sexual encounters. One of the women said the following:

I met a good-looking man when I used to go to evening classes last year. I liked him so much since he knows how to treat a woman. As our relationship grew stronger, he asked me to have sex with him. I told him that we had to take HIV test first before we had sex. He tried to convince me that he didn't have the virus since he hadn't any sexual relationship with a woman for a long time. One day we had a long discussion on the subject and he tried to make me change my mind. I insisted that we had to take the test first. I never saw him again after that day (Informant 2).

As we could see from the narration above, the woman refused and resisted the man's sexual demand in order to avoid risk. It was mentioned earlier that the issue of trust was repeatedly mentioned by both men and women informants. Most informants

recognized that AIDS is a danger and a risk of a very uncertain kind because one cannot easily tell who has the virus. They mentioned some cases where men involved in extramarital relationships were asked to take HIV/AIDS test by their wives before restarting sexual relationship.

A few informants also stressed that a woman should ask for divorce if she suspects that her husband may have had extramarital relations, in order to protect her own life. I found that there were a few cases reported to the Lideta Women's association where women left their husbands and refused to have sex when they suspected that their husbands were HIV infected. Here we can say that the AIDS epidemic has led women to take unprecedented steps to protect their safety.

The Lideta Sub City Women's Association leaders mentioned examples of cases where women who suspected their partners to be unfaithful to them sued their husbands for demanding sex without condom. These women came to the association for help and their partners were given an ultimatum to respect the interests of the women. Although these women were very small in number, there were some attempts to bring and discus the issue of women's condom use openly.

Most of the commercial sex workers at one of the NGOs said during peer education session that they always made condoms available before any sexual encounter. One of the ways mentioned by the women to avoid risk of HIV infection was to scream loud if forced to have sex without condom so that people would come and rescue them. The following was another 'technique' mentioned by a commercial sex worker:

I usually come across men who try to force me to have sex with them without condom. Most of these men are very drunk and they don't seem to know what they are doing. It is very difficult to convince men to use condom. One technique which worked for me is to tell the men that I am HIV positive and that they need to use condom to protect themselves. This technique worked for me because most men left the room in a shock when I told them that I was HIV positive and the others used condom (Informant 78).

This woman used her wit to convince her clients that she was HIV positive after trying different ways to convince the men to use condom. In order to avoid the risk of infection, she went as far as telling a lie to her clients that she was HIV positive. The woman knew that she would lose these clients in the future; as it is unlikely that those men would choose to have sex with an HIV positive woman again. As she said, *'losing clients means losing income and starving to death'*. While using what she called her own 'technique', this woman resisted the dominant gender discourse by controlling access to her sexual services in one way that she could do so.

During peer educations sessions, commercial sex workers said that woman must put condom on a man's genital since, according to them, most men are not good at using condoms properly. These women insisted on being in charge of condoms because as they said, some men use pinched condoms which would easily be destroyed or removed during intercourse. They said this is a trick men use to have unprotected sex with women. Some of these women said that they would never drink with a client to a point of loosing control so as to avoid the risk of indulging in unprotected sex.

In a study on commercial sex workers and HIV/AIDS in Addis Ababa, 74 percent of the women said that they would never provide services to man who was drunk and 66 percent of the women said that they would never accept a man outside of a specific area while 65 percent of the women said that they would never go with a man to a destination they did not know. Furthermore, the same study stated that 96 percent of the respondents said they exchange information about dangerous/bad men. 95 percent of the women said, they would try to protect each other against danger (Pankhurst 2005:65). All these are but different forms of resistance that women use to avoid risk of infection in multiple sexual relationships. I strongly believe that the different strategies used by individual women deserve due emphasis as they seemed to be on a very small scale, but realistic and practical means to avoid the risk of HIV infection.

Most of the unmarried young men and women at Lideta said that they chose abstinence to the other methods of avoiding risk mainly for religious reasons. These informants told me that the church taught them that a Christian marriage should be celebrated in holy matrimony*. They said that their plan was to be virgins until the time of their marriage and in this way the risk of infection was not their biggest worry. One of them explained: "*God created one man and one woman in His first creation to illustrate that marriage should be confined to one man and one woman, and one woman for a man*". As it was discussed in detail in chapter five, religion intersects with sexuality and HIV/AIDS discourses, and people frequently activate the religious discourse in conversations. Here it is mobilized to support the young women's choices.

Women's Role in Prevention Efforts Aimed at Reducing Risk of HIV Infection

In the prevention activities of HIV/AIDS that I have attended, women shared information about different ways of protecting themselves from HIV infection. For example members of the Lideta Women's Association shared experiences about sexual issues during their meetings. Although only a few women had the courage to stand up and narrate their sexual experiences during meetings, most of the other women asserted that they supported the idea of sharing experiences. Two of the members I talked to said that they had learned a lot from the experiences of women who were able to avoid risky sexual encounters. These women added that these potent examples have led them to think of such possibilities, as running away, demanding divorce and refusing sex in order to avoid the risk of HIV infection.

In one meeting a woman was narrating her experience of refusing sex without condom because she suspected that her husband was not faithful to her. A woman told her to be ashamed of speaking about it, while the others were concurring excitedly at this blunt statement of their common dilemma. Some of the women were

* Holy Matrimony is a sacrament in which the priest prays and blesses the bride and the groom who make their marital vow in the church to create unity and fulfill the obligations required by marriage.

bowled over by the women's frankness howling with laughter and shame, covering their faces with their 'Netela' (hand woven cotton cloth). Another woman raised her hand and told the audience that she could not imagine a woman refusing to have sex with her husband and said she could not at all believe the woman's story.

It is worth noting here that Giddens' (1992) exploration of 'transformations of intimacy' mainly focuses on the western world, and discloses a new world in which sexuality is no longer hidden in the private domain, but opened up to public negotiation and discussion. In the case of Ethiopia, also we could say that the AIDS epidemic has to some extent drawn sex and sexuality into the realm of public discourse.

Since women are not a homogeneous group, there are considerable differences in the way they address their personal sexual problems. In spite of the fact that the majority of the married women I talked to were not at all comfortable to discuss their personal sexual lives, I was able to observe peer education sessions for commercial sex workers where open discussions were held on sex in general and the use of condom in particular. For these women, it was not at all 'embarrassing' to demand condom use during sexual intercourse.

According to the interviews with members of the two NGOs, women beneficiaries were more interested in their programs than men. They said women had been actively participating in their programs and showed keen interest to know more about the epidemic. It was the view of most of the staff of the organizations that women tend to be much more reliable than men when it comes to taking responsibilities with regard to prevention activities. This may be taken as a sign that the women exerted effort to counteract the dominant AIDS discourse that labels them as 'hopeless victims' of the epidemic. They are also taking responsibility for their children not contracting the virus.

Almost all the women I interviewed had much knowledge on HIV/AIDS in general and about the risk of infection in particular. This does not harmonize with the commonly held assumption that women have less awareness about the epidemic and its risk, an assumption that always portrays women as 'victims' of the epidemic. As the earlier discussion tried to explain, women have the capacity to resist the suppressive discourse of gender and sexuality that might expose them to HIV infection. A very important point to note here is that these women's resistances must be understood and analysed in relation to the socio-economic and historical contexts of the Ethiopian society.

Most of the female informants at Lideta have told me that they always tried to make their children aware of the dangers of HIV/AIDS. These women seemed to express concern for their partners and families over themselves. Although some women felt that their views were not taken seriously by their children, considered as unfashionable, it was the opinion of some that they were exercising their duties by alerting their children about the dangers of risk related to the epidemic. This was what a woman said:

Whenever my two children are about to go out of the house, I tell them to be aware of this disease. Very often their response was that I shouldn't be worried that much since they know about the epidemic. Although I don't have the courage to discuss sexual matters with them, I am doing my best to make them aware that there is danger out there and they should take care of themselves (Informant 12).

Although this woman did not break the society's taboo to speak about sexual matters, and to discuss with her children about how they should protect themselves from the epidemic, she is in her own way contributing to the fight against the epidemic. Women strategize within a set of constraints defining and controlling their sexuality in order to achieve their own end. However, my fieldwork showed that the individual efforts of women were not given due attention and were not considered as that much important in the fight against the epidemic. There seemed to be a tendency by

members of the NGOs to consider the efforts of these women as insignificant while labelling the women as 'powerless'. My talks with the leaders of the Lideta Sub-city Women's Association support my point since most of them did not give sufficient emphasis to individual resistances of women to the epidemic. Rather they highly praised those women who had the courage to discuss sexual problems in public while labelling the rest of the women as silent and submissive. I criticize these women for not giving proper attention to minor displacements of women to the AIDS epidemic.

Like the Women's Associations, I believe that the NGO's had a problem regarding their focus on men's and women's resistances. During peer education sessions I attended, the focus was mainly on women's stories in which men were totally denied sexual contact where minor efforts of women to protect risk were almost ignored. I was struck by the difference between the opinion some women gave in peer education sessions and during our private discussions. These women were more open in our discussions and gave me details of their opinion regarding risk in their sexual relations. They mentioned to me ways to avoid risk, ways they did not raise during peer education sessions.

One of these ways is asking relatives and elderly people to warn their partners about the dangers of their risk taking behaviour. This is just one example of women's efforts to avoid risk using the traditional way of solving disputes with the help of close relatives and the elderly. Praying to God to protect them from HIV infection was also mentioned by a number of informants as a way of avoiding risk, alignment with God considered as a position of strength. The intriguing point here is that these efforts were hardly discussed during peer educationsessions. The question is why the women discussed certain issues during the NGO's activities and mentioned other issues during the one to one interview. The reason might be what Petchesky (2003:233) contends:

> ...assuming that the terms in which people justify their own ('private') behaviour or decisions will often differ from the more 'public' forms of

> legitimation that activists may invoke, it becomes necessary to develop careful ways of listening to grasp the expressions, local codes and even silences that may signal a sense of entitlement (Petchesky 2003:233).

I assume that the NGOs had to take control of the HIV/AIDS prevention education activities mainly because the women tended to keep quiet and seemed not to have much interest in sharing their knowledge. In a culture where silence is considered as a virtue, the women's lack of interest in sharing their experiences in public should not at all be surprising. Sayings like *'Zimita Work New*/Silence is Gold', and *'Zim Bale Af Zinb Aygebabetim*/A fly won't go into a closed mouth' are but just two examples indicating the high value the Ethiopian society gives to silence.

Here I contend that the silences of women attending AIDS prevention activities should not make us consider that the women were totally submissive and that they had no interest in resisting the dominant gender and sexuality discourse that relate them to the epidemic. It is important to consider the way the Ethiopian society structures gender relations because women might have different ways of expressing their needs rather than speaking in public.

In line with this point of criticism, it is my contention that we need to look at silences by thinking in terms of a continuum model in which accommodative and resistant acts are linked by a large grey area in between, reflecting the specific cultural and material circumstances in which Ethiopian women find themselves. Scott (2001:147) pointed out: "*women and men are active participants - though not necessarily equal participants - in the construction of their gendered identities and their personal biographies*." A good example to support this point would be the story of a woman at Lideta. This woman told me that she sometimes created her own stories of AIDS and told them to her children and her husband pretending as if she heard them from a source. Mostly she told her family that she heard the stories from the radio knowing that there are no way these stories could be verified. This woman devised her own strategy, a strategy that she calls 'my own tactic'; to support whatever information she

wants to pass to her family with reference so that the information could have credibility. She said she did that to avoid the common question 'where did you get this information from?' Some of her own stories included stories about men who got drunk and had unprotected sex. She told stories to her children about friendship and risky sexual behaviour. This woman's experience indicates that women may devise their own ways to break the socially imposed silence on sexual matters. I strongly believe that it is by giving due consideration to such individual efforts that we could pave the way for breaking the silence surrounding the issue of HIV/AIDS in Addis Ababa.

7.4.2. Suppressive Gender and Sexuality Discourses and Practices Challenged

It must be emphasized that it was only when asked different questions and details of their accounts that my female respondents produced information that contradicted the dominant discourses and practices of gender, sexuality. Resistances of my women informants were more subtle individual resistances or 'private' subversion. These resistances include running away from abusive sexual relationships and criticisms on suppressive gender and sexuality discourses and practices.

Running Away

A number of my female informants at Lideta were migrants from rural parts of Ethiopia. Some studies also indicated that a large number of rural women migrate to Addis Ababa in search of better life. These women mostly come to cities running away from early marriage and abduction and other harmful cultural practices (Mulumebet 2001; Pankhurst et al. 2005). Consider the following report by an informant:

After I decided to leave my husband, day and night I used to think of how I should get away. It was a friend of mine who brought up the idea of escape. We took almost nothing with us to avoid suspicion. That day I couldn't wait until the bus drove away.

First I stayed with my friend's relatives for some time. Later on I moved to the house of my aunt who lived at Kolfe area of Addis Ababa (Informant 18).

The story of this woman tells us that women try to resist oppressive sexual relationships in whatever way they can, and running away is one form of resistance. But it does not mean that this resistance necessarily brings better opportunities for such women. In the case of Ethiopia, the women who run away from early marriage and abusive sexual relationship might end up in more abusive relationships in cities. Most women run away from their homes without knowing their destiny. As women beneficiaries at the NGOs told me, most of them would run away from their rural birthplaces to urban centers hoping for better life but they were more likely to become domestic servants or prostitutes. Most of the commercial sex workers complained about their work and wished to leave it because of the risk of HIV infection. A number of them said they came to the NGOs not to get information about HIV/AIDS but to explore possibilities of getting another means of income so that they could leave commercial sex work. The following experience of a woman illustrates this point:

I was so unhappy with my marriage. My husband was much older than me and used to beat me so much. He also used to force me to have sex with him. Whenever he beat me I ran to my parents as my parents' house was not very far from where we lived. I realized that he would be fed up of fetching me from my parents' house if I ran away from him all the time. I started to go to my parents' house repeatedly. I was persistent in my actions even though my parents severely reprimanded me for running to them whenever I had a disagreement with my husband. Finally, I won. He got fed up of looking for me and asked for a divorce (Informant 26).

