NEVER THE TWAIN SHALL MIX: AIDS PATIENTS' REJECTION OF ANTIRETROVIRAL

DRUGSIN FAVOR OF CHRISTIAN HOLY

WATER IN ETHIOPIA

by

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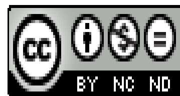

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The laity in the Ethiopian Orthodox Church have always tapped into holy water as a therapeutic for health issues. A fundamental article of faith within the Church, this treatment necessitates total devotion on the part of the faithful. Consequently, it often leads to a tension with the biomedical treatment as patients forgo their prescribed medication in its exclusive pursuit. In 2007, PEPFAR, a global U.S.-government program focusing on HIV/AIDS prevention and treatment, attempted to introduce antiretroviral drugs into holy water sanctuaries in hopes of improving adherence among those receiving holy water treatment in the ecclesiastical realm. Denounced by the clergy and laity at the initial site of dissemination as a defilement of the sacred by the profane, it led to many of the faithful departing the holy water site.

Following the above-mentioned inflection point, this dissertation analyzes the health and illness narratives of clergy and holy-water treated, AIDS-stricken laity at four holy water sites in Addis Ababa, Ethiopia and its environs. In addition, it incorporates the perspective of the biomedical side through dialogical engagements carried out with healthcare professionals. By adopting the culture-centered approach to health communication and informed by social constructionist and diffusion of innovations theories, this study, through in-depth interviews and thematic analysis of media materials, foregrounds health experiences in the local context situated in the nexus between the biomedical and the religio-spiritual. Through the analysis of meanings

negotiated in the realms of social norms, structure, and identities enacted through social construction, as well as a range of relationships, the study brings to the fore voices from the margins.

The findings point to a marked divergence between the biomedical and ecclesiastical realms in nosological constructions of HIV/AIDS itself. In the latter domain, the chronicity of the disease does not tend to get adopted. This complicates the smooth adoption of the biomedical drugs which are essentially palliative. Notwithstanding the act of symbolic violence committed by PEPFAR, incompatibility of the two healing systems remains at issue. From the culture-centered approach, cultural and structural conditions rob the AIDS sufferers of agency more so in the divine realm than in the biomedical.

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CHAPTER I

INTRODUCTION

In Ethiopia, members of the Ethiopian Orthodox Church have always sought remedy in the holy water ritual when faced with physical and mental health problems. Some only seek this divine intervention when modern medicine fails to cure the ailment while others stick to the religious treatment regardless of circumstances. As a general rule, using other forms of treatment, particularly in combination with holy water, is considered to be a sign of skepticism on the part of the faithful.

When the HIV pandemic swept the country in the early 1990s, those who were affected by the malady flocked to holy water springs in search of the divine cure. It was only since 2005 that antiretroviral drugs (ARVs) were introduced and consequently made available free of charge on a national scale (Assefa Yeseni et al., 2009). One of the suppliers of the ARVs, the U.S. government program known as PEPFAR (the President's Emergency Plan for AIDS Relief) worked with the patriarch of the church in an attempt to disseminate ARVs at holy water sites across the country.

After facing resistance from both clergy and laity at those sites, those who ran the PEPFAR program sought the blessing of the church's top leadership. In April 2007, the patriarch, the top official church, went in person to the most renowned holy water site located in the capital Addis Ababa on the premises of Entoto Mariam Church to preach to the faithful about the

compatibility of the spiritual and biomedical therapies. The leader of the parish church vigorously opposed this new move, denouncing it as a defilement of the sacred by the profane. It was believed that the arrival of antiretrovirals at the site weakened the power of the holy water to cure. The site known for its miraculous cures for AIDS patients lost its popularity. Many of the faithful who sought cure at the site departed, in search of less "defiled" sites.

Despite the official position of the Ethiopian Orthodox Church that antiretroviral drugs are compatible with holy water, the issue remains controversial among both the laity and the clergy at various holy water sites across the country. Before the pandemic rapidly spread, the church had discouraged any discussion in favor of the biomedical option and stressed that the only treatment option for those infected with HIV was holy water combined with prayer and faith ("Stories of Success," 2014).

According to the UNAIDS', the United Nations agency that is leading the global efforts in the fight against HIV/AIDS, (Ethiopia UNAIDS, 2021) recent statistics, 620,000 Ethiopians are currently living with HIV/AIDS. Whereas PEPFAR's 2018 Ethiopia report boasts a substantial increase in the coverage of antiretroviral treatment, standing at 78.6%, details on how this particular issue has been handled are not spelled out in this particular report. For instance, in one phenomenological study, it was indicated that out of 17 participants interviewed, only two had favorable views toward the combination of ARVs and holy water treatment (Berhanu, 2010).

By adopting the culture-centered approach to health communication, my dissertation project delves into the health and illness meanings of AIDS patients and clergy at holy water sites in Addis Ababa, Ethiopia. Out of 120 churches and monasteries in the capital, four holy water sites were selected primarily on the basis of their participation in PEPFAR-funded endeavors aimed at widening the reach of and enhancing adherence to antiretroviral treatment (ART) among Ethiopia's Orthodox Christian community, the largest Christian denomination as well as religious group in the country. Due to time and access constraints, but for the most part, because I learned of the PEPFAR's most recent initiative that had ended a few months prior to my fieldwork, the initial criteria according to which four local churches, namely Entoto Mariam, Entoto Kidane Mihret, St. Urael, and St. Teklehaimanot had been identified as the most famed ones (Berhanu, 2010), had to be modified. Accordingly, the list was updated to include Shegolé Kidane Mehret, Shegolé St. Arsema's, Shinkuru St. Michael's, and Entoto Mariam parish churches. The first three in this list took part in the most recent PEPFAR project while the last one, a carryover from the original list, was maintained for its status as an inflection point in this study. Clergy and laity from these ecclesiastical localities were dialogically engaged through in-depth individual interviews.

According to Dutta (2008), dialogical engagement that centralizes the voices of cultural communities and thereby locates the meanings of health and illness in the realm of cultural communities constitutes the essence of the culture-centered approach. In approaching health communication from an

alternative perspective other than the dominant paradigm that aims at changing people's ways of life through the application of one-way transmission models, this approach views the audience as actively communicating about health through illness narratives. Interviews were therefore conducted to generate these narratives. Exploring these narratives of health, healing, and illness "opens up the discursive space to culturally situate health and illness experiences, locating health experiences in local contexts" (Dutta, 2008, p. 89). Through the analysis of meanings negotiated in the realms of social norms, structure, identities enacted through social construction, as well as a range of relationships, I bring to the fore voices from the margins. In addition, illness narratives illustrate the extent to which the holy water ritual as a symbolic and communicative act enables the PLWHA participants to deal with living and dying with AIDS.

It is important to point out here that the culture-centered approach is closely associated with the social construction approach to health communication, which emerged out of the criticism of the dominant biomedical model, the same way the culture-centered approach did. The biomedical model emphasizes the use of objective language "information about organic, verifiable, measurable signs of disease conveyed in the authoritative voices of physicians and other health providers, evidenced by clinical signs, laboratory tests, imaging, and other technologies" (Thompson, 2003, p. 11). However, the social constructionist view transcends the material signs and symptoms, and as Thompson (2003) further adds, focuses on the realm of illness experience

through the application of subjective language as “people undergoing health problems and their families develop their own understandings about physical symptoms, revealing health beliefs, augmented with personal and cultural significance, that transcend the material signs relied upon by clinicians” (P. 11). Mishler also observes, “whether or not a particular behavior or experience is viewed as a sign or symptom of illness depends on cultural values, social norms, and culturally shared rules of interpretation” (p. 141). According to his observation, there has always been a conflict between the voice of medicine and the voice of the lifeworld (Thompson, 2003). In the case explored in this project, the voice of the lifeworld is situated in the realm of spirituality. Interestingly, the biomedical approach to health and illness had no such conflict with spirituality before the Enlightenment era and with it the advent of the scientific method, and actually had a central place in the history of biomedicine at least in the West to which its provenance can be traced (Wills, 2009).

In sum, while centralizing the patient agenda by way of making sense of their illness narratives and their consequent meanings, the objective of this study was not to merely celebrate these narratives but to interrogate them, trace their origins, compare them, and analyze the ways in which the participants interpret the meanings of health and illness in their lifeworld. Some of these meanings are foregrounded whereas others are backgrounded in illness narratives and afford us insight into the values, beliefs and hallowed cultural practices embraced by the cultural participants. In addition to the health and illness narratives drawn through interviews, thematic analysis of

media materials was included in an attempt to delve into the various ways in which the interaction between ART and holy water treatment gets portrayed across varied platforms.

Significance of the Study

My dissertation makes positive contributions to the rapidly growing body of research in culture-centered approach to health communication and the underexplored nexus between religion/spirituality and health communication. Both of these areas offer alternative entry points beyond the biomedical model for which health and illness meanings are constituted through alternative cosmologies and worldviews which determine healing practices. Exploring the intersection between religion and cultures directs attention to the multiplicities of meanings that are co-constructed in the realm of health (Traphagan, 2005). Though the link between physical health and religion and spirituality has been extensively investigated in other health-related fields such as psychology, it remains less studied in health communication. Parrot (2004) describes the absence of scholarship that focuses on the religious faith and spirituality and health communication connection as collective amnesia, implying that health communication scholars have generally forgotten to investigate such an important area of inquiry.

Similarly, culture has not been represented in the dominant health communication models and theories. The biomedical model is put forward as acultural and objective, upholding a monolithic, universal logic of health though each culture eventually shapes a unique *Gestalt* of health (Illich,1976).

The approach to culture, in much of health communication scholarship, has been to view it as a barrier to healthcare delivery. This approach has also been widely referred to as the cultural sensitivity approach (Resnicow et al., 2002). The central premise of this approach to health communication is based on the assumption that health interventions and campaigns should take into account the cultural variables of the target population, especially the ones that might stand in the way of implementation. Accordingly, messages and strategies that address such cultural characteristics would be more effective in communicating health vis-à-vis messages and programs that do not take into account these sensitivities.

For instance, in the United States, cultural sensitivity is one of the focal areas of health communication research (Brislin & Yoshida, 1994; Dennis & Giangreco, 1996; Jackson & Haynes, 1992; Ulrey & Amason, 2001), responding to a growing need to cater to various cultural groups immigrating to the country. This approach may even be more relevant in global health interventions such as the case for this dissertation as the immigrant population may be expected to assimilate unlike foreign targets. Airhihenbuwa (1995) notes how global health interventions that are essentially top-down, and monocentric, rooted in biomedicine and individual psychology, end up being culturally inappropriate. In this regard, this dissertation adds to the scholarship exploring this area, particularly in global health communication.

More importantly, my dissertation adopts a culture-centered approach to health communication—a framework that emphasizes the erasure of subaltern

populations from the dominant discursive spaces of health communication thereby centralizing the knowledge claims and voices rooted in the lived experiences of such communities often located at the global margins (Dutta, 2008, 2011). The absence of the voices of these communities, and mostly the general public on the receiving end of health care services, is often undergirded by the taken-for-granted assumption that such groups are apathetic and ignorant, holding ill-informed health beliefs that need to be changed by all means (Lupton, 1994). The culture-centered approach, therefore, gives agency to these subaltern communities, which would in turn lead to structural transformations of benefit to them. In addition, my dissertation builds on the growing body of knowledge in interpretivist, and critical-cultural body of knowledge exposing the modernist politics of health and the way it does violence to other ways of knowing and dealing with health and illness (Zoller & Dutta, 2008; Lupton, 1994).

Mapping the Context

HIV/AIDS in Africa

It was in the early 1980s that the Acquired Immune Deficiency Syndrome (AIDS) was recognized as a public health threat to populations across the continent. Five years after this initial discovery, it became even more apparent that the continent was facing an epidemic of hitherto unseen proportions (Jamison, Feachem, and Makgoba, 2006). Sub-Saharan Africa, the part of the continent south of the Sahara Desert, where Ethiopia, the focus of this study is

located, remains the hardest-hit region since the outbreak of this global pandemic.

According to the United Nations Program on HIV and AIDS' (UNAIDS) latest statistics, 36.7 million people live with HIV worldwide (www.unaids.org, 2017). Of these, the region is home to some 25.6 million. This is alarming given the fact that 70% of HIV-related deaths occur here even if the region accounts for only 10% of the world population (Flint, 2011).The regional prevalence rate was found to be higher in southern African states which fall under what came to be known as Africa's "AIDS belt" (Trinitapoli & Weinreb 2012, p. 15). This includes smaller countries such as Swaziland, Botswana, and Lesotho, but also much larger ones such as South Africa, and Zimbabwe. Even though there are different definitions of the AIDS belt, UNAIDS characterizes it as consisting of 16 countries (*2002*). It thus stretches from Djibouti and Ethiopia in the Horn of Africa region, adding in Somalia, Kenya, Uganda, Rwanda, Burundi, Tanzania, Mozambique, and Malawi along the way, all the way down to the south.

As the population of the entire continent continues to suffer from this devastating scourge, sub-Saharan Africa can be said to have taken the full brunt of the disease. The security, economic stability, and social fabric of the countries in the region have been severely threatened by HIV/AIDS (UNAIDS, 2012). As a result of high rates of mortality and morbidity, communities faced economic hardship. The impacts are most direct "at the individual and household levels" (Barnett and Whiteside 2006, p. 198), but many structural impacts are similarly severe at the community level (ECA, n.d.). There was

stigma and social discrimination toward the individuals and families affected by the virus.

On the whole, however, there is a dearth of data to fully comprehend the socio-economic, cultural, demographic, and political implications for countries in sub-Saharan Africa (Kloos & Tadele, 2013). My study would shed some light on the cultural implications of the global fight against the malady. As a single country case study, it may not be representative of the entire sub-Saharan Africa region or even the Horn of Africa sub-region, but it would add to the existing literature in this area.

Ethiopia's Case

Ethiopia is situated in eastern Africa, a region also commonly known as the Horn of Africa. With a population of 110 million, Ethiopia remains the continent's second most populous nation, only next to Nigeria. It is bordered to the east by Djibouti and Somalia, by Kenya to the south, Sudan to the West, South Sudan to the southwest and Eritrea, which had been part of Ethiopia until 1993, to the northeast.

Historically, Ethiopia occupies a unique position as the only African country to have successfully defended itself against the European colonization of Africa. Ethiopia's history stretches back to antiquity, with references to Ethiopia in the Bible and classical Greek literature (Saheed, 2007). Saheed writes about the exceptionality of Christianity in Ethiopia as it was not introduced by Europeans as had been the case in the rest of Africa. Historical records show that it developed in the country since the 4th century. In fact,

Doughty (1957) writes how Ethiopian Coptic Christians rejected Italian and French missionaries during the first half of the 20th century.

The Ethiopian Orthodox Church, more officially known as the Ethiopian Orthodox Tewahedo Church, had been a state church from its formation in the fourth century until 1975 (Ancel, 2006). Given its long history and position, therefore, it has strongly influenced Ethiopian culture and society. Among its influences, the beliefs of the church impact the decisions many Ethiopians make regarding their health care. “A significant number of the followers of the Ethiopian Orthodox Church believe that diseases have supernatural causes and thus seek medical help in the church through spiritual healing rather than in modern health facilities” (Lauren, 2007). More than two-fifths of Ethiopians follow the teachings of the Ethiopian Orthodox Church.

In the context of the fight against the HIV/AIDS epidemic, the church did not formulate an official response until 2000 whereupon it established its own administrative body, Ethiopian Orthodox Tewahedo Church HIV/AIDS Prevention and Control Office, responsible for coordinating efforts in the fight against the malady. However, the faithful did not wait until the church came forward with its official position. They had long been seeking a cure in the sacrament of the holy water within church and monastery premises, relocating to holy water sites, in search of spiritual care (Ketema, 2015).

Organization of the Dissertation

This dissertation consists of six chapters. The first chapter introduces the background of this work, including the context and nature of the problem, an overview of the approach adopted to the overall exploration of the subject as well as contributions the study makes to the field of inquiry. In the second chapter, a detailed discussion of the conceptual framework along with a wide-ranging survey of pertinent literature is presented. The chapter ends with a rundown of the research questions that constitute the core of the study.

Chapter Three focuses on the methodological approaches employed and procedures followed in undertaking data collection and analysis. The consequent chapters: chapters four, five, and six present the major findings and discussion. Tackling research questions 1 and 2, Chapter Four focuses on issues pertaining to the complementarity between ARVs and holy water treatment as expressed through the positions taken by both the clergy and the PLWHA laity, along with the portrayals of this issue across various media typologies.

Chapter Five presents the health and illness meanings of the devout PLWHA through the analysis of health and illness narratives. Also included in this chapter are the discussion of the treatment decisions of the holy-water-treated PLWHA laity, and the voice of the biomedical world incorporated through dialogical engagement with medical practitioners.

The final chapter, Chapter Six, deals with the causal explanations and narratives proffered by the clergy and the devout PLWHA laity. In drawing

things to a close, the chapter culminates with a few concluding thoughts, a reflection on the limitations of the study, as well as suggestions for further research.

CHAPTER II

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

The Culture-Centered Approach

As indicated earlier, this dissertation project adopts the culture-centered approach (CCA) to health communication. The culture-centered approach to health communication is relatively a new paradigm that grew out of the critique of the dominant health communication model. The dominant health communication paradigm draws on the expert position of health communication scholars and the object position of those they study (Foucault, 1988). According to Dutta (2008), “It is important to question this expert-object relationship in the context of the geographic, socio-economic, racial, and gendered lines along which it plays out” (p. 49). In the context of international health communication, health campaigns are conceptualized and designed in the West and are essentially “shipped” to the so-called Third World countries as is the case in the research problem for this project, often leaving out the cultural context of the target population.

In response to this criticism, there emerged what came to be known as the cultural sensitivity approach whose focus is geared toward creating health campaigns that take into account and are receptive to cultural beliefs and values. In other words, it is based on the understanding that adopting the characteristics of a given culture in communicating about health enhances the effectiveness of such endeavors (Dennis & Giangreco, 1996; Resnicow et al., 2002; Sue & Sue, 1999; Ulrey & Amason, 2001). Health communication

adopting this approach operates in comport with the overarching agenda of the powerful actors such as funding agencies and health care organizations except that health messaging is informed by the culture of the target audience.

As such, it is, therefore, deemed as an adaptation by the dominant paradigm to the criticism that health communication theory and praxis haven't traditionally laid much emphasis on cultural context (Airhihenbuwa, 1995). Its approach to health promotion largely remains top-down. Defining what it means to be culturally sensitive falls within the ambit of the health communicator. Van den Broucke (2016) emphasizes the importance of moving health out of the professional frame in order to engage and empower people so they have control over their health.

Contrary to the cultural sensitivity approach, the culture-centered approach theorizes communication inequalities as inequalities in opportunities for community voices to be heard (Dutta-Bergman, 2004a, 2004b). Outlining the principles underpinning this framework, Dutta-Bergman (2004a, p. 259) further states:

> The culture-centered approach to health communication emphasizes dialog and mutual understanding, locating the agency for examining health practices in the culture being studied, not in the researcher and the institutional practices that inform his or her practice. Cultural context is located at the center of the culture-centered approach, emphasizing the meanings that are co-constructed by the researcher and the cultural participants. (p. 56)

It goes without saying that the issues much of health communication and health promotion deal with are generic and global problems as pain and suffering constitute common bodily experiences for all human beings across the board. However, their manifestations, treatments, and determinants remain largely influenced by local conditions and cultural contexts. Noting the importance in health communication scholarship to take a broader view of culture, Lupton (1994, p. 57) posits that "apart from their biomedical manifestations, health, illness, and disease may be considered products of cultural practices." One of the central tenets of the culture-centered approach is to put the voice of the Other, subaltern participant, at the center through dialogical engagement (Beverley, 1999; Bauman, 2000; Giddens, 1986).