Although this woman was unable to refuse to have sex with the man while she was living with him, she used her own wit to find a way to resist him and free herself from sexual abuse. What is very perplexing in the case of this woman is that after running to Addis Ababa she became a commercial sex worker. Even though she left her

marriage to avoid sexual abuse, as a commercial sex worker, she said she experienced sexual abuse all the time. Like this women some respondents at Lideta told me that they divorced their husbands before running away to Addis Ababa. Although divorce is common in rural Ethiopia, it is not easy when the demand for a divorce comes from a woman.

Young girls react in different ways when they become victims of parent's excessive control. One informant told me a story about the daughter of her neighbour who ran away to *Dire Dawa* city and became a commercial sex worker. She believed that the mother's strict disciplinary measures were the reasons for the young girl's decision to run away to another city. She said the young girl was regularly beaten even sometimes for trivial mistakes she made.

The runaways' life as a sex worker might not have been what she dreamed of, however. But as far as the neighbour was concerned the daughter's reaction was provoked by the mother's bad treatment. The woman quoted above vividly described the guilt-ridden remorse of the mother when the sad news of the death of the young woman came from Dire Dawa about two years ago. From the description of her sickness the neighbour stated that the cause of the death of the young women was likely to have been HIV/AIDS. The story of this young woman indicates that a teenager may react against her or his background, reject parental and community opinion, and search for what she or he perceived to be a more 'authentic' self, which may be achieved by moving away from parental control. Here we could see that running away is considered as one way of resistance to suppressive gender and sexuality discourses in Addis Ababa. Foucault (1997:292) also contends: " *...in power relations there is necessarily the possibility of resistance because if there were no possibility of resistance (of violent resistance, flight, deception, strategies capable of reversing the situation), there would be no power relation at all".*

Suppressive Gender and Sexuality Discourse and Practices Criticized

During interviews, women at Lideta were highly critical towards the dominant gender and sexuality discourses and practices that position them as victims. In my analysis I will not rely on the commonly held viewpoint that individuals need to strongly oppose the dominant gender and sexuality discourses or bring about significant changes, in order for their actions to be considered as resistance. I would argue that criticizing dominant discourses and practices is one way of resisting them.

No doubt, marriage is a highly respected institution among the public but my material shows that it is not without criticism. According to a study on rural areas of Ethiopia, women complaining against multiple marriages are on the increase; so are cases related to sexual incompatibility (MHRC: 2004: 61). Three women at Lideta confided in me telling me that they were not that happy with their marriages. These women considered marriage as oppressive to women. They seemed to be highly aware that they did not share equal responsibilities or have similar authority with men within the household simply because they were women. These women recognized that they were treated unequally mainly because of culture and their economic dependence on men.

Some of the women at Lideta said marriage was not a choice but an obligation that they had to fulfill as women. A few expressed their envy towards educated and career women whom they thought had more freedom to decide on their lives. A mother of seven children said, she had no goal in life because she barely had time to think for herself because her whole energy was consumed by "*Lij Mefelfel*/incubating babies'.

This woman's opinion was shared by many others since all felt that raising children is a burdensome job consuming almost all the time and energy of a woman. Some of these women went as far as equating raising children to 'failure' in life. For them, taking care of children is a set back to success because it deprives them of pursuing education and heralding their independence. Moreover, a number of the women mentioned household chores as boring and unending.

Young women and men at Lideta expressed concern about the way the Ethiopian society suppresses the sexuality of young girls and boys. Parents use cohesive measures to control their children's sexuality. The young informants added that the measures are so controlling that children tend to use every means to free themselves from parental domination while at the same time putting themselves at risk of HIV infection. The pressure to conform to peer pressure, especially among the youth, was closely related to their resistance to forms of sexuality that they considered as old-fashioned, boring and out-dated. A young informant said her parents would reprimand her if she laughs loud due to their belief that a woman should suppress her emotions so as not to sexually attract men. She mentioned that not only her parents but also her elder brother was very controlling. He repeatedly beat her for being seen on the street with school boys. This was what she said:

I can't tell you how my parents try to control me. It is so irritating. They try to follow all my moves. I can't talk to any of my friends over the phone. If I come home from school 10 minutes late, they would be furious suspecting that I was flirting with 'Goremsoch'(young men). They make me feel like I am irresponsible and naive. There were times when I wished that they were not my parents. I envy children who have parents that trust them (Informant 6).

The young woman is provoked by what she interprets as her parent's lack of trust in her. She feels that they do not treat her as a responsible and sensible person. The opinions of my young men and women informants on sexual matters seemed very different from most parents. The young ones strongly criticized the widely held attitude that rape and other forms of sexual violence result from women's own behaviour that may tempt men to put pressure on women. Compared to their parents, my young informants were highly critical of the culture that suppresses the sexuality of young women and men. There were some young respondents who criticized the Ethiopian culture in general for not allowing men and women to openly express romantic feelings. As Dowsett (2003) notes, global youth culture has repositioned young people with a legitimacy of erotic concerns and possibilities. It is my belief

that we can better understand the AIDS epidemic among young people if we configure youth as constructed within emerging and globalizing sexual cultures.

I sensed that there had been changes with regard to people's general attitude towards men and women's sexuality. Modernity was mentioned by a number of respondents as a cause for this change. A number of respondents at Lideta for example expressed their worries about the bulk of pornographic movies coming from the West. Nevertheless, there were informants who described the change of attitude towards sexual matters as inevitable.

A good example with regard to counter discourses seen as changing attitudes towards gender and sexual matters is my informants' attitude towards wife beating, a practice that is said to be widely prevalent in the society. Some of these respondents mentioned the common Amharic saying '*ሴትና አህያ ዱላ ይወዳል::/A woman and a donkey like the sticks'*. The Ethiopia Demographic and Health Survey gathered information on women's attitude toward wife beating. Women were asked whether a husband is justified in beating his wife under a series of circumstances. A sizable majority of women (85 percent) believe that a husband is justified in beating his wife. One in two women believes that a husband is justified in beating his wife if she refuses to have sex with him. Two in three women believe that a husband is justified in beating his wife if she burns the food or neglects the children. A slightly smaller percentage agree that if a woman argues with her husband (61 percent) or goes out some where without telling him (56 percent), then he is justified in beating her (CSA 2001:33).

Except for two women, all informants were against wife beating saying that it is out-of-fashion. Both women who thought wife beating was important are women over 50 years. The women's age might indicate that the practice is fading away. This can be seen as an example of how discourses are prone to change. Even those who did not condemn the practice did not think it would continue to be practiced in the future. This is what a woman of 75 said:

I believe a husband should beat his wife once in a while. How could a man express his love for his wife otherwise? My husband used to beat me very often. Although most of the time I used to feel the pain, I never complained. Don't ask me what I feel if my sons-in-law beat my daughters because I don't want that to happen to my children. The world has changed. Today, men have different ways of expressing their love to their wives and beating is not one of them (Informant 1).

The woman still believes that wife beating is a good practice in marriage but she did not want it to happen to her children. The woman also reflected on the changes by quoting a common Ethiopian saying, *'Bedero Bere Yarese Yelem*/No one uses an old ox to till', an Amharic saying which explains that time changes and we could not stick to old ways of doing things. This implies that gender and sexuality discourses are not stable but fluid and they change over time. As the woman's varying opinions on wife beating testify to, one woman can occupy contradictory positions in discourse, as both in favour of and opposed to the practice.

The women may occupy contradictory positions in the discourse, but sometimes different and competing discourses exist side by side. One such area was premarital sex where most objected to it while some said it should be tolerated. As Rachel (2001:199) notes, one of the major conflicts that emerged from her study is that women in Addis Ababa are having sex in a context in which there is still a high premium on female virginity. Thus, there is conflict between normative and actual sexual behaviours; that is, there is a gap between young people's sexual standards: what is considered normative and what people actually do. This is not exclusive to Ethiopia. Danaher et al. (2000:145) try to explain the cause of such gaps as follows:

> ...Direct prohibition doesn't effectively control behaviour, because the more the network of rules and regulatory devices increases, the less possible it is to successfully police all of its aspects; and the more that people explore

prohibited or controlled practices, the more those practices become 'normal' (Danaher et al, 2000:145).

This difference of opinion on sex indicates that a society creates a 'normal' sexuality but different families and subcultures can have their own ideals. In the case of Ethiopia, society at large may not accept premarital sexuality but this does not mean that there aren't different practices implying that men and women do things that the society might not approve of. A mother of two young girls said:

In our culture, sex before marriage is unacceptable. In my generation it was almost unthinkable for a woman to be involved in premarital sexual relationship. Now a days, we parents are more tolerant so we will not react so aggressively if we find out that our daughters are involved in a sexual relationship. Times have changed (Informant 10).

Most informants mentioned that there is a high prevalence of commercial sex work in Addis Ababa. As discussed elsewhere, this may be easily related to poverty as uneducated and unskilled women might tend to join sex work due to lack of alternative jobs. But the proliferation of sex work had been an issue way back at the beginning of the nineteenth century when poverty was not a serious problem as it is at present.

In his study of the social history of Ethiopia, Pankhurst (1990: 261) states that prostitutes' profession was considered entirely natural at the beginning of the 19th century in the then capital Gondar. He mentions two Europeans who visited the place saying that the prostitutes were not despised in the capital like those in Europe for nothing shameful or degrading was associated with their occupation. But this has changed drastically. It was the opinion of most of my informants that the AIDS epidemic has played a big part in enhancing the negative image of commercial sex work. The contradiction still remains as the number of prostitutes in Ethiopia has increased drastically over the years (Pankhurst et al 2005).

It is only when we look at how the discourse of gender and sexuality intersect with the religiosity of Ethiopians that we start to see the contradiction more clearly. Levin tried to look at this contradiction in the religious Amhara ethnic group of Ethiopia describing it as 'the dichotomy between decency and sexuality'. He states that the proliferation of brothels in Ethiopian urban centres made sexual initiation for men easy, while it separated marriageable girls from the 'enjoyable' ones (1965: 126).

Resistance by legal means

I had to leave my husband two years ago. He used to come home always drunk. I was worried for my life suspecting that he could have had sexual relationships with other women. He used to beat me all the time. I had enough abuse and humiliation that I decided to leave him. My parents were against the idea of divorce thinking that I would be unable to raise my child by myself because of the humiliation that would bring to my children. They said I shouldn't allow my child to be called 'Yeset Lij' (Informant 7).

*'Yeset Lij/*A woman's child' is a commonly used insult for children with bad manners and it also signifies being a coward. Children of a single woman are considered to have had lax upbringing, as they are believed to lack the firm guidance of a man. The absence of a man in the household is associated with a marginalized social status. This kind of insult of single mothers could be seen as a way that society uses to keep women where they are so that they can not resist and demand divorce. The woman in the above quotation didn't listen to her parents but followed her own plan.

Another example of resistance by legal means is the case of the sick woman who came to the Lideta Women's Association to sue her husband for forcing her to have sex without her consent. The woman was severely sick with tuberculosis and the reason she came to the association was to have legal protection so that the man would be banned from demanding sex. As the leaders of the Association said, the woman

was so sick when she came to their office as she barely had energy to describe what was happening to her for months.

Two of the leaders of the association somewhat blamed the woman for bearing the pain of having sex with her husband for so long, suggesting that she should have looked for help much earlier. Although it is true that the women would have got help, had she come to the Association earlier, the comment of the leaders of the association does not take into account the power relation of the woman vis-à-vis her husband since the man was threatening her to throw her out of her own house if she refused to have sex with him. Having no income to support herself or to cover her medical expenses, this woman endured sexual abuse for months. The man was legally warned by the Women's Association to stop abusing his wife.

"Although women have been entitled to legal protection in cases of sexual abuse, they rarely have brought cases related to their sex lives to the association", said the Public Relations Officer of Ethiopian Women Lawyers Association. The rarity of such cases itself indicates women's difficult position to act publicly against sexual dominance. Instead women used traditional means of solving disputes when it came to their personal relations with their partners. As discussed earlier, in such cases, mostly close relatives and elderly people played the mediating role. Although mostly this benefits men, yet the very fact that women try to bring their cases out in the open could be considered as resistance.

Resistance with the Use of Force

Different from the method of resistances discussed above, some respondents told me a few cases where women took unprecedented and strong measures to resist sexual abuse. The highly publicized story of a young schoolgirl could be said to be the most famous story of such resistances. The following is the account of her case:

Defendant Aberash Bekele was walking back from Kersa School on Tikimt 2/1988 (Oct. 1995) in Munesa Woreda, Ego Yadel Kebele in Arsii Zone. The deceased, Gemechu Kebede, came with other people...and forcefully abducted her, took her to his home and raped her. On the morrow, at 9 am, the defendant took the deceased's pistol and attempted to return to her parents. The deceased gave a chase; the defendant fired three times in the air and on the fourth she shot the deceased on the chest and killed him. The judges considered the case of the prosecutor and the defendant, heard witness, and rendered the following judgment: "...the defendant has the legal right to live in peace, maintain her virginity, and marry whom she wants, or not marry at all. The deceased abducted her by force and raped her and never consulted her wishes nor tried to get her consent. When she tried to escape, he wanted to retain her, satisfy his sexual desire and force her to live with him, and took steps to use force to deprive her of her legally protected right... Therefore, the court finds that, the case of the defendant falls under article 74 of the Penal Code [Self-defense]. She cannot be penalized for her actions. Hence defendant is set free by virtue of article 141 of the Criminal Procedure Code of Ginbot 7/199 (May 1998)* (NCTPE 2003:158).