The position of subalternity is accompanied by erasure from the dominant discourse. For instance, Airhihenbuwa (1995) points out the subalternity of African cultures in general, arguing that they have been omitted from the dominant health communication discourse. A critical element of the culture-centered approach in filling this void is, therefore, to engage with these absences, examine structural conditions that enable these absences, thereby articulating alternative constructions of health and giving agency to subaltern communities (Dutta, 2008).

Within this overarching framework, culture-centered scholarship, therefore, draws on key concepts such as power, ideology, and hegemony, *inter alia*, in addition to the issue of culture, context, meanings, as well as resistance. As the CCA has its roots in critical theory, cultural studies,

postcolonial theory, and subaltern studies, the analysis of the data will be informed by concepts and notions from these areas. In what follows, let us turn to the discussion of specific theories that undergird this project.

Social Constructionism

Social constructivism propounds the perspective that everyone perceives the world in different ways and, in so doing, creates their own unique meanings from events and experiences (O'Reilly & Lester, 2017). In the context of health and illness, social constructionism argues that universal human bodily experiences are "understood and interpreted differently according to the historical and cultural settings in which they take place" (Lupton, 1994, p. 58). Berger and Luckmann (1996) are considered to be the founding fathers of social constructionism. The central assumption in their theoretical position is that human beings interact within a social system and create their own concepts whose meaning over time becomes embedded in social beliefs, and thus reality is socially constructed (O'Reilly & Lester, 2017). However, social constructionism does not seem to be overly concerned with reality but rather focuses more on knowledge, eventually rejecting absolute knowledge, and proposing that language allows people to share knowledge and develop shared constructs (Zein, 2013).

Within the realm of social constructionist perspectives on the human body, Michel Foucault has been recognized as radicalizing the understanding of the body. From a Foucauldian perspective, what we know

as diseases themselves are products of powerful and privileged discourses rather than truth discoveries *per se* (Weinberg, 2014). By tracing the ways in which a certain knowledge or discourse emerged, he aims to accentuate previously marginalized voices and accounts that are omitted from prevailing sets of knowledge. Thus, the application of social constructionist views to health and illness has been to problematize medical knowledge.

Collyer (2014) identifies the three most significant themes that run through social constructionism concerning medical knowledge. The first theme has to do with the rejection of the idea that medical knowledge is essentially different from other forms of knowledge, marking it a product of social context. "Even supposedly biological facts, embody and express social values and social inequalities. Indeed, the very structure of medical knowledge is an outcome of the social, political, and economic concerns of the social groups who produce it" (Collyer, 2014, p. 2). Consequently, medical knowledge is tied to the notion of the distribution of power and authority.

The second strand of social constructionism posits that medical knowledge mediates social practices. According to this view, by embodying social structures of inequality and through the use of its powerful and privileged position, medical knowledge plays a significant role in maintaining social order, as well as shaping and controlling social practices (White, 1991).

The third theme maintains that medical theories, whatever their truth value, are shaped by social factors that determine their development and propagation. These themes along with the other concepts discussed here have been drawn upon to explore issues about the two conflicting ontologies at the center of this research problem.

Diffusion of Innovations Theory

Originated by the eminent American communication theorist and sociologist Everett Rogers in 1962, the theory of diffusion of innovations addresses how new ideas, products, or social practices spread over time within a given social system (Rogers, 1995). The communication process may include both formal and informal means. The theory has been widely applied in the area of public health and health promotion in order to study how health-related innovations and practices are embraced or rejected by the target population. Studies informed by this theoretical framework analyze the characteristics of the innovation in question as well as those of the adopters (Rogers, 2003). In the final analysis, the central objective in such studies remains to be gaining a better grasp as to why a particular innovation gets accepted or rejected or even remodeled.

Though the theory has been largely recognized as a community- or collective-level theory, primarily used with initiatives targeting communities, societies, or populations (Glanz et al., 1997), it begins by identifying the major characteristics of the individual decision-maker and locates that in the social context (Mitchell, Kelly, Potgieter, & Moon, 2009).

The decision-making process includes five stages: knowledge (decision-makers are exposed to and evaluate information about the innovation), persuasion (opinion formation), decision (steps are taken toward making choices), implementation (involves adopting or adapting the innovation), confirmation (involves evaluating the decision and perhaps upholding it). The innovation-decision process, therefore, goes from being cognizant of the existence of the innovation to the point at which the new product, idea, or practice becomes adopted or rejected. In addition to adopter attributes, the perceived features of the innovation play a critical role in the adoption process. According to Rogers (1995), these features include relative advantage, compatibility, complexity, trialability, and observability. Relative advantage refers to the superior qualities that the innovation has compared to whatever it is intended to take the place of. Compatibility has to do with the consistency of the innovation with the values, norms, and mores of the target population.

Haider and Kreps (2004) attach a great deal of significance to the identification of societal norms such as a community's cultural and religious principles that may stand in the way of the diffusion of a health innovation. This aspect, in particular, coincides with the fundamental problem explored in this dissertation, i.e. the apparent encroachment upon religious values in the process of diffusing ARVs as a public health innovation. The scholars note that "catering to the societal norms of the community can lead to a greatly improved rate of diffusion and adoption of

the innovation" (p. 7). The third innovation characteristic, complexity, pertains to the ease with which the product or practice being touted can be implemented. The other construct of the theory is trialability. It refers to whether the innovation can be tried for a short period to decide whether or not to adopt it. In a systematic literature review, Greenhalgh *et al.* (2005) note that in most studies they reviewed, trialability was linked to complexity. Observability, which has to do with the innovation's ability to produce tangible results, is yet another attribute that has been widely researched.

In his review of innovation attributes, Rogers (1995) pointed out that the list may not be exhaustive. While those five are the most commonly recognized ones, for instance, reinvention was introduced as the sixth innovation characteristic decades after the theory had been formulated (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2005). However, only the first five have been extensively explored in innovation characteristics and adoption studies while reinvention mostly remains omitted. Reinvention refers to the changes and modifications adopters make to the original innovation before adoption. Overall, relative advantage was found to be the most significant and consistent determinant of adoption.

In addition to the innovation attributes, adopter attributes are also central to this theory. Compared to innovations, adopters can be harder to study as people are more complicated than products or social phenomena. On the basis of their rate of adoption of a new behavior or product, people

generally fall into five categories. These are innovators, early adopters, early majority, late majority, and laggards (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2005; Haider & Kreps, 2004). The categories are not based on personality traits *per se*, one might argue. According to Rogers (1995), innovators are the first to adopt the innovation. In comparison to their peers, they tend to have the ability to cope with high uncertainty, cosmopolite and educated. As such they are opinion leaders and gatekeepers more or less at the forefront of the diffusion process. Early adopters, on the other hand, are believed to be less cosmopolitan and educated in comparison with innovators, and also less equipped to deal with a high degree of uncertainty; they are still more likely to adopt the innovation earlier than the average people. A third of the members of a given system fall into the early majority category. Those included in this category "are likely to deliberate before adopting an innovation" (Haider & Kreps, 2004, p. 5).

Also constituting one-third of the general population, the late majority adopts innovations after the early majority, often characterized as skeptical and thus requiring peer pressure to take action. Greenhalgh *et al.* (2005) suggest that both early and late majority members can in turn be an influential peer pressure. Those last to adopt, also referred to as laggards, are characterized as belonging to low socioeconomic class, least educated, cosmopolitan, and exposed to mainstream communication channels.

For the most part, diffusion research has been rather highly structured and quantitatively oriented. Rogers *et al.* (1977) recognized the need to break with this tradition and move toward more qualitative approaches that are capable of producing more perceptual data from the end-users. Whereas much of this research, which mainly analyzed data obtained through survey instruments, contributed a great deal to understanding the attributes of innovations and adopters, but it left a lot to be desired in terms of answering questions pertaining to "why" or "how" adoption occurs or fails to take place (Meyer, 2004).

By adopting a qualitative approach, this dissertation project, therefore, contributes to the growing body of research in this tradition. In addition, it addresses the common critiques of the theory such as pro-innovation bias and individual blame-bias (Meyer, 2004; Haider & Kreps, 2004). Inherent in the diffusion of innovations model is the assumption that a given innovation has to be diffused and adopted by all members of the target population. Rogers (1995) notes that this pro-innovation bias causes researchers to overlook or underemphasize issues pertaining to rejection, reinvention, or discontinuance after adoption. Diffusion research is also blamed for siding with those spearheading diffusion efforts, being pro-source in that way, and laying blame on the individual rather than the system in which the individual is a part. Sundstrom (2016) suggests that applying the diffusion of innovations model through qualitative research

addresses these weaknesses thereby empowering the audience whose voices are often left out.

African Response to HIV/AIDS

HIV/AIDS and the State

The term state is used here to refer to the institutional body that is responsible for the management of the geopolitical space as well as the allocation of resources for the needs of the population in a given country. This also includes the management and provision of health-related services. Again, the focus would be sub-Saharan Africa as it remains to be the most affected region of the continent. The sub-Saharan region has borne the brunt of the epidemic with AIDS-related mortality rates exceeding those of the rest of the world combined (UNAIDS, 2007).

The response of African nations to the AIDS crisis has included assorted policies and laws determined in part by the legal background of reporting nations and in part by the size of the national outbreak. In fact, there is no single AIDS epidemic in Africa; rather, there are many different, interwoven epidemics (Piot et al., 1990). That is to say that not every country was affected to the same extent.

In West Africa, high levels of prevalence have been reported in Abidjan, Côte d'Ivoire, and adjacent areas of Ghana and Burkina Faso (Caldwell and Caldwell, 1993). In Senegal, after the first case was reported in 1986, clinical scientists convinced the then President Abdou Diouf of the threat it posed (Meda et al., 1999; Putzel, 2003). This led to the launch of the country's first

HIV/AIDS campaign. Senegal is one of the countries lauded for curbing the epidemic. This success is attributed to its coordinated state response: “Political leadership and conservative sexual mores were both important in the fight against HIV, together with Senegal’s long tradition of taking a pragmatic and participatory approach to primary prevention” (Simms, Sow & Sy, 2006, p. 228).

Generally, Senegal and South Africa represent opposite ends of the spectrum. In South Africa, there was little to no response from the government in the early days of the epidemic, despite it having acknowledged close to a one percent infection rate among all sexually active people in 1990 (Department of Health, 2001: 9). According to Mulwo, Tomaselli and Francis (2012), South Africa’s President Thabo Mbeki came to represent the face of denialism in Africa, owing to his controversial statements questioning the causal relationship between HIV and AIDS on various occasions between 1997 and 2003. Mbeki began to seek advice from a dissident, outspoken panel of experts who similarly denied the causal link between the human immunodeficiency virus and AIDS (Van Rijn, 2006). His controversial position later led to the adoption of what came to be known as the Durban Declaration. Signed by a group of over 5,000 scientists from around the world, the declaration came out of deliberations held in Durban, South Africa, before the 13th of July 2000 (Lumb, 2000). Finally, in 2002, the government decided to allow antiretroviral treatment for victims of rape.

Another controversial case arose from The Gambia in West Africa. In 2007, the then President Yaya Jammeh announced that he was launching a program to cure people with AIDS and asthma with a remedy prepared from seven herbs named in the Koran. Quoted directly in Cassidy and Leach (2009), his call laid out regimen rules, but also caveat that it was a limited offer:

> I can treat asthma and HIV/AIDS and the cure is a day's treatment. Within three days the person should be tested again and I can tell you that he/she will be negative...I will not treat anybody who is not diagnosed as asthmatic or a HIV/AIDS patient by a doctor. I don't want to give my medicine to the wrong person...I am not doing it for money or popularity. The mandate I have is that HIV/AIDS cases can be treated on Thursdays. That is the good news and the bad news is that I cannot treat more than ten patients every Thursday. There is nothing I can do about it and if I go beyond that I will have to pay the price. (p. 562)

In addition, the president also indicated that his regimen was not compatible with ARVs, and therefore patients who had been on the biomedical treatment had to be taken off ARVs before joining the program. As controversial as it was, the president's treatment drew people in the hundreds both from near and far, including from neighboring countries such as Senegal (Cassidy & Leach, 2009). Unlike Mbeki, Jammeh incorporated biomedical preconditions into his claims requiring pre-tests as well as post-tests. He was able to procure

laboratory test results from Morocco and Senegal that proved the effectiveness of his treatment, though the latter later claimed that the results were rather misinterpreted (Cassidy & Leach, 2009). The authors indicate that as controversial as this treatment and cure claims by this leader of a small West African country have been, little has been said about it in both local and international contexts.

Whereas these debates and denials originate from the realm of politics, the causal link between the HIV virus and AIDS has also been contested from the early days of the discovery of the epidemic by a number of experts. In her article reviewing 30 years of such debates, Goodson (2014) notes that the wrangling between orthodox and unorthodox scientists has continued to rage on as has the epidemic. Among the dissenters is Kary Mullis, a 1993 Nobel Laureate in Chemistry, who once said, “The HIV/AIDS hypothesis is one hell of a mistake” (1996, p. 14), claiming that the HIV-causes-AIDS hypothesis is false. Aligning with this position, *inter alia*, were other prominent scientists such as Peter Duesberg, a professor of Molecular and Cell Biology at UC Berkeley.

In Ethiopia, when the first cases of the virus were reported in the period between 1984 and 1985, the military government, also known as the *därg*, took control of the infection (Lehmani, 1991). The military regime was overthrown in 1991, creating a void in leadership until the new government put in place programs after five years. As Okubagzhi and Singh (2002) note this phase represents a sort of denial and limbo in the fight against the epidemic. They

also add that intense campaigns were launched by the government in the early 2000s.

HIV/AIDS and Religion

Trinitapoli and Weinreb (2012) write that Africa is perhaps "the most religious place on Earth"(p. 5). Not only do people throughout the continent report high levels of religious affiliation, but also high levels of participation in religious beliefs and traditions. This has far-reaching implications in the fight against HIV/AIDS.

However, Christian and Islamic religious organizations are mainly portrayed as barriers to a more effective and just response to AIDS. They have been accused of perpetuating AIDS-related stigma and failing to contest discrimination, in each case linking back to religious groups' presumed sexual conservatism (Ahiante 2003; Atatah 2004; Moonze 2003; World Bank 1997). The logic behind this perspective is that these major belief systems condemn sex outside of wedlock, and consequently an HIV-infected person is believed to be in such transgression.

Nevertheless, this does not tell the whole story. More positive perspectives refer to the countless examples of congregations and religious nongovernmental organizations (NGOs) actively combating stigma (e.g., Gatheru, 2002; Komakech, 2003), providing care and support to people living with HIV/AIDS, or being key players in preventive education despite the limited funds at their disposal (Liebowitz, 2002; Pfeiffer, 2002).

As the target of this study has to do with Christianity, let us particularly look at how the church responded to the scourge of HIV/AIDS since the early days of the epidemic.

The Role of the Church in the Fight against HIV/AIDS

According to the World Book Encyclopedia (2002), Christians form 45% of Africa's population. This large population depends on the church for guidance through life and sanctuary during trying times, including the HIV/AIDS epidemic. Though there have been gradual improvements, several studies have shown that the church tends to stigmatize persons afflicted with HIV/AIDS. In a South African study by Haddad (2005), one participant said, "Church groups always come when we are dying or even already gone. But when we are trying to live with HIV, when we really need them most, Christians are nowhere to be seen" (p. 33).

In recent years, the church seems to have become more accommodative than it was during the early years of the epidemic. In Ethiopia, for instance, the Ethiopian Orthodox Church, the largest Christian church in the country, joined hands with many non-governmental efforts in fighting HIV/AIDS, focusing on prevention and care, as Yamamori *et al.* (2003) observe. They further point out, "many in the church strongly believe holy water has been given to Ethiopia to heal AIDS" (p. 114). This is also reflected in several other studies on the challenges of adherence to antiretroviral treatment.

The Advent of Antiretroviral Drugs

Antiretroviral treatment (ART) is aimed at suppressing viral replication, thereby decreasing susceptibility to opportunistic infections and eventually decreasing mortality and morbidity as well as onward transmission (Jesson, & Leroy, 2015). Since ART is a lifetime treatment, adherence to the regimen is critical.

However, with strict adherence come a number of side effects such as gastrointestinal problems, and metabolic dysfunctions, among other things (Zhang et al., 2016). These iatrogenic problems are among the main factors that affect patients' adherence. However, the side effects remain underexplored in the ART literature. This is in line with what one of the ardent critics of biomedicine Ivan Illich (1976) writes in his book *Medical Nemesis:* "…the damage done by medicine to the health of individuals and populations is very significant. These facts are obvious, well documented, and well repressed" (p.5).

Currently, antiretroviral drugs have been made widely available in Africa. This has changed the view that being HIV-positive is an immediate death sentence. With antiretroviral therapy (ART), the survival of patients with HIV and AIDS is expected to improve and life expectancy has been predicted to reach near normal (Mills *et al.*, 2011). Antiretroviral drugs (ARVs) are a means of tertiary prevention aimed at improving the quality of life.

According to UNAIDS recent statistical data, nearly 22 million people living with HIV/AIDS the world over are on ARVs (UNAIDS, 2018). In sub-Saharan Africa, there has also been a rising trend in ART, with the statistic

jumping from 100,000 in 2003 to nearly four million at the end of 2009 (Reda & Biadgilign, 2012). The year 2009 is considered to be a landmark in the region as two countries Rwanda and Botswana have reached the so-called universal coverage—80% or more treatment coverage (WHO, 2010). According to the same WHO document, Ethiopia, along with Senegal, Zambia and Namibia, was listed as well on course to reach the universal coverage target. Recent studies out of Ethiopia, for instance, indicate that the country remains way behind the global UNAIDS treatment targets (Gesesew et al., 2020; Lulseged et al., 2022). A combination of factors, including holy water treatment, medication side effects, poor healthcare service delivery,economic constraints, and stigma and discrimination contribute to the lack of adherence to the biomedical treatment.

In this connection, a number of reports have indicated that the achievement of long-term virus control among patients in developing countries is due to simplification of therapy, improvement of patient adherence and minimization of drug resistance (Kumari and Singh 2012). In order to produce good clinical outcomes, the patient must adhere to the antiretroviral regimen. In many parts of sub-Saharan Africa, however, maintaining high treatment adherence for a lifelong condition is a considerable challenge (Nachega *et al.,* 2010). The HIV/ART management is further challenged by various social and clinical obstacles (Nachega *et al.* 2010; Coetzee and Kagee, 2012) where inadequate suppression of viral replication by ART is resulting due to poor adherence to therapy, losses to follow-up, low potency of the antiretroviral regimens, and viral resistance to antiretroviral medications (Friedland and

Andrews, 2001). In the absence of treatment, HIV-infected patients experience the onset of symptoms such as weight loss, fever and night sweats, deterioration in their immune function and general wellbeing and all aspects of quality of life (O'Keefe and Wood, 1996).

In Ethiopia, one of these challenges comes from religious institutions such as the Ethiopian Orthodox Church, where believers diagnosed with this malady undergo church-based holy water treatment. According to Tarekegn (2013), there is consensus to use ARVs together with holy water, but there is a gap in the implementation.

Research Questions

As indicated earlier, the primary data was generated in the form of illness narratives from participants at four of the most popular holy springs in four parish churches in Ethiopia's capital Addis Ababa and its environs. The following six major research questions were addressed. The first four questions will be tackled through in-depth individual interviews. The fifth question will be explored through thematic analysis. Needless to say, specific questions were derived from these overarching questions. All individual interviews were conducted in Amharic, Ethiopia's national language, and were later translated into English. Similarly, data for thematic analysis available in Amharic were translated into English.

RQ1. What does combining ARVs and holy water treatment mean to clergy and the devout PLWHA?

RQ2. What are the dominant themes that run through media portrayals of the holy water treatment as it pertains to the treatment of HIV/AIDS?

RQ3. How do the devout PLWHA construct health and illness?

RQ4. How are treatment decisions made?