Aberash's story was highly admired by a number of my female informants but they said it was a rare case in Ethiopia since women would not get such an opportunity to escape from abductors. A number of informants at Lideta stressed the need for more legal support for women who face problems including the risk of HIV infection due to abusive sexual relationships. Most of these women criticized the legal system in Ethiopia for not giving proper support for sexually abused women†. Similarly, a poor woman who made her living on washing clothes for her neighbors at Lideta said the following:

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* On the morrow means on the following day.

† The Public Relations Officer of EWLA also said that most women refrain from bringing their cases to court, due to the long and tiring legal process. Some women at Lideta complained that women do not get the necessary support from the police or other law enforcing bodies.

I was raped by a man while I was working as a maid in his house. I got pregnant but the man denied that the child was his and threw me out of his house. I went to the police but I didn't get any help. Then I went to the Ethiopian Women Lawyers' Association on the advice of some people but they told me that I should sue the man. Since I had no money, I wasn't even able to afford the transportation cost to go to the Association. Then I went to the Women's Association. Since the man was a highly 'respected' rich man, the ladies of the Kebele Women's Association seemed to believe his words against mine. They told me to go to 'shemagilie' (a group of elderly men to solve disputes). You might not believe it but I slapped the man in the presence of the ladies and went home. I never attempted to ask the man to support his child (Informant 21).

The woman's face was covered with tears as she was narrating her story. Slapping the man was the only part of her story she narrated without tears but with a look of satisfaction on her face. She said she only hoped to get justice from God. This women's story is another example that points to the need to look at power relations at the individual level. It was difficult for the woman to convince the people at the Association that she was telling the truth. Here, the irony is that in the woman's understanding even those who are said to defend women's rights were not prepared to believe her story, whereas they believed the man who had raped her. This may be examined in relation to the deep-rooted gender discourse which positions men as rational and women as irrational. The widely used Amharic saying *'Min Set Bitawk Bewend yalk'*/Whatever knowledge a woman has, the final say has to come from the man' also supports this biased attitude.

Contrary to what this proverb states, an interesting example is the case of *Yakka*, a highly acknowledged traditional women's institution in Sidama region of Ethiopia. In this association a woman tries to counteract maltreatment within marriage by taking her complaint to the *Qaricho*, the leader of the *Yakka*, a woman responsible for organizing the activities of the association. *Qarichos* are appointed to the position of leadership by virtue of their wisdom, oratory skills and seniority of their husbands in

the chronological class system of the Sidama. Each *Qaricho* has a group of elderly women with whom to consult matters before final decisions are made.

A woman who feels that she is badly treated by her husband, a son, a father-in-law or any of her relations can summon her neighbors and appeal to the *Qaricho*. Beating could be one of the reasons to call *Yekka*. The motive and seriousness of the case has to be weighed for *Yekka* to be called. The first step to be taken would be to mobilize all married women by constructing a temporary hall for a meeting. Men, children and unmarried young girls are not allowed to participate in the event. An absentee woman without sufficient reason would be severely reprimanded and her property may be destroyed.

Women at *Yekka* sing and dance stumping their sticks while marching to the offender's homestead. Besides making the march colorful, the purpose of the singing and dancing is to make the whole community aware of the incident and to show their power. Male members are not expected to be around when the women are in the vicinity. The women enter the compound of the offender in order of importance and announce that mothers have sent them to settle a dispute. The offender may submit and negotiate with the women on the amount and kind of punishment or compensation. Such a man will be blessed by the women. If a man refuses to submit, members of this association may physically attack the man. As a group the attack could take different forms and may also include severe beating with a 2.5 meters stick called *Siiqe* kept in each woman's house for that purpose. It is also reported that the women even take-off his clothes by force, tie a small stone or a traditional jug of the Sidama on his genital and force him to go around the village' (Dilu 2001). This is hence a rather unusual example of women acting collectively and publicly to punish a man.

As the above discussion attempted to explore, women do not only resist the victim position in the HIV/AIDS discourse but also the related gender and sexuality discourses and practices I strongly believe that the different strategies used by

individual women deserve due emphasis as they seemed to be on a very small scale, but realistic and practical means to avoid the risk of HIV infection.

7.5. Conclusion

This chapter has endeavoured to explore the intersection between gender, sexuality and the perpetrator and victim positions made available and negotiated in the HIV/AIDS discourse in Addis Ababa. The point was made that HIV/AIDS does not only intersect with gender and sexuality but a web of factors including religion and tradition. In the analysis, I have showed that the discourses are not monolithic and fixed but that they are contradictory and change in the course of time. Not only do gender and sexuality discourses construct the HIV/AIDS discourse but also the onset of the AIDS epidemic itself have necessitated serious changes in the ways issues of gender and sexuality are taken up and negotiated by the people.

Even though men's and women's positions in the social context predispose them to HIV infection, this does not mean that they accept everything without resistance. Men and women resist dominant discourses and practices that put them as victims of the AIDS epidemic. As the third section of this chapter discussed in detail, women's resistance to victimhood and risk of HIV/AIDS are mostly private and individual and not public and collective ones. The absence of public resistance may be related to the point that the subject of sexuality is a taboo in Ethiopia. Accordingly, the following chapter attempts to analyze not only sexuality but also AIDS as a taboo because it is a sexually transmitted disease.

Chapter Eight - The Workings of Sexual Taboos in the HIV/AIDS Discourse

8.1. Introduction

There may not be a better example to indicate that the subject of sexuality is taboo in the Ethiopian society than the Amharic phrase '*Balege Neger/* the indecent thing' used to name sex. In many ways Ethiopia is a 'closed society'; a society in which, at least publicly, sex is shrouded in silence, and single women have historically paid a high price for open expression of their sexuality (Rachel 2001:3). During interviews a number of my informants at Lideta did not feel at ease responding to sex-related questions on HIV/AIDS, their reply mostly being *'Newir New/* it is a taboo'. To the contrary, the dominant scientific HIV/AIDS discourse stresses that open discussion on sexual matters is essential to break the silence on the epidemic. Hence, people's unwillingness to freely discuss AIDS contradicts with the main task of prevention programs which is to encourage open discussion on sexuality and the epidemic.

In this chapter I will look at the workings of the sexual taboos in the HIV/AIDS discourse. Although the general tendency is to consider sex as taboo, society does not totally prohibit sex but presents it in a dichotomous way as 'bad' and 'good' sex in which the 'bad' sex is mainly related to exposure to HIV/AIDS. The chapter analyzes the intersection between gender, sexuality, age, tradition and religion. Emphasis has been given to the role played by religion and tradition in creating sexual taboos. The first three sections of the chapter will focus on informants' illustrations of silence about sexuality. In the last section of the chapter focus will be on resistances to the taboos in HIV/AIDS and sexuality discourses.

8.2. AIDS, Sex and Taboo

People are not free to talk about AIDS because it is a sexually transmitted disease. I believe that the AIDS epidemic would have been eradicated from the face of the earth

long ago, had it been a disease which people talk about freely, a disease like malaria for example (Informant 55).

As this peer educator at one of the NGOs stated, AIDS is a taboo subject in the Ethiopian society essentially because of its intimate relationship with sex and sexuality. Other informants working at the NGOs also told me that their beneficiaries did not feel at ease to speak about sex because of the general attitude that the subject is not for open discussion. Furthermore, I observed that most of the beneficiaries of the two NGOs were not speakers but listeners during discussions on sexual matters.

As it was discussed in previous chapters, the AIDS discourse is also another example of how individuals are compared and differentiated according to a desired norm. Controlling the transmission of the AIDS virus has been very challenging mainly due to the stigma attached to the infection. Having HIV virus has been experienced by many as shameful, therefore something to conceal. It is considered as a curse, a punishment and embarrassment. The association of AIDS with death is too powerful. Susan Sontag (1989:112), in her essay "AIDS and Its Metaphors" describes HIV infection as a '*rebuke to life and to hope*'. She says "*to get AIDS is precisely to be revealed, in the majority of cases so far, as a member of a certain 'risk group, a community of pariahs*'". The metaphoric trappings that deform the experience of having the AIDS virus have real consequences since they inhibit people from seeking treatment early enough, making prevention activities very difficult.

I want to tell everything about the epidemic to my children. My boys are 18 and 21 years old and I suspect that they know a lot about sexual matters. I wish I had the courage to discuss with them about sex and the precautions that they should take in order to keep themselves away from HIV infection. Many times I wanted to ask them if they have already started to have sex but I felt that I might embarrass them. I think I am the one who is shy and embarrassed to raise the issue. Although I don't tell them openly about sexual matters, I always tell them that they should protect themselves from AIDS. I always say, 'Children, I want you to know about this epidemic. I want

you to protect yourselves from it'. This is the only thing I say. I wish I could tell them more (Informant 16).

As the quotation indicates, the dominant sexuality discourse in Ethiopia constructed the woman's subjectivity in such a way that she refrains from discussing the subject of HIV/AIDS with her children. Like this woman most of my informants at Lideta told me that they wanted to take the responsibility of educating their children about the epidemic but they were unable to do so because they did not have the courage to speak about sex. These parents choose silence over informing their children about the risk of HIV infection because of taboo. Similarly, in his study of the sexuality of the Victorian period Foucault writes about the ways sexuality is repressed:

> These are the characteristic features attributed to repression, which serve to distinguish it from the prohibitions maintained by penal law: repression operated as a sentence to disappear, but also as an injunction to silence, an affirmation on nonexistence, and, by implication, an admission that there was nothing to say about such things, nothing to see, and nothing to know (1978:4).

During my fieldwork at Lideta I asked my informants why they did not discuss the subject of sex, some asked me back, '*how can I talk about sex when I was brought up in a family where sex was never mentioned?*'. The contradiction here is that parents seemed to be highly interested in informing their children about the AIDS epidemic but at the same time they were afraid to discuss the subject of sex. A national survey also affirmed that there is almost no discussion on sexuality between parents and children in Ethiopia even in this age of HIV/AIDS (NCTPE 2003:130-131).

The language of discourse offers a useful way to explain the silence surrounding the AIDS epidemic. As it is known, dominant discourses permit and legitimate certain vocabularies and values while marginalizing or silencing others. Understood in this way, silence could be considered as a suppressed discourse since dominant discourses

deprive certain acts and phenomena of names. Hence, silence is an effect of unequal power relation. The silence on the subject of HIV/AIDS and sex could be taken as an effect of in particular dominant religious discourses.

Sex is sacred. We don't need to talk about sex everywhere and all the time because it is a sacred gift of God (Informant 22).

As this quotation indicates, religion plays a role in silencing the subject of sex. According to this informant, unnecessary indulgence in sexual matters weakens ones bond to God. This woman added that religious moral values help men and women to fear God but a person who is obsessed with sex will not have time to call and praise the name of God as '*Whosoever calls the name of God shall be saved.' (Joel 2:32; Romans 10:13)*. Another informant at Lideta asserted that Christians should not talk about sex. The woman added that too much indulgence in sexual matters makes one outside the boundaries of religion and morality making him/her unstable. According to her, sex is *'Atfi /* Destroyer' which puts men and women at risk of HIV/AIDS. This woman's opinion might be related to the highly entrenched attitude that sex belongs to the devil and is associated with darkness, wickedness and evil.

For a number of my informants at Lideta, religious morality means sexual morality. They seemed to feel that their sexuality is nature's strongest competitor for their loyalty to God, the reasoning being that a Christian cannot love both God and sex. Similarly I was told by some of my informants that the Ethiopian Orthodox Church teaches its members to keep their chastity and virginity in order to protect themselves from HIV infection. I came across a number of respondents at Lideta who believed that the best solution to control the spread of the HIV virus is to suppress sexual feelings. There was one informant who described strong sexual feeling as a *'wrath from God'*. As Foucault notes, in the case of Christianity, the pleasures of the 'flesh' are regarded as sinful or evil and should be renounced (1978). Similarly some informants at Lideta mentioned the need to control sexual desire and not to fall into the trap of '*Siga* / the flesh'.

In our tradition, an Ethiopian is expected to be 'Chewa/ decent'. A decent person doesn't talk about sex openly (Informant 9).

As in this quotation, tradition was mentioned by a number of informants at Lideta as a reason for putting restriction on sex. According to this informant, the tradition of Ethiopia demands '*chewanet/* decency' and talking about sex in public is considered culturally taboo. One informant described a person who openly speaks about sexual matters as *'Liq /*a person with loose moral values' *and 'Keletam/* a person who is not worthy of respect'. As mentioned in the previous chapter that discussed the relation between tradition and HIV/AIDS, informants blamed the western world for 'polluting' the Ethiopian youth by 'dumping' sexual information without any restriction. In relation to this point, some informants stated that the western world is partially responsible for the spread of HIV/ AIDS for encouraging the youth to practice sex freely. Abstinence from sex was mentioned by these informants as the best solution to control the spread of the AIDS epidemic.