RQ5. Where do health professionals stand on the tension between the two healing systems?

RQ6. What dominant causal explanations of the AIDS epidemic emerge in the health and illness narratives?

CHAPTER III

METHODS

In addressing the above questions and generating the data that would then serve as grist in the subsequent analysis and interpretation, individual in-depth interviews and thematic analysis were employed. Data obtained through interviews and discussions produce fragments for narrative analysis for the identification of key meaning points (Hurwitz, Greenhalgh, Trisha, & Vieda, 2004).

In any research design, the nature of the questions asked determines the methodological choices that have to be made to delve into the subject of inquiry. The subject for this research deals mainly with issues of health and illness in a social context and the role that communication plays in addressing the conundrum arising from uncertainty surrounding whether to opt for a biomedical or spiritual remedy or both for a peculiar illness. The conundrum is also rooted in a religious belief which can be hard to pin down. Simpson and Freeman (2004) suggest that health communication research must take into account such situational, psychological, and societal factors to fully examine the often-hidden dynamics of healthcare and health promotion. It is not possible to examine every facet of these areas in a research project such as this.

The methodological tools, which are often guided by our perspectives, will afford us only a particular level of view. As Whaley (2014) beautifully puts it, “methods are a way of seeing, but also a way of not seeing.” (p. 339) This

means that we will not be able to see everything from a particular vantage point.

As discussed earlier, this dissertation primarily hinges on the culture-centered approach, which centralizes the understanding and co-creation of health meanings of cultural members by engaging in dialog with them (Dutta, 2008). As Koenig *et al.* (2012) point out, "This approach treats communication as the articulation of shared meanings of health experiences as integral to cultural members' socially constructed identities, relationships, and social norms (p.4). By emphasizing the voices of the marginalized, it aims to give them agency and context, through exploring the locally situated meanings of health and illness in the form of illness narratives, also alternatively referred to as health narratives.

Within this overarching framework, the specific theories of social constructionism and diffusion of innovations serve as a blueprint underpinning methodology and the eventual analytical approach. Based on the research questions outlined above, the central subject being investigated, and the perspective adopted, a qualitative approach was, therefore, found to be more apt.

Qualitative methods have proven to be instrumental in incorporating the voices of patients and marginalized groups, which are not often represented in the mainstream health care and health communication discourse (Britten, 2011; Kidd & Parshall, 2000). According to Green and Thorogood (2004), qualitative approaches are ideal for questions that require an answer about

understanding participants' views, observing a process in-depth, or for questions that address the meaning given to phenomena. Mellis, Williams, & Xuan (2001) also note that "qualitative studies are invaluable for collecting information about questions such as why some patients do not adhere to treatments, what patients require from their local health care systems, or what patients feel about changes in their health care" (p. 54).

In other words, qualitative research provides an in-depth understanding of human behavior and the reasons that underpin such behaviors, eventually investigating the why and how of decision making. In light of these justifications, the study, thus, utilized in-depth interviews and thematic analysis.

Individual In-depth Interviews

As a form of qualitative interview, the face-to-face individual in-depth interview is used to get a deep insight into an individual's perspectives on a given set of issues. Also referred to as depth, intensive, or qualitative interviews, in-depth interviews are designed to elicit participants' experiences, perceptions, and narratives expressed in their own words (Noller & Feeney, 2004). The use of interpretive and narrative-oriented research in health-related fields, including health communication, thus gives more attention to patient experience and sociocultural influences on beliefs and action. As Kleinman (1988) notes, health and illness are not merely matters of physiology but are socially constructed through cultures, communities, and conversations.

In in-depth interviews, the fact that data sets are generated through self-reported narratives leads to questioning their validity. However, several scholars argue on the contrary that in-depth, unstructured personal interviews and focus group discussions can help reduce concerns about the validity of self-response measures by encouraging in-depth answers to questions, the sharing of stories, and the use of probes to encourage the sharing of full, relevant, and complete information (Colon et al., 2001; Dholakia & Morwitz, 2002; Harrison, 1997; Linhorst, 2002; Mitchell & Branigan, 2000; Riley & Hawe, 2005; Tourangeau & Smith, 1996).

In terms of format, the individual interviews were set up as semi-structured in the main, organized around a set of predetermined open-ended questions, with other questions emerging from the dialogue between the researcher and the interviewees. According to Whaley (2004), research interviews tend to be successful when they are active and structured enough to keep informants focused, but give people plenty of leeway and emphasize that, as participants, they are the experts. Chirban (1996) states that the interactive-relational approach, based on positive reciprocal interaction, in particular, is quite useful in giving us access to the inner view of the interviewee.

The semi-structured interview was designed based on the McGill Illness Narrative Interview (MINI), an interview blueprint and guide widely applied in health-related research undertakings aimed at generating health and illness meanings and narratives as well as explanations related to treatment and etiology (Groleau et al., 2006). MINI has been adapted and applied in various

socio-cultural contexts such as Nigeria, Brazil, and Spain to explore individual and group illness narratives regarding chronic illness experiences (Pelaéz & Caballero, 2011; Adeponle et al., 2017; Leal et al., 2016). Since the MINI interview schedule follows the illness trajectory of a particular illness from the onset of the illness and follows its course, it manages to capture the whole gamut of illness experience, including initial reaction, patient causal explanations as well as care sought in the biomedical realm or elsewhere.

Prior to conducting the interviews, the original English version of the MINI interview guide was translated into Amharic, Ethiopia's major language and the language in which the interviews were conducted. With the first rendition, a limited number of pilot interviews were held. The purpose was to aid in the refinement of the translated version of the MINI interview guide. Pilot interviews can help with refining research questions and revising the interview protocol (e.g., see Kosenko, 2010). Questions that did not seem to be effective at eliciting the necessary information were then dropped out and new ones were added in the process of perfecting the Amharic version of the MINI. In general, interviews lasted approximately 20-60 minutes on average.

Gaining Access to Informants

Given the stigmatizing nature of the health condition this population suffers from, the PLWHA meet the qualifying criteria for a hidden or hard-to-reach population (Lindlof & Taylor, 2019). Directly approaching them at the holy water sanctuaries was not an option because it was not possible to identify them on the basis of outward appearance. The clergy at the selected

parish churches were not cooperative at first. Initial resistance was encountered from clergy, but once the EOTC-DICAC provided a letter of support, clergy sites agreed to cooperate.

After several unsuccessful attempts, I was directed to take the letter to the church's Development and Inter-Church Aid Commission (EOTC-DICAC), Health and Social Affairs Department. As an entity attached to the top echelons of administrators within the ecclesiastical hierarchy, the EOTC-DICAC took the prerogative to enlist the cooperation of the parish churches through communication dispatched to the same. Initially, four churches were proposed to be the sites of the study, selected on the basis of their popularity for holy water treatment, but later on, after a discussion with the lead project manager at EOTC-DICAC, some adjustments had to be made. The list was updated to five parish churches purposively chosen due to their recent participation in a PEPFAR-funded push for accelerated prevention and treatment of HIV/AIDS, focusing on training clergy from these local churches. These were Shinkuru St. Michael's, Shegolé Kidane Mehret, Shegolé St. Arsema's, Entoto Maryam, and Alem Bank Selassie. All but one of the parish churches acted in compliance with the upper-level directions promptly.

In view of the brevity of the timeframe within which data collection had to be completed, after several attempts at persuading the local church authorities that the research activity was an innocuous undertaking, Alem Bank Selassie was, perforce, excluded. At those four churches where I had had success with getting the clergy on board, the next hurdle was finding PLWHA undergoing

holy water treatment. Interestingly, it was even difficult for the priestly authorities to get the PLWHA faithful to participate in the study.

Sampling

Interview studies in health communication are often iterative in nature, as scholars engage in sequences of concurrent sampling, interviewing, analyzing, and theorizing (Strauss & Corbin, 1990). In identifying potential respondents, it was worthwhile to think through the various sides involved in this complicated matter, including the clergy, believers who are undergoing holy water treatment at the various sites who adhere to either therapeutic remedy or both the biomedical and religious treatments or neither, healthcare professionals as well as the clergy who oversee the holy water treatment at various local churches and monasteries.

Because qualitative research methods are often concerned with garnering an in-depth understanding of a phenomenon, the sample size used in qualitative research methods is often smaller than that used in quantitative research methods. Dworkin (2012) observes that there is no consensus as to how many interviews are enough among experts in the field. She, however, points out that “an extremely large number of articles, book chapters, and books recommend guidance and suggest anywhere from 5 to 50 participants as adequate” (p. 1319). Participants were selected by using purposive and snowball sampling techniques, with particular focus on their experience and understanding of the subject matter being investigated. Also known as theoretical sampling or purposeful sampling, purposive sampling entails

purposefully handpicking, as the name implies, “cases that by their nature and substance will illuminate the inquiry question being investigated” (Patton, 2015, p. 402).

Accordingly, five members of the clergy and five health professionals, four doctors, and one ART nurse who has a wealth of experience dealing with the PLWHA who struggle with adherence to the biomedical drugs as they navigate the two disparate treatments. Put differently, the participants from these were selected because they met the criteria set in terms of their positionality to the PLWHA. Needless to say, the clergy are the authority on holy water treatment in the spiritual domain and the medical professionals are authorities and experts in the biomedical field.

Snowball sampling technique was applied to recruit the PLWHA faithful. Named after a putative rolling snowball that knocks on other snowballs, picking them up and growing larger and larger as it rolls on, it reflects the notion that the list of the cases sought after grows every time a recommended contact volunteers to participate. In an interview situation, the first interviewee that participates in the study provides the researcher with a referral to at least one participant, and so on and so forth (Kirchherr & Charles, 2018). While the sampling technique gets negative reviews for lacking diversity of research subjects as most of the referrals are based on personal relationships often established through membership in the same group, it works very well with hidden or inaccessible populations such as PLWHA (Whaely, 2014). The diversity of the participants, in this case, was not a desired characteristic.

Uniformity in terms of being a person living with HIV/AIDS, a believer in the curative powers of holy water treatment, and also being on ARVS, with or without maintaining strict adherence to the treatment regimen was an integral part of the recruitment criteria. A form of diversity that was missing was gender diversity as 19 of the PLWHA participants were female and only two were male.

Because many of the PLWHA faithful undergoing holy water treatment at the local churches and monasteries did not usually go public with their health condition and did not declare their HIV status, it was often difficult to locate them. Their status would usually remain confidential by the clergy and fellow congregants until such time as they feel cured of the malady and thus announce the nature of their illness from the pulpit. After the initial contact had been established with the first interviewee at Shegolé Kidane Mehret local church, a total of 21 in-depth individual interviews were conducted through "a chain of interviewees based on people who know people who know people who would be good sources given the focus of inquiry" (Patton, 2002, p. 451). Nominations of potential interviewees through this line of referral eventually snowballed into 20; the last participant was outside of this snowball sample, and thus an outlier as she was the only one who was found willing to take part in the study after so much effort was put into getting her to agree.

In total, therefore, 31 interviews were carried out over 25 days. At that point, however, data saturation was rather evident as the number of participants hit 31. A review of the data at that juncture indicated no new themes were emerging. The issue of saturation of information has been widely

written about in the qualitative research literature with various scholars going as far as pointing out at what point a researcher should expect it to materialize (Douglas, 1976; Glaser & Strauss, 2017; Lincoln & Guba, 2006; Rubin & Rubin, 2016; Weiss, 1995). Douglas (1999), in particular, maintains that if he were to put a number on the high point, it would be in the vicinity of 25 participants, which, for all practical purposes, does not appear to be wide of the mark vis-à-vis this study.

Thematic Analysis

Thematic analysis refers to the identification, analysis and reporting of patterns or themes (Braun & Clarke, 2006). There is a debate as to whether thematic analysis is a stand-alone qualitative method or if it is just an analytical tool that can be applied to the analysis of qualitative data across the board. While Braun and Clarke (2006) maintain that thematic analysis is a stand-alone qualitative method, Boyatzis (1998), for instance, argues that it is not another qualitative method, but a process of qualitative data analysis that can be used with most, if not all, qualitative methods, including interviews, that is.

In fact, thematic analysis is rather less clearly demarcated as a method compared to other qualitative methods such as discourse analysis, ethnography, narrative analysis, etc. Due to this fact, there are qualitative researchers who are using thematic analysis, but they are not referring to it as such (Patton, 2002). Moreover, Whaley (2014) points out that particularly micro-level thematic analysis that focuses on transcribed text

is less frequently used in health communication research. Such analyses frequently consider contextual issues as well as text (e.g., Young & Rodriguez, 2006).

A theme captures an important feature as it pertains to the research question. In his book titled *The Coding Manual for Qualitative Researchers*, Saldana (2009) argues against thematic analysis that aims at identifying themes. For him, themes come later and the researcher should first identify codes and categories. Categories are a cluster of codes put together according to a particular pattern. Such a pattern could be based on similarities, differences, correspondences, sequences, frequencies or causation. In the coding process, therefore, codes lead to categories, and categories to themes, which may or may not lead to theories. The analysis could be based on semantic level or explicit themes or latent/interpretive level.

Braun and Clarke (2006) have come up with the following phases that the researcher needs to go through in applying thematic analysis.

Familiarization with the data. This phase involves reading, and re-reading the data to become immersed and intimately familiar with the data.

Coding. This phase involves the generation of succinct labels or codes after closely examining in view of the research question. All the data should be coded and collated into categories for later stages of analysis.

Searching for themes. This phase involves examining the collated data and identifying broad patterns within them.

Reviewing themes. This phase involves checking the themes and carefully analyzing them, which could lead to the themes being split, combined, or discarded altogether.

Defining and naming themes. At this stage, the researcher has to do another close reading of the data, making sure the themes tell a convincing story of the data, and deciding on the name that captures that story.

Writing up. This phase involves interweaving narratives based on the themes identified and also contextualizing the extracts of the data with existing literature.

There is no ideal set of data for thematic analysis. Braun and Clarke (2006) further observe that thematic analysis can be used with any kind of qualitative data, including in-depth individual interviews, focus groups, printed and online materials, broadcast media and film, etc. For instance, Kummervold et al. (2017) use thematic analysis to investigate issues pertaining to the introduction of the Ebola vaccine in Ghana in online news outlets. The news materials included interactions between health authorities, political actors, and the public at large. They were able to identify 27 themes and two overarching themes: critiques that directly or indirectly argued that vaccines should not be administered and those who argued to the contrary. They also identified fear among the public that the Ebola vaccine could give the disease to Ghanaians.

Specifically, textual and non-textual data were analyzed by following the steps outlined above. The latter data set was obtained in the form of in-

house church communication materials produced by the church's HIV/AIDS Prevention and Control Department identified as church-affiliated materials, set up under its Development and Inter-church Aid Commission in 2000, reports by PEPFAR-affiliated players, and conventional media pieces that report on the issue of holy water treatment and ARVS. In the first category were pamphlets, booklets, sermons uploaded to YouTube, and T-shirts emblazoned with campaign messages. Included in the second category were reports by outlets that openly proclaim their association with PEPFAR.

Finally, in the conventional media category, domestic and international media reports on the issue were analyzed in order to get the overall picture of media representations of the issue of holy water treatment. Most of the items analyzed were available in Amharic; summary translation was used to focus on the most important and dominant leitmotiv that ran through each item. In this process, also known as gist translation (Barette, 2022), two steps were followed in the rendition of the items: reading/watching through the material with the aim of determining the most important thematic nodes; then, the item was then summarized and translated into English for further analysis.

All but one of the interviews was carried out in a face-to-face format. The phone interview was with a physician per her format request. In all the cases, interview arrangements were made through telephone contact. With considerations of privacy and confidentiality, interviews, especially those

with patients, were held at a time and place of their preference. Upon obtaining consent, all interviews were audio-taped.

Analysis and Interpretation of Interview Data

Translation and transcription of the audio recordings yielded extensive data for analysis. Transcription and translation were done simultaneously. Though both transcription and translation are normally thought of as run-of-the-mill technical activities, in actuality, they tend to have far-reaching implications. Temple & Young (2004), for instance, note that "the relationships between languages and researchers, translators and the people they seek to represent are as crucial as issues of which word is best in a sentence in a language" (p. 162). So, as I was engaged in both of these undertakings, I was well aware of my positionality and practiced reflexivity as I constructed and co-constructed narratives. While transcription itself is a deeply interpretive enterprise, translation, especially between languages that share little cultural propinquity, could prove to be a rather onerous task. In this connection, Riessman (2008) writes that an hour of interview requires around four hours of translation work.

To confirm translation accuracy, transcripts were re-read while the audio played. After a second-level review had been undertaken, personally identifiable information was removed from the transcripts. At this stage, with the review of the transcripts and employment of close reading of the texts (Charon, 2008), participant narratives were beginning to fall into place. For the sake of identifying narratives of health and illness in the

context of ARVs and holy water treatment at the nexus between the biomedical and the religio-spiritual realms, meticulous attention was paid to the illness experiences as related by the devout PLWHA, as well as ecclesiastical and biomedical stances as represented by the clergy and healthcare professionals respectively. Positioned in the overarching theoretical framework of the culture-centered approach to health communication, I also paid attention to the social, cultural, economic, and structural issues that underpin those health and illness meanings.

By adopting the Braun-and-Clarke iteration of thematic analysis, I immersed myself in the data again as I engaged in close-reading for thorough familiarization. This was followed by the identification of a thematic framework, which led to indexing (generation of succinct labels/codes), codes were then collated into themes. I finally reviewed and renamed the thematic labels as I saw fit. Guided by the research questions, data was classified into clusters that speak to the topics the research questions purport to explore.

Cases were drawn on to illustrate strands of health and illness meanings throughout the analysis. Such case-centered analysis helped preserve the "unity and coherence" (Mishler, 1996, p. 80) of narratives thereby reducing the risk of losing the nuances of individual meanings. Put differently, each participant's story was distinctly analyzed paying particular attention to every bit of detail and idiosyncrasies within

individual narratives. Overall, it is the cases brought into play through individual accounts that provide the basis for the analysis in this study.

To this end, in addition to Braun-and-Clarke's iteration of thematic analysis, Riessman's (2008) case-based thematic narrative approach was also employed specifically to delve into the stories of devout PLWHA that navigate holy water treatment and biomedical drugs, and their articulations of health and illness meanings. In thematic analysis, the primary focus is on the discursive content communicated by a narrative—what Mishler (1986, p. 158) refers to as "the told" vis-à-vis in what manner or to whom and for what purpose the narrative is being told. Again, the analysis process was informed by a pre-existing theoretical lens, namely the culture-centered approach, social constructivism, and the diffusion of innovations theory, and also by taking contextual issues into consideration.

On the whole, the use of thematic analysis both as a stand-alone method and a tool of analysis used for examining narrative data qua grist engendered by way of in-depth interviews proved to be viable for this study. As a systematic qualitative method that allows for a detailed description of themes, thematic analysis was used to analyze the interviews and examine the media materials data set leading to the ultimate interpretation of the study results. Using these methods, robust and nuanced exegeses of media portrayals of the issue of holy water treatment in the context of adherence to biomedical drugs, articulations of health and illness meanings, and

views drawn from both the biomedical and ecclesiastical authorities on the subject matter was developed.

CHAPTER IV

CLERGY AND LAITY POSITIONS ON THE COMPLEMENTARITY OF ARVS AND HOLY WATER TREATMENT AND THE ISSUE IN THE MEDIA

This chapter seeks to explore the understandings and views of the clergy and laity on whether the antiretroviral drugs and *tsebel*—holy water treatment— offered by the church can be used in combination for the treatment of HIV/AIDS. In addition, it deals with unpacking the portrayals of the holy water treatment across various media platforms and formats. As such, the chapter's development tackles Research Question 1: "What does combining ARVs and holy water treatment mean to clergy and the devout PLWHA?" and Research Question 2: "What are the dominant themes that run through media portrayals of the holy water treatment as it pertains to the treatment of HIV/AIDS?" It does so by drawing on the analysis of themes that emerged from interviews held with the PLWHA laity and parish priests.