Although most informants at Lideta gave reasons related to religion and tradition for supporting the idea of putting restriction on sex, a number of respondents did not have specific reasons. The response of most of these informants was that sex must be prohibited because it has been that way for generations. Others related their point specifically to the spread of HIV/AIDS.

The tendency to consider sex as negative was also observed in some HIV/AIDS prevention education messages. An example is a billboard posted at the heart of Addis Ababa. The billboard reads: '*Wosib Yefikir Meglecha Aydelem* /Sex is not an expression of love'. This message may imply that there is no relationship between love and sex and that sex is just a physical act detached from emotion. We could say that message is embedded in the moralistic belief that sex is bad. As it was mentioned earlier this may be related to the pervasive notion that the sexual drive is evil and hence to be combated. Hence, the fear and shame of talking openly about AIDS could

be related to the negative depiction of sex. This negative depiction of sexuality may also be related to the way some of my informants described sex as *'Askeyami /*ugly*'* *and 'Chemlaka/* Messy *'*.

Not only in discussions about sex and sexual pleasure, but there were also restrictions with regards to talk about romance and sexual relationships in general. Most of the men and women I talked to at Lideta stated that love should not be expressed verbally. A good husband is expected to provide everything for his family and a good wife takes good care of her household. A woman informant at Lideta said a man's love and affection to his wife is expressed in his efforts to provide for his family. According to this woman, it is not of Ethiopian tradition to say *'Iwedishalehu/*I love you'. As for her, that is *'Yeferenj Bahil/* White people's tradition'.

As mentioned earlier, informants at Lideta said they were unable to provide information on HIV/AIDS to their children because of embarrassment to openly talk about sex. Another group of parents consists men and women who were against the provision of sexual information to children. For most of these men and women, talking about sex with children is considered to have an effect of encouraging the young to indulge in risky sexual encounters. Some said sex is a subject for grown ups and not for children. This was what a father of two asserted:

I don't believe in discussing sexual matters with children because that will only encourage them to involve in sexual relations and put themselves at risk. I believe the subject of sex has to be discrete mainly not to draw unnecessary attention to it. Students at school have to focus their attention on their studies but if schools contribute condoms, how could children concentrate on their studies? (Informant 39).

Like this man, a number of informants at Lideta were against the provision of condoms to young men and women at school. Furthermore, my informants told me that they rarely discuss life issues with their children let alone sexual matters. The

response to the question on children's knowledge of sexual matters was '*Lij Mawok Yelebetim'*/ Children shouldn't know'.

There were some young informants at Lideta who said that parent-child relationships in Ethiopia are very formal and authoritarian. Obedience is expected and children's opinions are rarely sought of. I contend that the silence about childhood sexuality is also an effect of power. The issue of childhood sexuality if fraught precisely because it has been denied and reduced to silence mainly through the notion of childhood innocence. The presumption of innocence means immunity from sexual knowledge. This imbues the adult with knowledge and power and the need for children to be protected from the supposedly pernicious influences of the adult sexual world. Similarly in his study of the sexuality of the Victorian period Foucault writes: *"Everyone knew, for example, that children had no sex, which was why they were forbidden to talk about it, why one closed one's eyes and stopped one's ears whenever they came to show evidence to the contrary, and why a general and studied silence was imposed"* (1978:4).

Although there has been a general silence and prohibition on children's sexuality in Ethiopia, there is a double standard in relation to female and male children's knowledge of sexuality. I found that daughters, but not sons, are being treated strictly -even repressively- by their mothers. Most of the parents at Lideta said they did not tell their daughters about their reproductive bodily parts or about reproduction in general. This was what a young girl of 21 said:

It was when I was 13 that I had my first period. Although I had a little bit information about it from two of my girlfriends, I felt very bad when I had my first menstruation. I didn't want any one to know about it including my mom because I was ashamed. I can say I am lucky that I had prior information about it but there were many girls who had no information whatsoever about menstruation and were shocked when they saw blood thinking that they were injured or they had serious health problems. Girls

consider menstruation as 'dirty' and this is mainly because it is not discussed openly (Informant 6).

This young woman also told me that she never had any discussion about sex with anyone. She stated that she had some talks with her girlfriends about love in general but these talks were held in discretion. Almost all the women at Lideta told me that sex is not a subject for discussion even between a mother and her daughter. My finding differed from the findings of some studies on other African countries' women's sexualities, studies like this one which noted: "*most patriarchal African societies taught young women how to please the man during coitus*" (McFadden 1992:179-180). To cite an example, the East African Swahili Muslim women are instructed on sex techniques and actual body movement in sex. They learn how to feign pleasure, through specific rhythmic body movements that should heighten sexual pleasure of the man (Mwai 1998:14). In Uganda too, sexual learning, which was provided by the paternal aunt and uncle, shifted from the kin networks to the public sphere due to the spread of HIV/AIDS (Parikh: 2003:62).

Unlike the Swahili Muslim women and the Ugandan women, almost all my female informants at Lideta told me that they did not get such information at all since the sexual act has remained basically a 'silent' issue. It is understandable that this silence may put women in a difficult position to be well informed about risk of HIV infection. Even when they are informed, it makes it difficult for them to be proactive in negotiating safer sex both as mothers and as partners. The traditional norm of virginity for unmarried girls paradoxically increases young women's risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Due to the strong norms of virginity and the culture of silence that surrounds sex, accessing treatment services for sexually transmitted diseases can be highly stigmatizing for adolescents and adult women. According to one study, men in Ethiopia do not tell their wives when they get infected with sexually transmitted diseases. They hide infections like gonorrhoea (MHRC 2004). Even though sexually transmitted diseases (STDs) increase one's

probability of HIV infection, women may not be treated for STDs properly. This is what a nurse in one of the NGOs said:

Most of our beneficiaries who use our clinic to be treated for STDs (sexually transmitted diseases) are very shy to talk about their problems. These women come for treatment very late and that always makes our efforts to cure them very complicated. Some are even unwilling to show their naked bodies (Informant 49).

The women's unwillingness to show their sexual organs could be seen in relation to the way women's sexuality has been portrayed in society. We could take 'woman and blood' as a case in point. In Ethiopia, a woman who is bleeding either as a result of her menstrual period or after child birth is considered unclean or polluted and is not allowed to join in religious or social services such as entering the Orthodox Church or carrying out the Solat for Muslim women.

In some parts of the country (e.g. Keficho) a woman in her menstrual period is kept isolated from every male including her own children. It is believed that males die if she dares to look them in the eye. In some parts of Ethiopia, women deliver their babies unattended in an isolated hut built for the purpose. This is mainly because the hut where the women deliver and everything in it is considered utterly unclean. Hence, a man who entered the room would be refused admittance to the church (Pankhurst 1990:267). This negative portrayal of women's sexuality could also be seen in the way women's sexual organs are depicted. The following joke may be taken as an example of such a portrayal:

A man was having sex with a prostitute. While enjoying the sex he became curious to look at the vagina that gave him all the pleasure. But when he looked down at the vagina, he found it unbelievably ugly. The disgusting look of the vagina made him throw up. He immediately stopped the sex act and left the room without looking back.

This joke is just an example of a number of jokes in my collection that portray the woman's sexual body negatively. Not only jokes but graffiti and oral poems also depict the sexuality of women as unpleasant. Graffiti is said to be subversive as it presents issues like sexuality, issues considered as taboos (Nielenberg 1994). In the graffiti, women's sexual bodies are however still depicted negatively as unclean and unpleasant. What is very perplexing is that in this graffiti, it is mainly women's sexual bodies that are portrayed negatively but not men's. While the vagina was portrayed as unclean, the penis is mostly described in relation to its size. The big penis is related mostly with aggressive sex and women's interest in having sex with men with big penis. This different depiction of sexual organs is a clear indication of the society's double standard in relation to men's and women's sexuality.

During my discussion with three young men from Lideta, I was told that young males are highly encouraged to be knowledgeable in the area of sex. One of the men confessed that there were times when he lied to his friends and told them about his sexual experiences, experiences that he never had. He said he had to make up his own stories since a young man who happened to have less knowledge about sexual matters than his peers is made to feel ashamed of his ignorance. This man was compelled to lie to his friends because of the deeply entrenched norms that expect men to be knowledgeable in the area of sex. Such norms put men at risk of infection because they prevent them from seeking information or admitting their lack of knowledge about sex or protection. They also coerce them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood. This was what one man said:

I know many men who visit prostitutes for experimenting with sex in different positions. What I am telling you about are happily married men. These men go to prostitutes because they know that they can do anything with prostitutes as they pay them money. Things they don't dare to try with their wives because abnormal sexual activities are taboo in our society (Informant 30).

Similarly a project coordinator at one of the NGOs commented that men think that they should know everything about sex. She said this is very dangerous during the time of HIV/AIDS. As my discussions with my informants showed, Ethiopian men are socialized to be self reliant, not to seek assistance in times of need and not to show their emotions. This expectation of invulnerability runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk.

As it was stated repeatedly in this study, women in Ethiopia are expected to be less knowledgeable in the area of sex due to cultural reasons. The importance of cultural context in constituting ones sexuality could be explained in relation to the construction of different sexualities across nations. A good example is the case of a rural Muslim community in Egypt called *Giza*. My assumption was that women in *Giza* would be silent on sexual matters since they are Muslims who live in a rural community in Africa. This assumption was totally wrong as the study stated that women in the village did not demonstrate any inhibition in discussing sex with researchers. For example the frequency of intercourse was discussed freely. Women in this community said they discuss sexuality, especially intercourse, with anyone including husbands, friends, relatives and neighbours (Khattab 1996: 29-33).

In the case of my informants at Lideta however, sexual intercourse is a topic that is hardly discussed even among married couples. Unlike the Muslim women in *Giza,* most of my informants avoided discussions on intercourse. During interviews most women would cast their eyes down when asked about sex related maters. It is quite easy to notice that they were very much uncomfortable with the subject. As it was very clear from our talks that most of the women would not at all be willing to discuss topics like sexual intercourse, I did not dare to ask them. Not only lay people like the women at Lideta but health professionals were also said to have reservations in presenting sexual matters to their audience. This is what an IEC expert at one of the NGOs told me:

As we know, in general people in our society are not free to talk about sexual issues. What is very surprising is that even some nurses and health officers who are expected to educate the public on sexual matters are not at ease to raise the subject. I remember a nurse whose face blushed and who was unable to speak in front of an audience while demonstrating condom use (Informant 45).

This expert added that health workers preferred to use English words to provide information to their audience. According to her, sexual organs and sex itself were named in English to avoid the embarrassment of mentioning the names of the words in the local language. This woman commented that the preference to use English to name sexual organs like the vagina and the penis was not to be insulting and vulgar. In relation to the problem of using open language, she said that explicitness in naming sex organs could be considered sinful by some of their beneficiaries.

Most of the elderly men and women I talked to at Lideta seemed to have low interest on the subject of sex while the younger ones demonstrated greater interest. For the elderly, sex and sexual pleasure were not that important. It seemed that the young men and women associated their appearance with expression of sexuality and acceptability amongst themselves, while the older men and women associated their sexuality with rising promiscuity, teenage pregnancy and of course HIV transmission. As Rachel (2001:204) notes in her research on sexuality in Addis Ababa, young people say they get most of their information about sex from peers and from school. For the young men and women at Lideta, sexual knowledge was important to prevent HIV infection. To the contrary, most of the parents of these young men and women said talks on sex have to be restricted to control the spread of the epidemic. Here we could see differences of opinion between two generations indicating change in relation to sexuality and openness.

Although the subject of sex is tabooed in general, the restriction on talks on HIV/AIDS relates more to the type of sex which is considered 'bad' or 'immoral'. As discussed in chapter five, HIV/AIDS has been considered as God's punishment for

the immoral corruption of humankind. As it will be discussed below the AIDS epidemic has been considered taboo amongst other things because of its relationship to negative sexual behaviours.

8.3. AIDS, 'Bad' Sex and Taboo

It is shameful to talk about AIDS because it is related to immoral sexual encounters like adultery and homosexuality (Informant 27).

During my fieldwork, one of the things that I noticed was the association between HIV/AIDS and what was called 'immoral' sex. According to a number of my informants at Lideta HIV/AIDS is the result of unlawful sexual encounter. "*...it is through the isolation, intensification, and consolidation of peripheral sexualities that the relations of power to sex and pleasure branched out and multiplied, measured the body, and penetrated modes of conduct*" (Foucault 1978:48). In a similar vein, there was a tendency among my informants at Lideta to isolate certain groups by associating them with 'immoral' sex.

The majority of my informants at Lideta stressed that sex out of wedlock is immoral and that in the Christian religion sex is only acceptable within the marriage of one man and one woman. As one informant explained, God created one man and one woman in His first creation to illustrate that sexual relationship must be confined to one man and one woman in marriage. Similarly she described sex before marriage as 'wrong'. To support her point this woman cited the Biblical verse *'God will judge the adulterer and all the sexually immoral'* (Hebrews 13:4). This quotation indicates that in relation to sexuality the religious discourse is central in constituting what is the norm and what is not.

The dichotomy between 'good' and 'bad' sex may be related to the common tendency to separate life into dichotomous categories. Some of the religious dichotomies include creation and redemption, the spiritual and the profane and body and spirit. As

an informant at the NGO said, the tendency to consider spirit as pure and all matter as evil has given priority to the spirit over the body. Taken as the demand of the body but not the spirit, sex is portrayed negatively. The informant added that this negative presentation is wrong as the Bible presented the body as a *'temple of the Holy Spirit'* (1 Cor. 6:19, 3:16).