The clergy in the Ethiopian Orthodox Church hold a great deal of sway over the faithful. On matters of health, even medical practitioners often refer their Orthodox Christian patients to the Abba (father) for priestly guidance for things the patient appears to be conflicted about. As we will see in the next chapter, the medical practitioners with whom I had interlocutions on the subject indicated that they would always defer to *yenefs abbat* (father of soul), also known as *yenisseha abbat* (father confessor), when faced with difficult topics.

In Ethiopian Orthodoxy, and by extension the larger Ethiopian society, a person is believed to consist of two constituent parts: *nefs(*soul) and *siga* (flesh). Ontologically, the former transcends the hereafter, the lifeworld in the vale of tears, and has a divine connection, thereby given a higher value. The deep veneration accorded to the clergy, therefore, appears to be the direct function of the spiritual entity he oversees and represents. Overseeing matters pertaining to the soul—matters which are deemed superior vis-à-vis concerns of the flesh—more readily fall under the purview of the clergy. Still, this does not mean that handling those soul-oriented affairs precludes the *abba* from making an intervention during the onset or the course of an illness with remedies from the realm of the divine. *Tsebel* or holy water, often accompanied by incantatory prayers and smacking with a cross, at times, when presided over by a priest, constitutes just one such remedy.

While holy water constitutes the primary form of spiritual treatment, other common modes of treatment practiced by followers of the Ethiopian Orthodox Church also include "*emnet* (holy ash or mud), *kiba kidus* (holy oil), and *mar* (holy honey) often in combination with prayers and the cross" (Anderson, 2007: p.23). A monastery or a parish church is usually known for one or more of these modes of treatment.

Of their clerical duties, two of the roles that they play as arbiters of sacred boundaries and transmitters of religious knowledge (Boyltston, 2012), make the clergy particularly pertinent in this study. In his work on

Ethiopian monasticism, Kaplan highlights the intermediary role the clergy play, pointing out that “repeatedly the holy men intervened between men and demonic, divine, or natural forces. They protected mankind from demons, illness, and wild beasts” (1984:70).

In fact, it was primarily for their catechismal knack that the clergy were drawn on by PEPFAR to bring around the AIDS-stricken faithful to either adhere to their biomedical treatment regimen or start one if they haven’t already. As conduits of divine power, the clergy are believed to fulfill an intermediary and protective function carried out in performative rituals such as holy water aspersions in order to cast demons or cure the faithful of various afflictions, including HIV/AIDS. Moreover, the clergy as arbiters of the boundary between the sacred and the profane, have the absolute authority to draw up the borders and see to it that the laity operate within them. Therefore, understanding their positions on combining the biomedical and the spiritual treatments and other matters pertaining thereto become paramount.

Clergy Views on Treatment

From its discovery in the early 1980s to the present, HIV/AIDS has no biomedically-approved cure (Cohen, 2014; Obadare & Okeke, 2011). A cure would mean that a person diagnosed with the virus would upon undergoing treatment become free from the virus and the ailments associated therewith. This does not, however, mean that alternative cosmologies of health, illness, and treatment have not made claims of

having found a cure for the notorious pandemic that has been raging for four decades now.

The Ethiopian Orthodox Church has been the ultimate destination for the faithful struck with illness and seeking a cure. Most popular for its cure for HIV/AIDS among the church's means of coping with illness and other forms of misfortune is the holy water treatment, also known as *tsebel*. With recourse to the sacred treatment, PLWHA often give up their biomedical drugs as a result of a deeply held belief that they will be cured of their illness. Often presiding over and counseling the faithful, the clergy are believed to play a monumental role in the decisions of the laity. It is, therefore, of paramount importance to explore their views on the treatment for this malady, and on whether antiretroviral drugs (ARVs) and the spiritual, holy water treatment, can be used in combination.

On the whole, none of the clergymen who participated in the study expressed bluntly antagonistic views on the complementarity of ARVs and holy water treatment. The logic of ascribing both to the same provenance was commonly applied in their responses. The reasoning first appeared in the late patriarch of the church His Holiness Abune Paulos' seminal sermon whereby he urged the laity in need to use both the holy water and biomedical drugs in combination and indicated that both were given to man by God (Tadesse, 2007). Abba Enkuselassie, head priest at Shegolé Kidane Mehret Church, for instance, noted, "The medicine was made with wisdom bestowed upon people by God; the holy water is also a divine gift from God,

a manifestation of His glory." He goes on to remark that regardless of this general consensus within the church, he frequently comes across laity who discontinue their medication upon their arrival at the holy water springs on the parochial church premises.

Also expressing a similar sentiment, Abba Hailegiorgis of St. Michael's at Shinkuru stated:

> Now, we believe that this medicine doesn't clash with the holy water because those who created it were created by none other than the Lord, who also bestowed His wisdom upon them. Scientific wisdom whether it's in the medical field or other advances such as space science and all the space explorations and technology is made possible by the wisdom God gave to human beings.

Since it appeared in the late patriarch's sermon, the reasoning that both the ARVs and holy water can be traced back to God as the originator has been utilized in messaging that targeted both the clergy and the laity. It turned up in conversations I had with the clergy, the laity, as well as medical professionals and training materials jointly prepared for ordained priests presiding over holy water aspersions. The apparent purpose of employing this aphorism has to do with countering the idea that holy water which emanates from a sacred provenance cannot mix with pharmaceutical drugs which have their origin in the mundane, profane world.

Although such thinking constitutes resistance against modern medicine, I argue here that the church maintains a rather discreet distance from “modernity” in other domains too, and the conflict with biomedicine is just an extension of it. For instance, the church does not allow the adoption of modern musical instruments such as guitars, pianos, or accordions, etc. for hymnal music due to its role as the putative arbiter of tradition and custom (Ethiopian Orthodox Church, n.d.). In a study that specifically explored the relationship between traditional medicine and HIV/AIDS, Kloos et al. (2013) indicated that compared to modern medicine, traditional medicine was more readily picked up by those who are also seeking faith healing primarily because the herbalists themselves were faith leaders. The existence of this link between the spiritual and the traditional creates an obvious cosmological nexus connecting the two. Several of the study participants indicated how they started with a visit to a traditional healer before they set foot in a modern health facility.

On the surface, the one-provenance-for-both argument does seem to take care of the existing dissonance. It has served as a form of cultural suture employed to patch up the rift between the two worldviews and find a common ground for both healing systems to join forces against a common enemy: the HIV virus. However, the biomedical and the spiritual are not coming from equal positions of power. Due to the overly privileged and powerful position of biomedicine in almost every human society, even the most powerful actors are rendered powerless in the medical encounter

(Lupton, 2003; Dutta, 2008). Margrethe Mork (2008) observed that in her dialogic engagements with both laity and clergy how she was told that the late patriarch made the proclamations regarding the complementarity of the holy water and antiretroviral treatment (ART) under pressure by the Americans.

Besides the God-as-originator-of-both notion that the late patriarch had initially utilized in his sermon, and which thenceforth became popular in messaging that targeted the faithful within the Orthodox Church, in particular, there was another interesting declaration in which he gave the laity an official blessing to swallow their HIV drugs with the holy water. The clergy did not fall in with this sanction even though it came from the top-ranking official of the church. For instance, Abba Hailegiorgis of St. Michael's at Shinkuru said, "People cannot use the holy water to swallow their pills. The two must be kept separate in that sense. They can be taken together but also apart if you see what I mean here." In his explanation about why the biomedical and the spiritual must not mix, Abba Teklemariam, the second-in-command at Shegolé, stated the following:

> Holy water must be taken on an empty stomach. The same rule applies when one takes part in the aspersions. After they eat, people can take their medication, but not with holy water again. The holy water is holy and cannot be mixed with anything. It cannot be mixed with the medication, nor can it be taken with food. The only thing that the holy water

> can be taken with is prayer. When we say they are complementary and can be combined as a treatment, it doesn't mean that they can be mixed.

As could be deciphered from the above quote, drinking holy water or even getting aspersed with it requires that the partaker stay away from consuming anything whether it be food or medication. This is contrary to the late patriarch's declaration that the faithful could actually swallow their medication with the holy water. In the clergyman's words, nothing other than prayer can be mixed with the holy water. In her book *Purity and Danger*, Mary Douglas (2015) observes that rules governing the sacred are meant for shielding the divine from being defiled by the secular. According to this bifurcated classification of sacred and profane, the holy water and the medication cannot occupy the same space at the same time. The rule enforces the separation of the two. The clergy think of themselves as protectors of the inviolability of the sacred rule. As far as they are concerned, never the twain shall mix.

From the perspective of the diffusion of innovations theory, it could be argued here that the medication as a public health innovation falls short of achieving compatibility, one of the main constructs of the theory, with the local religious customs within the Ethiopian Orthodox Church. Speaking from the position of power and authority, the clergy as enforcers of the sacred rule indicated in the foregoing paragraph that the holy water was not to be admixed with the biomedical drugs. To indicate the

sacrosanctity of the rule governing the interaction between the biomedical and the spiritual treatments, the priest opined that nothing other than the immaterial, ritualistic act of prayer could touch holy water, implying that if it did it would be a sacrilegious act. While this does not amount to a categorical restriction discouraging PLWHA believers from utilizing the biomedical treatment, it certainly creates an obfuscation—especially in view of the dissensus between the top and the lower-level clergy on the matter. Mork (2008) maintained that the difference in the educational level of the clergy contributed to the lack of consensus among the clergy. However, such a pattern was not readily observable in this study.

Furthermore, the clergymen spoke of the ability to cure as yet another feature for drawing a comparison between holy water and ARVs. Abba Enkuselassie had the following to say:

> Now as far as we know, the medicine that is currently available doesn't cure the disease, but lessens its burden, and allays the suffering of those afflicted with it. That said, people can be completely cured if they have faith: by drinking the holy water and by applying *emnet* (holy mud) to their bodies. I am not saying these things based on my gut feelings or anything, but based on my own experience; based on numerous testimonies, including from my own, personal spiritual children that they have found a cure.