AIDS was explained by some of my informants at Lideta in relation to contagion and vulnerability. Both contagion and vulnerability are not at all value-neutral, but they may be seen as self-induced, the consequence of carelessness bringing in a moral element along them. The church preaches that the only solution to the AIDS catastrophe of human kind is to be bound by the guidance of a 'one to one' relationship. Hence, the epidemic has been presented as a punishment for those who failed to control their sexual feelings by engaging in multiple sexual relations. The following excerpt from a poem on HIV/AIDS by an Ethiopian female poet illustrates the point:

> My relatives are jaded of being nurses
> And my bed is sick and tired of bearing me always
> I have spent all my money and exhausted every wealth
> My hair and weight have left me away.
> Therefore, youngsters! Do not rush into **unrestricted recreation** (emphasis mine). Learn much from my experience not to reach that worst destination. (Mulu Solomon, taken from Zerihun 2005:7)

As the poem may illustrate, AIDS is considered as a disease caused by unrestricted sexual practice. Since any sexual practice out of marriage is considered as unlawful and immoral, the AIDS patient may be taken as a person who became a victim of the epidemic due to his/her *'unrestricted recreation'*. Hence, this stigma attached to people living with the AIDS virus may be seen in relation to the way AIDS has been portrayed as the disease of those who could not control their sexual feelings. Similarly abstinence was recommended as the best solution to avoid the risk of HIV

infection for unmarried men and women. A number of informants at Lideta expressed their conviction that AIDS would be eradicated if people tried to control their sexual urge and keep themselves away from adultery. One informant cited a Biblical verse to support her point. *'For this is the will of God, your sanctification, that you abstain from fornication; that you know how to control your own body in holiness and honour, not with lustful passion, like the gentiles who do not know God'* (1 Thess. 4:3-5).

As it was mentioned repeatedly, AIDS is considered as the problem of mainly the sexually immoral groups like prostitutes. One informant tried to make analogy between Ethiopia and Sodom and Gomorrah, the places mentioned in the Bible as being burned by fire for the crimes of their people. This woman said: "*Ethiopians are being burnt by AIDS fire like Sodom and Gomorrah because of the 'moral decadence' of its people*".

As the above discussion illustrated, the negative presentation of sex may be identified as a reason for the silence about HIV/AIDS. But this does not mean that the subject of HIV/AIDS and sex are totally suppressed. Although sexuality is generally a taboo subject, I found during my fieldwork that some of my informants were very keen to know more about AIDS, sex and sexual matters. These informants stressed that now a days, men and women are more exposed to information on sexual matters. As the following discussion illustrates, people talk about sex in different ways.

8.4. Confession – Negotiating the Silence

Most of the female informants at Lideta told me that they usually talk to their *'Yeniseha Abbattoch/* father confessors' about their private sexual issues. As it was stated in chapter five, each follower of the Orthodox Christianity is expected to have a father confessor whom he/she tells everything pertaining to his/her life. The obligation to confess to a father confessor is an effect of power that constrains the confessor since the religious father has the mandate to controlling each activity of his

'children'. According to the belief and teaching of the church nothing should be hidden from the father confessor (Kefyalew 1990: 29). The Ethiopian saying '*A Priest and a grave never reveal secret'* also means a secret told to a priest remains sealed.

Sexual matters are one of the most important issues that followers of the Orthodox Christian religion in Ethiopia discuss with confessor fathers. According to the information from respondents at Lideta, a person who committed adultery tells his 'sin' to his father confessor asking for God's forgiveness. In relation to Christianity and the control on sex, Foucault (1978:21) said: "*The forbidding of certain words, the decency of expression, all the censorings of vocabulary, might well have been only secondary devices compared to the great subjugation: ways of rendering it morally acceptable and technically useful".* Informants at Lideta said the person who transgressed God's rule by committing adultery will be told what to do and this may include asking for God's forgiveness by '*Sigdet/* falling down and worshiping God'. According to an informant, this religious practice has its source in the Bible where followers of Jesus worshiped him by falling down at His feet. 'Sins' related to adultery are told to a father confessor in the way described in the following quotation and joke:

Adultery is named 'Kealga Mewdek/ falling from bed'*; we cannot mention such an act by its name as it is very shameful* (Informant 22).

The joke goes like this:

> *A priest who used to live in one of the remotest monasteries in Ethiopia was assigned to work at a church in a big town. As he used to live in a remote area, he never came across a person who confessed to him about adultery. Hence the priest didn't know 'Kealga Mewdek/ Falling from bed', the common expression used for adultery. As many men and women came to him and confessed that they fell from bed he thought the beds in that town were*

poorly made. This priest was unable to understand why the people of that town thought falling from bed was a matter worthy of confession. One day he asked another priest about it and he was told the real meaning of 'Kealga Mewdek'.

Members of the two NGOs told me that the efforts to break the silence on sexual matters in Ethiopia were not that significant because people did not start to openly talk about sex or HIV/AIDS. But the above quotation from an informant at Lideta and the joke both indicate that people express sexual matters in different ways even if sex is taboo in Ethiopia. The following section also looks at some of the resistances to the taboos.

8.5. Resistances to the Taboos

The spread of HIV/AIDS was mentioned by some informants both at Lideta and the NGOs as one of the reasons that encouraged more open talks on the subject of sex. Although most of them emphasized the need to restrict the kind of information children have to be exposed to, a number of them stressed the importance of providing useful information on sexual issues. This indicates that there are always resistances to dominant discourses and that power relations are mobile.

I and my children discuss sexual matters without any restriction. I know this is not common in our culture. If parents do not discuss sexual matters at home, children would ask why the subject is hidden and they would have the curiosity to know more about it. That is why children involve in sexual relationships at early age and become victims of unwanted pregnancy. I had my first child when I was at school and I remember how that experience was shocking both to me and my parents. I don't want that to happen to my children and that is why I want them to know everything they should know about sexual matters (Informant 25).

This informant was one of the very few mothers who said they would talk about sexual matters with their children freely but most parents said they did not discuss the subject of sexuality with their children. Hence some of the young girls I talked to blamed their parents especially their mothers for not giving them the necessary information about sexual matters and more specifically about their sexual bodies. These girls called into question the idea of virginity and the category of the young girl as unknowing. This was what a young woman said:

I never had any discussion with my mom about sexual relationship or pregnancy. I was shocked when I found out that I was pregnant. I could imagine the shame I would bring to my family because I became pregnant while I was still in high school. I had to run to my aunt in the countryside just not to see my mom's reaction when she found out about me. Had she been a little bit open to me, I might have told her that I was pregnant. If I had told her, may be she would have found a solution to my problem. She should be partially blamed for my problem because she was too strict on me (Informant 8).

Although this young girl was well aware that her mother was influenced by culture, she still blamed her for not trying to be a little more open. Knowing that the world is changing with regards to the relationship between parents and children, the young men and women wondered why there was not much change in their own country. We may say that the power relations between the children and the parents were challenged when these young informants criticized their parents for not informing them about sexual matters.

Two of my young male informants at Lideta had an opinion that they had a lot of interest in knowing more about sex because of the society's strict rules on the subject. They told me that they and their friends had excessive interest in pornography and they very much enjoyed sex videos. One of the informants made me swear that I would not say a word to his parents about his interest in pornographic movies as that would put him in conflict with them. This indicated that young men and women are

not passive beings but they do have the capacity within their structural constraints to imagine a different life for themselves (Bhana 2005:12). When it comes to pornography the young men were not however confronting and challenging their parents openly.

The strong interest in knowing more about sexual matters could be considered as one form of resistance to the dominant sexuality discourse that presents sex as taboo. Sexual desire is fuelled by the experience of privilege and taboo regarding sexual pleasure, that is, the very rules that control sexual desire shape it and even enhance it (Foucault 1990). As the above testimony of the young men with high interest in pornography indicated, too much control may bring about an increased interest in what has been highly controlled. Similarly, some informants at Lideta related the spread of HIV/AIDS to the excessive control of sexuality in the culture. This point holds water when we try to compare the religiosity of people with the spread of sex work and multiple sexual relationships in Ethiopia (MHRC 2004).

> ...In general terms: rather than referring all the infinitesimal violences that are exerted on sex, all the anxious gazes that are directed at it, and all the hiding places whose discovery is made into an impossible task, to the unique form of a great power, we must immerse the expanding production of discourses on sex in the field of multiple and mobile power relations (Foucault 1990: 97-98).

During my fieldwork I came to realize that there was a tendency of neglecting the subtle ways used by men and women to express sexual matters, ways similar to the one mentioned in the above joke about *'falling from bed*/adultery'. Here again I argue that women's and men's resistances to the dominant discourses of gender and sexuality must be viewed in relation to the context of all significant family, cultural, social and economic relationships in Ethiopia. My argument is in line with Petchesky's (2003) assertion that accommodation and resistance should not be looked at as dichotomy and that accommodation should not be seen as passive compliance

with dominant norms while resistance is active opposition. In relation to women's situation she asserts that their concessions to traditional forms of gender subordination have been considered as always one-dimensionally self-destructive. Petchesky (2003:235) stressed: "*Women often choose to go along with traditional expectations they dislike, in order to gain other advantages under existing domestic and community power relations in which their manoeuvrability is constrained*". This kind of continuous process of negotiation, through the most compromising and limited circumstances, also reminds us that, for many women, success means the ability to get beyond the position of victim to that of survivor. It is important to ask whether and how women's strategies begin to change existing power relations within the household and beyond it.

Most of my female informants at Lideta tried to raise the issue of HIV/AIDS and its ways of protection only in indirect ways. '*Take care of yourself!*' and '*Control yourself!*' were said to be the commonly used phrases parents used to tell children to avoid risk of HIV infection. One may argue that these men and women were not strong enough to resist the dominant sexuality discourse which restricts open discussion on the subject of sex. In similar vein, some members of the NGOs I talked to mentioned countries like South Africa and Uganda where people were said to be relatively more open in discussing the subject of AIDS and rated Ethiopians' efforts as very minimal.

I am critical towards this comparison as it does not take into account the social contexts into which men's and women's subjectivity in Ethiopia, Uganda and South Africa had been differently constructed. If I take my women informants at Lideta as examples, our discussions proved that these women were brought up in a society were childhood sexuality is fraught precisely because it has been denied and reduced to silence. To the contrary, in Durban of South Africa, children between the ages of seven and eight know about sex and many have witnessed sexual activity. These children even engage in sexual activity in games like '*hide and seek*' (Bhana 2005:12-13). We may guess that South African women are more open in discussing the issue

of sex than women in Ethiopia since they had more exposure to the subject than their Ethiopian sisters.

Similarly most female informants at Lideta emphasized the need for considering the cultural context of Ethiopia in prevention education programs on HIV/AIDS and preferred indirect ways of dealing with the subject of sex. This is may be because the strategies most of these informants adopted to express or act on their sense of entitlement existed in a context of domination and limited power or resources. In relation to this, some of the commercial sex workers I talked to at one of the NGOs blamed the culture in general and parents in particular for being too discreet in relation to sexual matters. According to these informants, having little knowledge on sex and related risks, young girls become commercial sex workers just to discover the unknown and to escape from their parents' control. These women noted that mostly it would be too late when runaway young girls realized that they put their lives at risk in order to make themselves free from their parent's excessive control on sexuality.

As it was mentioned earlier, some informants said that whenever young children are deprived of information on sexual matters, they would have more interest to know about it and they might also be encouraged to indulge in risky sexual relationships just to experiment with the hidden. Although these young women's reactions to parents' strict rules didn't bring about positive results, it is a form of resistance. Here it is important to note that the exercise of power is not synonymous with negation, repression, or prohibition; on the contrary, relations of power are productive. Power is action upon other actual or potential action and by implication it may only be exercised over 'free subjects', subjects with a choice of possible courses of action before them, including inaction and/or resistance. Similarly the runaway girls mentioned by my informants had a choice to make to free themselves from a complete information blackout on sex. Given the conception of the exercise of power as actions that *'structure the field of other possible actions',* social life or society is deemed to be synonymous with the existence of relations of power (Smart 1995:203).

Flooding people with condoms cannot be useful without adequate information on sex. Condoms are of course very useful but their usage depends on thorough knowledge on sex and sexual matters (Informant 56).

Like this woman from one of the NGOs, some informants at Lideta criticized the efforts of distributing condoms as '*an easy way out'* without encouraging the youth to talk about sex. Two young women said the issue of silence is compounded by spiritual perceptions and criticized the church for not trying to open up and break the silence on AIDS. Most women beneficiaries at the NGOs stated that they liked peer education sessions where they could share experiences on sexual matters openly. Similarly some members of the Addis Ababa Women's Association I talked to said they appreciated the kind of information they got from the organization because they were helped to become more informed about their bodies and their rights in relation to their sexuality. The women added that the information was important to protect themselves from HIV infection. Concerning the importance of the knowledge of the self, Foucault affirms that, by knowing and asserting the truth about ourselves, we can resist domination by the state, by institutions and by an interpersonal level (1978). The women at Lideta did not get information on sexuality and HIV/AIDS only from the Wereda Women's Association Meetings. As the following discussion illustrates, women use their own voluntary associations in an attempt to break the silence surrounding sexual matters and AIDS.

Some of informants at Lideta told me that they had discussions on sexual matters during meetings of women's voluntary associations. Although these discussions were not that much open, most of the women said participants were interested in the subject. The major reason for this interest was the secrecy of the issue of sexuality itself. The informants mentioned that some women tell jokes about sexual matters during meetings. This is what a woman said:

It seems that we use different ways to discuss such matters. We even select carrots while cooking and we talk about its resemblance with a man's genitals. We don't

mention sex organs by name but everybody laughs when a big carrot is picked up by a member and shown to the rest of the women. There is a woman who is very much liked by all of us because she tells us 'Bilgina/ dirty' jokes all the time. She makes us laugh so much and that is why we like her (Informant 26).

In a society where sex is taboo, there is no wonder that women try to devise their own ways to break the silence. The women's groups in Addis Ababa could not however talk about sex among themselves as freely as women in *Giza* Muslim community in Egypt did (Khattab:1996:30). Common remarks among *Giza* women like '*Look at her bright face and her red cheeks, she must have had it last night'* were non-existent among my female informants. Instead they told very few jokes that only indirectly dealt with the subject of sex. As in the above example, without using words, the women used carrots to symbolize the penis while cooking in a group. We may say that it would have been difficult for these women to raise the subject of sex in a group with out their associations (Idir and Mehaber).

The women of Lideta gave high regard to their women's associations. Two of the major forms of voluntary associations in Ethiopia are burial associations (Idir), and religious associations (Mehaber). There are women's Idirs and Mehabers in which only women are members. As Pankhurst (2005: 44) defined them, Idirs are indigenous voluntary associations established primarily for the purpose of mutual aid in matters of burial but also addressing other community concerns. Households become members of the associations and pay fixed contributions monthly or when a member of the family dies. Whenever death occurs among the members, the association will raise an amount of money (depending on the specific bylaws) and handle the burial and related ceremonies. In addition, certain members are assigned to stay at the house of the bereaved for two to three days to assist the household.

During these three days, the female Idir members divide up the work of cooking and cleaning. In the Ethiopian tradition relatives, friends and neighbours stay for some days with the family of the deceased for condolence. According to my informant at Lideta, it is mostly during late evenings that one or two women might tell what she

called 'Bilgina/dirty' jokes. Women Idir members also meet at each others house ones a month to pay monthly contributions. One informant said it was during these monthly meetings that a female member told jokes about sex. This informant named the female Idir member who told such jocks *'Ibd/* insane' but added that the Idir meetings would have been so boring without this woman.

Most of my female informants also have Mehabers. These Mehabers are religious associations where women gather on a monthly saint's day in commemoration of their allegiance to that saint. The Mehaber is named after a saint like *'Yemariam Mehaber/* Saint Marry's Mehaber' and members meet on the 21st day of each month as this specific date was assigned by the Ethiopian Orthodox church to commemorate Saint Marry. Food and drinks are served. Mostly home made bread *(Difo)* and a home brewed alcoholic drink *(Tella) are* prepared by the woman who has a turn to bring all Mehaber members to her house.

All the women I interviewed said they always enjoyed the time they spent at the Mehaber meetings because for most of them it was the only time when they relax and enjoy the company of their acquaintances and friends. A study in Northern Showa of Ethiopia stressed that members of a Mehaber are considered brothers or sisters spiritually, and are expected to help each other out when they face problems. The study added that membership in a M*ehaber* is expected of one as a social adult in the community (Yared 1999:162-163).

Since it is mostly like-minded women that form the Mehaber, usually there would be a lot of fun and hot discussions during meetings. Some informants said AIDS had been one of the issues discussed at these meetings with serious concern. The women told me that these associations created a means for women to support each other both economically and emotionally. They mentioned cases in which they made efforts as group to give a special support to members of their Mehabers affected by AIDS. This is an indication that women have struggled and created spaces for themselves through their friendship as women.

Because of the nature of Mehabers and Idirs, there have been some efforts in Addis Ababa to use them in educating the public on HIV/AIDS. According to a study, in terms of participation more than half the Idirs in Addis Ababa have been involved in some sort of activities relating to HIV/AIDS, with the lowest participation among women's Idirs. The participation of Idirs and Mehabers in HIV/AIDS activities began in 1994 but was limited until 2000 and became most significant in 2002 when women's and youth Idirs also began to participate. The main forms of involvement of the Idirs are limited to information and education in particular awareness raising in meetings, participation in workshops, discussions at funerals, and obtaining statistics. The most significant activities of the associations include support for people living with the AIDS virus and AIDS orphans (Pankhurst 2005:152). Although voluntary associations try to break the silence on HIV/AIDS by conducting formal meetings where the epidemic and related sexual issues are discussed, people use other more informal ways to talk about sexual matters. The following section looks at one of these ways of expression.

Oral Literature as a Form of Expression

Each society exhibits its own specific sexual behaviour, through song, dance, artistic expression, dress, colour and ritual (McFadden 1992:168). Both in rural and urban Ethiopia, most of the oral literature like oral poems, jokes and tales circulate around the issue of sex. Even though sex is considered a taboo subject, the jokes I collected mainly present the sexual act and the sexual bodily parts. AIDS is also one of the issues discussed. The following joke is an example:

A doctor and a nurse had the urge to have sex while they were on duty at a hospital. After undressing themselves they found out that they didn't have a condom. Even if they both knew that they couldn't have sex without a condom at the time of AIDS, they decided to have sex since they were unable to control their sexual feelings. Since

they didn't have a condom, after the man put the hospital bandage that he used for rapping up his patients' broken arms and legs on his penis, they made love.

Similar to this, most of the jokes in my collection present the sexual act mainly in a comic manner. In the jokes we commonly find words that are mainly considered as 'unnameable' in the Ethiopian society. Furthermore sexual acts that are considered taboo are described in detail. We could see that with the use of jokes men and women expressed their sexualities which society tried to suppress in different ways.

Some of my informants recited for me love poems which they remembered from their childhood days for me. These men and women had their childhood days in rural part of Ethiopia and told me that they used to recite oral poems to express their sexual feelings towards the opposite sex. Compared to formal settings and language, attitudes and thoughts are more freely expressed in the different forms of oral literature. We may say that Ethiopian oral narratives have their own narratological structure, with codes of dissimulations and allusion such as the Amharic *'Semina Worq*/wax-and-gold' discourse, a literary feature of Ethiopian poems where the poem has double meaning. Most of the poems my informants cited to me used the Ethiopian *Semina Worq.*

Semina Worq is built of two semantic layers. The apparent, figurative meaning of the words is called *'wax',* the more or less hidden actual significance is the *'gold'*. The terminology is derived from the work of the goldsmith, who constructs a clay mold around a form created in wax and then, draining the wax, pours the molten gold into the form. *Semina Worq* is quite important to express matters like sexual feelings that need to be concealed to avoid any embarrassment on the part of the narrator of the poem. "*In essence, wax and gold is simply a more refined and stylized manifestation of the Amhara's basic manner of communicating. This is indirect, often secretive*"(Levine 1965: 5-9). The following is an example of such poems:

እንጀራና ወጡ መች ይበላልኛል፡ *(Ingerana Wotu Mech Yibelalignal)*
እንደ ሶስት አመት ልጅ ጡት ጡት ያሰኘኛል፡፡ *(Inde Sost Amet Lij Tut Tut Yasegnegnal)*

I don't feel like eating Ingera and Wot[*],
Like a three- year old child I crave for breast.

This poem has two messages. The apparent message of the couplet is that the narrator of the poem does not want to eat the traditional Ethiopian food that is commonly served for grown up but wishes to have breast milk like a three years old child[†]. The hidden message or the gold of the poem is what holds the sexual meaning of the poem. The gold is that the man craves to have sex with a woman while being fascinated mainly by her breast. Such poems with hidden sexual meanings are common in the Ethiopian culture. The '*Azmaris* / local singers or minstrels' also use such poems to entertain the public. The *Azmaris* sing songs with sexual messages, messages that are not told in public because they are considered taboo in the society. Furthermore, such *Semina Worq* poems provide an outlet for criticism, be it parental, religious or political (Levine 1965:9). These poems are warmly received at weddings and nightclubs mainly for their sexual and political messages.

The messages of oral poems on sexuality in Ethiopia are mainly about the physical beauty of women and sometimes men. Other messages include disappointment in sexual relationships. The issue of *'Wushima* / concubine' is one of the most frequently appearing topics in the oral poems indicating the attention the practice drew in the society. *Wax and Gold* is not only used to express physical beauty and sex but also to criticize some of the traditional practices like arranged marriage. In the following poem, a young girl expresses her discontent and sorrow for loosing her lover:

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[*] *'Injera'* is a typical Ethiopian traditional homemade bread like pancake prepared out of a grain called 'teff'. '*Wot*' is any type of sauce that is eaten with '*Injera*'.
[†] It is quite common for a mother in Ethiopia to breast feed a child as old as three years.

ማግባቱንስ አግባ አልከለክልህም (Magbatunis Agba Alkelekilihim)
እየመጣህ እየኝ ናፍቆትህን አልችልም። (Iyemetah Iyegn Nafkothin Alchilim)

I cannot forbid you from marrying another woman,
But I want you to visit me ones in a while because I long to see you.

It seems that the woman lost her lover because he got married to another woman. We may guess that in the poem the traditional practice of arranged marriage is criticized by the woman. This is a common incidence in Ethiopia as a young man may be forced to marry a woman that his parents selected for him even if he wished to marry the girl he loved. Young men and women in a number of ethnic groups in Ethiopia can have *'Yekenfer Wodaj*/literally translated as 'a friend of the lips' but meaning a girlfriend'. In the Ethiopian tradition most young men and women in rural Ethiopia do not have a chance to marry their *Yekenfer Wodaj* since parents use their own criteria to select wives for their sons and these criteria mostly do not take into account the sons' choices. The name '*Yekenfer Wodaj'* itself explicitly tells that the relationship will only allow kissing. Here we could see that the community puts a restriction on sex even in the form of language.

In the way they narrated to me some jokes and oral poems, I observed that my young informants had high interest in oral literature on sexual matters. Danaher et al. (2000:144) said: "*The discursive and regulatory attention paid to sex and sexuality means that we are continually being called to focus on it, to think about what is approved and what is not*". Similarly, *s*exually curious men and women in Ethiopia employed creative strategies to explore and express their sexualities and subjectivities. This indicates that power is a distinctly productive relation, one that creates resistance in the same moment as it exerts force.

8.6. Conclusion

This chapter endeavoured to analyze the workings of taboos in the HIV/AIDS discourse. It was shown in the discussion that gender, sexuality, religion and tradition intersect to create *'good'* and *'bad'* sex and also to enforce silences as well as resistances. We have seen that the silence about the AIDS epidemic can be the result of the general taboo about sex. The workings of the taboos or the silences make it difficult for individuals as well as NGOs to explicitly address the questions of protection and risk.

As the examples in the discussion show, men and women have started to discuss sexual matters related to HIV/AIDS and sex. Women tried to raise the subject of sex during their association meetings. Furthermore, some informants used oral literature to express their sexual feelings. The proliferation of jokes and oral poems on the subject of sexuality may indicate the considerable attention given to the subject. I may conclude this chapter by saying that men and women in this study used different strategies to resist the dominant sexuality and HIV/AIDS discourses. As Foucault (1978:95-96) contends: " *...in power relations there is necessarily the possibility of resistance because if there were no possibility of resistance (of violent resistance, flight, deception, strategies capable of reversing the situation), there would be no power relation at all*".

Chapter Nine -Conclusion

The present study has tried to show how the dominant scientific HIV/AIDS discourse was negotiated by my informants in Addis Ababa. The main focus of the study was to show the diverse contexts in which meanings were attributed to the HIV/AIDS discourse. Furthermore the study tried to analyze the intersection between different discourses in the construction of the HIV/AIDS discourse in Addis Ababa. These intersecting discourses include gender, sexuality and religion. I would say that the present study would fill the gap in the study of gender, sexuality and HIV/AIDS in Ethiopia mainly for dealing with the major contradictions and paradoxes in relation to negotiations with the dominant HIV/AIDS discourse in Addis Ababa.

In its assessment of previous research, the present study has pointed out that most previous studies conducted on HIV/AIDS in Ethiopia attempted to obtain information about people's attitudes towards HIV/AIDS. These studies tried to classify people into different groups based on their responses. As it was discussed in the second chapter, research on the epidemic often continues to rely on quantitative survey methodologies. These include behavioural surveys that measure changes at the individual level, focusing on factors such as HIV-related knowledge or condom use. Clearly, such studies are vital for measuring the spread of the epidemic. They are also important to find out whether or not interventions have had their desired effects.

Although research on attitudes to AIDS is certainly important, I have argued that it should not be the main focus of concern. This is mainly because such a research agenda on HIV/AIDS is incredibly narrow and it does not tell us any more than how people respond to questionnaires about AIDS. If we take the studies that evaluate HIV prevention programs, they often contribute little to the understanding of the processes whereby programs do or do not succeed in having an impact on the biomedical and behavioural factors. I would say that these studies have little to teach us about the major determinants of program success, such as the degree of trust and

identification with which members of target communities regard particular interventions. Most importantly they do not analyze the role of various forms of social inequality in undermining program efforts.

The AIDS pandemic was and is still mainly perceived as a medical problem. Hence, biomedicine plays a major role in constructing the dominant HIV/AIDS discourse in Addis Ababa. What is more, the validity of the practices of health promotion is maintained by the legitimatising of science. It is known that each discipline will determine what methods, forms of propositions and arguments will be considered to be true (Mills 2004: 62). In the case of biomedicine and AIDS, the enduring hope has been that once the 'causative agent' of the 'disease' has been identified, a cure or a vaccine will soon be developed and the disease will be 'controlled'.

As it is shown in chapter four, there have been different activities in Addis Ababa especially designed to give awareness about the AIDS epidemic. Condom distribution and the provision of health services can be mentioned as the major activities aimed at controlling the spread of HIV/AIDS. But we have seen that individuals try to negotiate with HIV/AIDS prevention practices and information. One example is the way the virus was variously negotiated by my informants. As it was stipulated, the virus concept was seen to be somewhat alien to most of my informants at Lideta.

We have seen in chapter four that the major HIV/AIDS prevention and control practices like testing and counseling were not readily taken up by informants but were seriously questioned. I have also argued that practices like testing have to be seen as forms of surveillance to control the population. Such practices induce the internalization of new norms and the management of one's sexual practices and health, in the interest of minimizing illness and HIV transmission. The main preoccupation of these practices has mainly been with categorizing individuals into groups. Similarly, informants of the present study were asked to review sexual practices and to provide a history of their sexuality. We have seen that some

informants questioned the importance of practices like testing and counselling, indicating individual's ability to resist dominant practices.

Although most of the individuals involved in implementing HIV/AIDS prevention programs said they did not focus on individual behavioural interventions and that their prevention efforts were informed by sound insights into the determinants of sex and sexuality, I found out that was not always the case on the ground. According to my observation of HIV/AIDS prevention activities, beneficiaries were informed on how to avoid 'risky sexual behaviour'. The various prevention activities seemed to be based on the assumption that individuals will take responsibility or act rationally and desist from unsafe sexual behaviour once they have been informed and educated about the dangers of contracting HIV and dying of AIDS. These biomedical and behavioural understandings of sexuality and health have located the cause of sexual behaviour at the individual level leading to individual behavioural interventions.

The tendency of looking at HIV/AIDS education as the best solution to retard the spread of the virus may be related to the general notion of considering the individual as sovereign and in control of his/her destiny. This can also be explained in connection to the humanist ideology of considering the subject as self- contained because he/she can think and reason (Hekman 1990). According to the dominant social cognition approach of psychology, the individual is conceptualized as a rational information-processor, whose behaviour is determined by a combination of psychological factors such as individual attitudes, personal action plans and perceived social norms. In the present study, I contended that the notion of considering individuals with agency and control over themselves needs to be questioned.

As I have said, the instant response of almost every informant to the question on ways of avoiding the risk of HIV infection was 'abstinence, faithfulness and condom use'. When asked about the practicality of these three ways however, most of these informants were found to be skeptical. As the present study tried to analyze, there are a number of factors that make individuals unable to use the information they have

obtained. This is mainly because health-related behaviours such as condom use are determined not only by conscious rational choice of individuals, on the basis of good information, but also by the extent to which broader contextual factors support the performance of such behaviours. The forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks, and the availability of medical services. It is my assertion that emphasis be given to explaining the underlying processes and mechanisms whereby contextual factors contribute to high levels of HIV-transmission. As I have tried to show, social context plays a key role in enabling and supporting health-enhancing behavioural change, particularly in less affluent settings, where people often have less control of their behaviour than their more privileged counterparts.

Although the focus of most HIV/AIDS prevention programs in Ethiopia has been on behavioural and biomedical interventions, I have observed a slow but steady 'paradigm drift'. This has involved a move away from highly individual-oriented interventions towards more participatory approaches. The practical interventions acknowledged the complex range of determinants of sexual behaviour and emphasized the need for approaches such as community-led peer education and collective stakeholder partnerships. These interventions sought to promote community contexts that enable and support behavioural change.

As it was seen in chapter four, HIV/AIDS prevention activities like peer education and coffee ceremony were very much liked by beneficiaries since they provided participants with the chance of expressing their own views. We have seen that some of the experts at the NGOs were observed trying to inhibit the participation of the beneficiaries to a certain level exhibiting the effect of the power relations between experts and beneficiaries. I would argue that a purely medical interpretation of the problem of HIV/AIDS is said to serve to reinforce the unequal relationships of having power/ being powerless which generally characterize most interactions between non-medical/lay persons and medical professionals. Because of its inevitable culmination

in the death of anyone infected by the AIDS virus, those affected by the virus have been made virtually powerless in the absence of a cure, whilst paradoxically those with medical knowledge of the virus seem to have become more powerful in their status as healers.

Another important conclusion drawn from observations made on participatory HIV/AIDS prevention activities is that the move towards more community-oriented intervention techniques has not been matched by the development of understandings of the community and social changes that are often necessary preconditions for behavioural change. For this reason the possibility of learning lessons from successful and unsuccessful programs is limited. In order to control the spread of HIV/AIDS in Addis Ababa, I contend that we need to revisit the dimensions of men's and women's identity and self-definition that are constructed by discourses such as religion, gender, sexuality, tradition and modernism.

In Ethiopia, religion and tradition have significant influence on the lives of the people. As it was mentioned in chapter five, the subjects of religion and religiosity surfaced a lot during interviews and the informants' understandings of HIV/AIDS was highly influenced by their religion. The influence of Orthodox Christianity on the informants' attitude towards life and sickness was clearly observed. Furthermore, we have seen that religion has a strong influence in constructing gender and sexuality discourses in Ethiopia. As it was discussed in chapter eight, issues of sex and sexuality were considered as taboos, some informants equating sex with sin. Although these considerations were said to be 'untrue' in the scientific sexuality discourse, informants believed that AIDS is a punishment for sexual immorality. This is but a good example that individuals negotiate with 'truths' coming from different sources of knowledge.

What I found interesting was the tendency to provide both religious and scientific explanations about the AIDS epidemic. As it was seen in the chapter on religion and HIV/AIDS, most informants took information from the scientific discourse but

mainly believed that the problem of HIV/AIDS can only be solved by religious means. The inclination of people towards religious solutions to the epidemic compels us to give proper emphasis to understanding the relationship between religion and HIV/AIDS in Ethiopia. However, as far as my observation goes, prevention programs are not giving proper attention to the way religion influences people's understandings of the epidemic.

Although HIV/AIDS prevention programs stress the fact that the epidemic affects the whole population, the dominant risk position in the HIV/AIDS discourse emphasizes that individuals are set in different groups. Chapter six of the present study mainly dealt with the issue of risk, criticizing the categorizations of individuals into two groups namely those 'at risk' and 'not at risk'. By delineating social categories where prevalence is high, such labelling contributes to the stigmatization of some sections of the society. The present study tried to illustrate with examples that the stigma and fear attached to the AIDS epidemic relate to the labelling of those individuals living with the virus. I have emphasized that HIV/AIDS related stigma and discrimination are intimately linked to the reproduction of social difference. Similarly Ussher (1997:53) affirms that AIDS science is itself heavily inflected by assumptions that lead to partialities or omissions, apocalyptic warnings, melodramatic over- or under-statements. Hence, the AIDS science is "*...committed not to understanding but to rooting out its own panic. As a result, this panic remains unacknowledged, yet integral: A property of the external objects science struggles to subdue*" (Ussher 1997 53).

The association of risk of HIV infection with 'deviance', which emerges as a strong theme in AIDS discourse, has been highly significant in constructing ways of thinking about women and married people. Married women were found to be largely invisible in AIDS discourse. This is mainly because of the categories mentioned earlier which label married women as 'not at risk' and make them feel invulnerable and safe. Here the power relations between men and women within marriage have been overlooked. As it was illustrated in chapter six, married women are also at risk

because of their less power to negotiate in sexual relationships. As we have seen, besides gender and sexuality, a web of factors construct risk and some of these factors include religion, tradition, economy and the law. Again I affirm that it is by looking at the multiple factors that construct risk in HIV/AIDS discourse that we have a better understanding of the reasons why men and women have been differently affected by the epidemic.

It is true that poverty and gender relations facilitate HIV transmission, and undermine the effectiveness of HIV prevention efforts. My argument is that the impacts of macro-social problems like poverty have been exaggerated while less attention has been given to micro level power relations between men and women. For example I say that women with no economic problem have not been properly addressed by HIV/AIDS prevention programs. These women need to be specifically addressed as power relations and cultural expectations regarding gender and sexuality are likely to influence women's possibilities for acting according to the knowledge that they have about HIV/AIDS transmission. Women find themselves doubly affected by the epidemic, both because of their vulnerability to infection and also because social expectations make them most responsible for care of the sick and the surviving. Furthermore HIV/AIDS has given an added urgency to issues of power relations in sexual relationships. I contend that men's and women's power relations in sexual relationships have to be more emphasized in HIV/AIDS prevention efforts.

As noted earlier, one of the contradictions surrounding the epidemic was the way women and men have been positioned in the HIV/AIDS discourses in Addis Ababa. The term 'woman' represents the 'ordinary', 'innocent', and 'victim' against which other 'women at risk' are constructed as 'deviations' who appear as a danger to others, as bodies which cause risks to men and to children. Whilst it is true to say that until very recently researchers, policy-makers, and governments have largely ignored how the AIDS epidemic affected women, specifically, certain groups of women were clearly visible in HIV/AIDS discourse. We have seen that women, especially commercial sex workers have been portrayed both as victims and perpetrators of the

epidemic. Richardson notes: "*this division between visible and invisible women in AIDS discourse is characterised by good woman/bad woman dichotomy, which is a common feature of representations of women*" (1996:164). Men have also been depicted similarly but the difference was that the women were blamed but not the men.

We have seen that gender and sexuality have been constructed in Ethiopia in different ways but certain themes- the suppression of women's sexuality reappear. As it was shown in chapter seven women have often been depicted as both 'hopeless victims' and 'perpetrators' in the dominant HIV/AIDS discourse in Addis Ababa. These victim and perpetrator positions have been informed by discourses like gender, sexuality and religion, discourses which legitimize the victimization of women. We may say that social institutions like religion and the family are effective settings for stabilizing meanings about HIV/AIDS, sexuality and gender. However, this stability can always be challenged.

In this study I was critical towards the general tendency of overemphasizing the problems Ethiopian women face due to HIV/AIDS. Here I am not at all trying to downplay the negative effect of AIDS on the lives of Ethiopian women. What I wanted to criticize was the notion of focusing on the way the HIV/AIDS discourse constructs women, while almost ignoring the vital role women play in constructing the epidemic discourse. In relation to cultural practices for example, Ethiopian women have been portrayed as individuals born into cultures and become members of them through processes of socialization and learning. This approach implies that women are singular entities which require a cultural imprint. As Moore (1994:54) asserts: *"The weakness of this approach is that it re-creates the individual and the social as antinomies, and is incapable of providing a coherent account of their mutual construction".* I argued that the victim position of women in the dominant HIV/AIDS discourse tends to keep women in that position and does not give room to resistance.

One of the issues that were emphasized in this study was resistance to the dominant HIV/AIDS discourse and practices. Men's and women's subject positions in the social context predispose them to HIV infection but this does not mean that they accept everything without resistance. We have seen men and women trying to resist dominant discourses and practices of gender, sexuality and HIV/AIDS by creating counter discourses and practices. These resistances indicate that power is not a coherent or coercive force but exists everywhere creating the subject. We have also seen that most of these resistances are not public and collective but private individual resistances. This may be related to the issue that sexuality is a subject considered as taboo. It is my assertion that a considerable emphasis be provided to women's resistances to the victim position and their efforts to prevent themselves as well as their families from the AIDS epidemic.

As we know the possibility of universally accessible and totally effective treatments or cures for HIV/AIDS remains remote in the less advantaged countries like Ethiopia where the epidemic often has its strongest hold. Within such a context, the challenge of containing the epidemic requires innovation and change in relation to both frameworks of understanding and modes of action and intervention. The present study looked at some of the contradictions surrounding the dominant HIV/AIDS discourse in Ethiopia in order to highlight the need for reassessing our ways of looking at the epidemic and creating new conceptual frameworks for understanding HIV/AIDS and sexuality.

I believe that change and innovation are of particular importance in relation to HIV/AIDS in order to address the particular form the epidemic takes. Not only is the HIV epidemic too complex to be dealt with through traditional biomedical or behavioural disease prevention, it is also too multi-faceted for any single constituency to deal with on its own. For this reason I believe it is essential that HIV prevention projects build alliances with the wide range of actors to create a new approach that is relevant to the precise manifestations of the disease in question. Rather than trying to persuade people to change their behaviour through educational programs, or through

encouraging them to attend STI clinics, the focus needs to be on the social and environmental determinants that facilitate or impede behavioural choice.

The present study has sought to expand its gaze beyond the scope of factors such as the sexual behaviour or local culture of HIV-affected communities. It has tried to understand the transmission and prevention of HIV as a social issue located at the interfaces of a range of constituencies with competing actions and interests. These constituencies include not only those local communities, individuals and organizations directly affected by the epidemic, but also local and national political leaders and business groups, overseas experts and international development and funding agencies. The analysis of power relations between these different constituencies must be considered quite important. It is hoped that such an analysis will bring about a greater understanding of the challenges facing even the best-intentioned and technically well-informed HIV prevention interventions and policies in the complex situation in which they operate.

The present study has tried to emphasize that HIV/AIDS prevention efforts need to be informed by sound insights into the determinants of sex and sexuality. Hence, the special place religion has in the lives of Ethiopians deserves considerable attention by designers as well as implementers of HIV/AIDS prevention programs. Finally I would say that HIV/AIDS prevention programs in Addis Ababa need to be based on understanding the distinctive characteristics of the people's sexual cultures shaped by relations of power, by history, and by differentiated traditions within the particular society.

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Appendices

Appendix 1- Interview Questions

a) Interview Questions for Informants at Lideta

General Questions of Gender and Sexuality

1. Tell me about yourself. Where were you born? What do you do for a living? When and how did you get married? How many children do you have? (The last two questions were addressed to married informants.)
2. What does the job distribution at home look like? (Sons/daughters, wife/husband)
3. How did you learn about marriage, love, and relationship?
4. Was it a boy or a girl that you wanted to give birth to? Why? (a question addressed to mothers and fathers)
5. What do you wish for your children? Marriage, work?...etc. (a question addressed to mothers and fathers)
6. Who must be in charge of asking a sexual partner for marriage? A man or a woman? Why?
7. When should a girl get married? Why?
8. Can a man stay single throughout his life? How about a woman?
9. What are the best qualities in a woman? For example what makes a woman a good wife?
10. What are the best qualities in a man? For example what makes a man a good husband?
11. What do you say about a man who is involved in an extra-marital affair? What if a woman involves in such an affair?
12. What is your opinion about wifebeating?
13. What is your opinion about a young school girl having a boyfriend? How about a young school boy having a girlfriend?

14. If a young school girl (for example your daughter or sister) gets pregnant, what will be your reaction?
15. If a young schoolboy (for example your son or brother) impregnates a girl, what will be your reaction? What will you do about it? Why?
16. How should a woman express her love to her partner?
17. How should a man express his love to his partner?
18. Who should be the first to ask a partner for a relationship? A man or a woman? Why?
19. Do a husband and a wife have to talk freely about their sex life? Why?
20. Who should be playing the leading role during sexual intercourse? A man or a woman? Why?
21. What is your opinion about sex before marriage? Do you think a woman can have sex before she gets married? How about a man?
22. If a husband knows that his wife has an extramarital affair, what measure should he take?
23. If a wife knows that her husband has an extramarital affair, what measure should she take?
24. If a woman can not have a child of her own, what should her husband do?
25. If a man can not have a child of his own, what should his wife do?
26. What should a woman do if her husband maltreats her? (if he beats her for example)
27. What should a man do if his wife maltreats him?
28. What should the response of a woman be if she doesn't want to have a sexual intercourse with her husband?
29. Do you discuss issues like sexual relationship and love with your children at home? If not why? (questions addressed to parents)
30. How did you learn about your sexual bodily parts?
31. Do you discuss with friends and family about your sexual life, your marriage, etc...?
32. What is your opinion about female circumcision, abduction and early marriage?

Questions on HIV/AIDS

1. What is HIV/AIDS?
2. What is the cause of HIV/AIDS?
3. What do you know about the ways of HIV transmission and prevention?
4. What do you think is the reason for the fast spread of the AIDS epidemic in the world in general and in Ethiopia in particular?
5. What are the factors that make men and women vulnerable to HIV infection? 6. Who do you think are more vulnerable to HIV infection, men or women?
7. Do you discuss about HIV/AIDS with family members and friends? Do you try to inform your children about HIV/AIDS? (The last question was addressed to parents.)
8. What is your source of information about HIV/AIDS?
9. What is you opinion about the HIV/AIDS prevention programs in Ethiopia in general and your vicinity in particular?
10. What do you think should be done to control the spread of HIV/AIDS?

b) . Interview Questions for Members of Organizations/Associations

1. What are the major issues addressed by your organization/association?
2. Who are your beneficiaries?
3. Does your organization/association make efforts to address the issue of gender? If yes, in what specific ways does it do this?
4. Do men and women benefit equally from interventions by your organization/ association?
6. Do you explore the implication of gender inequality in relation to HIV/AIDS and STDs?
7. Have you researched barriers to men's/women's participation in programme activities?
8. What is the response of your beneficiaries to your programs?

9. What are the major difficulties you have encountered while implementing your programs?

10. What do you think are the limitations of your programs?

11. What must be done to minimize the spread of HIV/AIDS in Ethiopia?

c). Interview Questions to Beneficiaries of HIV/AIDS Prevention Programs

1. Why did you come to this organization/ association?

2. What kind of services do you get from this organization/association?

3. How satisfied are you with the service you are provided by the organization/ association?

4. Which activities of the organization/ association do you like most? Why?

5. What are the limitations of the programs of the organization/ association?

6. Do you have difficulties attending the programs of the organization/ association?

7. What do you think the organization/ association should do to improve its programs?

Appendix 2

Short Descriptions of the Two Organizations Selected for the Study

a). Integrated Service for AIDS Project Support Organization (ISAPSO)

Integrated Service for AIDS Prevention and Support Organization (ISAPSO) is an indigenous, non-profit making, secular humanitarian organization dedicated to curbing the spread of HIV/AIDS/STIs; to mitigating their impact and to providing care and support to those who are infected and affected by the disease. ISAPSO's mission is to initiate, promote, and sustain HIV/AIDS/STIs prevention, care, support and reproductive health and family planning services to communities and workplaces both at Federal and Regional levels. The goals of ISAPSO are:

- To enhance individual and social change conducive to the reduction of HIV/AIDS/STIs transmission and the promotion of safe sexual behaviour.
- To develop ISAPSO to its mature stage to enable it scale up HIV/AIDS/STIs prevention, care and support programs.

The objectives of the organization are the following:

1. To create awareness and increase knowledge of 650,000 target population, on HIV/AIDS/SIDs.
2. To empower 250 commercial sex workers through vocational skills training and self-employment scheme.
3. To give reproductive health education and provide community-based family planning service to 10,800 women of reproductive age.
4. To provide educational access to 200 and skills training to 50 AIDS orphans.

b) Medicines Sans Frontier- Belgium (MSF-Belgium)

Medicines Sans Frontiers is one of the pioneer international nonprofit humanitarian organizations that provide medical assistance to the needy regardless of race, creed or border. Medicines Sans Frontiers-Belgium has been engaged in humanitarian activities in Ethiopia since 1985. It has been creating awareness and providing psychological support to vulnerable groups since 1996, especially to female sex workers through its STD, HIV prevention program.

The MSF-Belgium 'Self Help and Empowerment Program for Women Living through Prostitution in Addis Ababa' is a project aimed at contributing towards the reduction of HIV/AIDS/STD transmission among female sex workers in Addis Ababa, and empower them through alternative activities. The different activities of the programs include creating awareness on reproductive health, HIV/AIDS, sexually transmitted diseases, condom use and other health related issues. Efforts are also made to create awareness among the general population on HIV/AIDS and gender and other related topics by strengthening the Information Education and Communication (IEC) component. Income generating activities are also important components of the program.

Appendix 3- List of Informants

a) Informants at Lideta

No.	Informant's Name	Sex	Age	Marital Status	Educational Level	Profession
1.	Informant 1	F	75	Widow	Illiterate	Housewife
2.	Informant 2	F	36	Single	College Graduate	Secretary
3.	Informant 3	M	27	Single	College Graduate	Accountant
4.	Informant 4	F	40	Married	8th Grade	Housewife
5.	Informant 5	M	68	Widow	Illiterate	Housewife
6.	Informant 6	F	17	Single	10th Grade	Student
7.	Informant 7	F	32	Divorced	High school graduate	Housewife
8.	Informant 8	F	35	Divorced	6th Grade	Housewife
9.	Informant 9	F	44	Married	8th Grade	Factory Worker
10.	Informant 10	F	51	Married	Illiterate	Housewife
11.	Informant 11	M	34	Single	High school Graduate	Petty Trader
12.	Informant 12	F	66	Widow	5th Grade	Housewife
13.	Informant 13	F	58	Married	Illiterate	House wife
14.	Informant 14*	F	46	Married	Illiterate	Housewife
15.	Informant 15	F	53	Married	8th Grade	Housewife
16.	Informant 16	F	49	Married	3rd Grade	Cleaner
17.	Informant 17	F	38	Married	6th Grade	House wife
18.	Informant 18	F	44	Married	4th Grade	Housewife
19.	Informant 19	F	48	Widow	Reading and Writing	Waitress
20.	Informant 20	F	53	Married	Illiterate	Housewife
21.	Informant 21	F	32	Single	Illiterate	Cleaner
22.	Informant 22	F	56	Widow	4th Grade	Housewife
23.	Informant 23	F	43	Divorced	8th Grade	Housewife
24.	Informant 24	F	39	Single	High school Graduate	Cleaner
25.	Informant 25	F	57	Widow	High school Graduate	Pensioner
26.	Informant 26	F	50	Married	Reading and Writing	Cleaner
27.	Informant 27	F	47	Married	Reading and Writing	Housewife
28.	Informant 28	F	31	Single	6th Grade	Housemaid
29.	Informant 29	M	28	Single	High school graduate	Unemployed

* Informant 14 passed away in February 2005.

No.	Informant's Name	Sex	Age	Marital Status	Educational Level	Profession
30.	Informant 30	M	26	Single	High school Graduate	Mechanic
31.	Informant 31	M	18	Single	10th Grade	Student
32.	Informant 32	F	37	Married	Illiterate	Housewife
33.	Informant 33	M	54	Married	Reading and Writing	Guard
34.	Informant 34	F	46	Married	Illiterate	Daily labourer
35.	Informant 35	M	32	Single	High school Graduate	Petty trader
36.	Informant 36	F	38	Married	High school Graduate	Business woman
37.	Informant 37	F	41	Married	University Graduate	Teacher
38.	Informant 38	F	48	Single	Illiterate	Housemaid
39.	Informant 39	M	53	Married	4th Grade	Guard
40.	Informant 40	F	28	Single	Illiterate	Housemaid

3.2. Informants at the Organizations, Associations and Schools

No.	Informant's Name	Sex	Organization/Association	Position
41.	Kelemewerk Asfaw	F	Lideta Sub-City Women's Association	Chairperson
42.	Azeb Begashaw	F	Lideta Sub-City Women's Association	Vice- Chairperson
43.	Asegedech Aberra	F	Lideta Sub-City Women's Association	Secretary
44.	Henok Alemayehu	M	MSF-Belgium- Women's Project	Income Generating Activity Officer
45.	Iftu Ahmed	F	MSF-Belgium - STI Treatment and HIV/AIDS Prevention Project	IEC Expert
46.	Liweyew Ayele	M	MSF-Belgium - Women's Project	Counselor
47.	Aden Teshome	F	MSF-Belgium -Women's Project	Project Coordinator
48.	Dr. Tedla Mekonnen	M	MSF- Belgium -STI Treatment and HIV/AIDS Prevention Project	Project Coordinator
49.	Sister Merry Gebremedhin	F	MSF- Belgium -STI Treatment and HIV/AIDS Prevention Project	IEC Nurse
50.	Gennet	F	MSF-Belgium - Women's Project	Social Worker

No.	Informant's Name	Sex	Organization/Association	Position
51	Konjit Worku	F	ISAPSO	Project Officer
52.	Aklilu Nega	F	ISAPSO	Project Coordinator
53.	Meron Negussie	F	ISAPSO	Project Officer
54.	Hiywot Abebe	F	MSF- Belgium - Women's Project	Peer Educator
55.	Alem Dinku	F	MSF- Belgium - Women's Project	Peer Educator
56.	Yemewodish Taye	F	MSF- Belgium - Women's Project	Peer Educator
57.	Meseret Ayele	F	MSF- Belgium - Women's Project	Peer Educator
58.	Tariku Molla	M	Wereda 2 HIV/AIDS Prevention and Control Office	Project Coordinator
59.	Dereje Seyum	M	Addis Ababa HIV/AIDS Prevention and Control Office	IEC and Training Expert
60.	Genet Taye	F	Wereda 2 Women's Association	Chairperson
61.	Henok Kebede	M	Menelik Secondary School HIV/AIDS Students' Club	Chairperson
62.	Helen Abebe	F	Menelik Secondary School Female Students' Club	Member
63.	Negussie W/Michael	M	Wereda 28 Health Bureau	IEC Coordinator
64.	Zebiba Abdi	F	Wereda 28 Health Bureau	Drama Actress
65.	Roman Lemma	F	Wereda 28 Health Bureau	Drama Actress
66.	Enatnesh Abebe	F	Wereda 28 Health Bureau	Drama Actress
67.	Meseret Kebede	F	The Ethiopian Orthodox Tewahido Church - HIV/AIDS Prevention and Control Department	Officer
68.	Yetinayet Andarge	F	Ethiopian Women Lawyers' Association	Public Relations Officer
69.	Haymanot Mammo	F	Wereda 18	Drama Actress
70.	Alemtsehay Mehiret	F	Wereda 18	Drama Actress
71.	Elsabeth Nigusse	F	Wereda 18	Drama Actress
72.	Almaz Tesfaye	F	ISAPSO - HIV/AIDS Awareness Program at Adey Ababa Cotton Factory	Beneficiary
73.	Kebedech Alemu	F	ISAPSO - HIV/AIDS Awareness Program at Adey Ababa Cotton Factory	Beneficiary
74.	Ayelech Taye	F	MSF- Belgium - Women's Project	Beneficiary
75.	Habtamua Dinku	F	MSF- Belgium - Women's Project	Beneficiary

No.	Name	Sex	Organization/Association	Position
76.	Meseret Tolosa	F	MSF- Belgium - Women's Project	Beneficiary
77.	Almaz Maru	F	MSF- Belgium - Women's Project	Beneficiary
78.	Yemisirach Abebe	F	MSF- Belgium - Women's Project	Beneficiary
79.	Kasech Alemayhu	F	MSF- Belgium - Women's Project	Beneficiary