The above excerpt shows how the antiretroviral drugs stack up to the spiritual treatments of holy water and holy mud in the eyes of the clergy. Discernibly, spiritual treatments are believed to bring about effective cures vis-à-vis the biomedical version, which only serves as a palliative form of treatment. This brings into focus another innovation attribute: relative advantage.

According to Rogers (2003) innovations that are perceived to have greater relative advantage and compatibility are adopted more rapidly and smoothly. That the medication could only be utilized as a palliative treatment to keep opportunistic infections at bay and not possess a curative effect as the spiritual treatments are believed to, places it at a distinct disadvantage in comparison. As Bezabhe et al. (2014) found, “patients preferred complete cure from HIV/AIDS with the holy water treatment rather than taking pills throughout their life” (p. 6). Moreover, Abba Enkuselassie noted:

> Though the medication doesn’t bring about a cure, as people take victuals after holy water aspersions, so can they take the medication. Maybe it would help to think of the medication as food. Food doesn’t provide a cure, but our bodies need it for survival. So is this medication.

The analogy with food reflects a lowering of the AIDS drugs from the rank of medicinality to an everyday nutritive substance. Obviously, some foods can be consumed for medicinal and protective effects, but in general

terms, food is not thought of as medicine or vice versa. Though there often exists some form of overlap, the two categories have mostly remained disparate throughout human history (Chen, 2009).

Since Abba Enkuselassie pointed out that he had personal spiritual children who were cured of HIV/AIDS by holy water treatment, they would have made a unique addition to the existing pool of informants. He promised to link me up with a couple, whom he said had found a cure rather recently. Unfortunately, attempts to include them in the study failed to come to fruition. The couple was not found to be forthcoming about their story, the cleric reported.

Another cleric, the catechist Abba Hailegiorgis of St. Michael's at Shinkuru, identifies the divine as the sole realm for a cure:

> According to our church's teaching, there is no other source of cure than God. When the Archangel Gabriel brought the news that Our Lady will give birth to our Lord Jesus, the Savior of the world, we were given the medicine for all our illnesses, both in our flesh and in our souls. Jesus is the savior and the medicine for all our health conditions.

Whereas the catechist's statement does not automatically proscribe treatments other than the spiritual ones, it could be construed as such. It could also be construed as a tacit discouragement to those who would be seeking a cure outside of the sacred realm. In a rather more specific and direct fashion, Abba Hailegiorgis also declared the following:

> I do believe that the holy water and *emnet* coupled with unquestioning, genuine faith constitute the primary treatment, and not just treatment but cure, for this malady. Unquestioning faith just like that of the woman with twelve years of bleeding problem who believed if she could only touch His clothes she would be healed, and so she got healed upon touching the clothes of the Lord. Let alone HIV/AIDS, there is not a single disease, including even cancer, that the Lord cannot cure. We hear testimonies of healing from the faithful here at our holy water sanctuary every day.

As indicated in the above excerpt, it becomes clearer that holy water and *emnet*, according to the catechist, and hence the church's teaching, constitute the most important form of therapy for PLWHA in the Ethiopian Orthodox Church. Implicit in this assertion lies the relegation of the biomedical to an adjuvant, secondary role as it does not provide a cure. Though the holy water ritual has been posited as a curative agent, the burden of making the cure materialize falls on the faithful.

In other words, according to both clergy and laity, if not backed by faith on the part of the sick, the divine miraculous cure cannot be effected. The steadfastness of the faith considered a prerequisite for the cure is represented in the scriptural exemplum of the hemorrhagic woman who had suffered from the condition for twelve years before receiving her

miracle cure from Jesus Christ in an incident whereby she made her way through a massive throng believing firmly that she would be cured if she could just touch the hem of Jesus' clothes (Holy Bible, King James Version, 1769/2017, Mark 5: 25-34).

In the description above, cancer epitomizes the apex of incurability, and HIV/AIDS, thus, stacked up against it appears comparably less lethal, but even these illnesses are not believed to prove untreatable in the divine realm. Abba Hailegiorgis draws on laity testimonies as an evidentiary basis.

Furthermore, Abba Hailegiorgis pointed out the biomedical treatment as an alternative next to the spiritual forms of treatment. He states, "As a second option, we have the currently available pharmaceutical solution, what they call ART medication." Although there is no mention of exhausting the primary option first and then moving on to the second, the ranking itself subtly suggests such a possibility. Nonetheless, he concluded by saying that the only rule for the faithful to observe when they undergo the holy water treatment would be to see to it that they drink or get aspersed on an empty stomach.

Referencing the biomedical status of HIV/AIDS as an incurable disease, Abba Teklemariam also indicates in his explanation how the church did not share that assessment. "We hear from the medical community that HIV/AIDS once contracted is an incurable disease. Nevertheless, for God all is possible. There is nothing that God cannot cure. Where humans fail, God has a solution. God has always cured people," he

noted. Then, he proceeded to specifically focus on the holy water treatment vis-à-vis not just its power to cure HIV/AIDS, but all sorts of illnesses and health problems.

> In the Ethiopian Orthodox Church, we believe that holy water can cure this illness. Holy water can cure all sorts of diseases. We have witnessed the blind see and the crippled walk again. So, I believe that God's spirit manifests itself in the water and cures all sorts of diseases, and HIV/AIDS is no different.

Unlike Abba Enkuselassie who cited his own spiritual children who he said had been cured of HIV/AIDS, Abba Teklemariam spoke in general terms pointing to the blind who regained their sight and those with ambulatory impairment to be able to walk again after undergoing holy water treatment. The underlying logic in his argument thus appears to be that if holy water cures blindness and ambulatory disability, then it should also be able to cure HIV/AIDS. Much like Abba Teklemariam, the head priest at Shinkru St. Michael's Abba Brook drew on the testimonies from his flock to back his claim that holy water provided a definitive cure for HIV/AIDS.

Of the clergymen I interviewed, Abba Gebremichael of Entoto Kidane Mehret parish church was an interesting outlier with regard to the curativeness of the holy water treatment. "For sure, the holy water rids them of the virus, though not completely. Patients go get tested after they

undergo the holy water treatment, and their results show that the virus has been seriously weakened.” As could be deciphered from this quote, he did not believe that the holy water treatment provided a complete cure. His belief that the holy water treatment only affected the potency of the virus draws an interesting parallel with the existing biomedical drugs which are only palliative (Fee & Fox, 1992; Buckley, 2012).

Another point that this priest brought up that no other clergyman raised was how committing fornication and drinking alcohol affected both the spiritual and the biomedical treatments. In his view, regardless of whether an HIV/AIDS patient is undergoing holy water treatment, taking biomedical drugs, or a combination of the two, indulgence in the aforementioned forms of carnality led to a rather rapid demise. Several studies found that alcohol consumption had a negative impact on antiretroviral treatment (Rehm et al., 2017; Hahn & Samet, 2010; Baum et al., 2010; Samet et al., 2003). However, there has been no known effect that promiscuity or “fornication” has on AIDS treatment.

On the whole, all the clergymen indicated their faith in the curative powers of holy water and *emnet*, save one of them who noted that holy water only weakened the potency of the virus. Contrary to the declaration of the late patriarch Abune Paulos, however, they maintained a firm position on the separate administration of the spiritual and biomedical treatments, citing an observance of a dogmatic principle that requires holy

water aspersion and consumption be conducted in a manner that does not allow it to be mixed with other substances, including food.

Having delved into the positions of the clergy on combining the biomedical and the spiritual treatments, let us now turn to the discussion of how these clergy positions are reflected in the counsel they give to PLWHA members of the laity.

Clergy Counsel to Patients

As pointed out earlier in this chapter, the clergy have considerable power over members of the laity. And especially so in the Ethiopian Orthodox Church owing to profound conservatism that lays considerable emphasis on hierarchical dealings between the clergy and the laity. Even medical doctors, who are very powerful actors themselves, admit to this state of affairs referring their patients to their religious fathers when their advice and prescriptions are not followed as much as those of the *abba*. It is with the understanding of this enormous clout that the clergymen wield that making sense of the kind of counsel they offered PLWHA among the faithful they are in charge of was thought to be illuminating.

In response to the question about the sort of advice he offered to those in his flock, the hierarch at the Shegolé Kidane Mehret parish church, Abba Enkuselassie, with a rather stern remark, stated: “First off, I want to make one point very clear. Those who try to deliberately engage in “fornicatory” acts should know that they are committing two-pronged sins for which there will be comeuppances of the same nature. It is a callous

act!" The reference to deliberately engaging in acts of "fornication" alludes to cases where infected individuals allegedly go on a transmission spree, specifically targeting those from the opposite sex who they believe gave them the disease. Since there exists no mechanism of distinguishing the "vindictive" transmitters from those who contracted it under circumstances unbeknownst to them, such a frame often gets applied wholesale to all afflicted with the malady. Elsewhere this frame of reference has been found to cause stigma and discrimination against PLWHA as it promotes the thinking that only "sinners" got the disease as a punishment from God (Anderson et al., 2008, p. 792).

With regard to recommendations on which treatment the sick need to follow, Abba Enkuselassie offered the below explanation:

> When it comes to the question of which treatment to follow, as I have already stated, I tell my flock to use both in combination, while still maintaining the precedence of the one that has curative powers should they have the necessary faith, and then follow that with the medication, which plays a supportive role. As long as they go in that order, and keep doing both, they should be okay, and their malady will one day vanish as long as they have the faith that the process requires.

For someone on the receiving end of this counsel, there would be two major burdens. Firstly, they must have and maintain the faith that is

considered a *sine qua non* for effecting the miraculous cure by holy water. Secondly, they have to ensure that the two treatments never mix throughout the process in the sense that the ARVS can never be swallowed with the holy water contrary to the official blessing given by the late patriarch in 2007. In fact, in her study, Mork (2008) found that one priest in southern Ethiopia actually told the sick to abandon their medications if they believed they had unshakable faith in the curative powers of the holy water treatment. None of the clergymen I had conversations with explicitly expressed that they had ever issued such fiats.

Relating his experience with the PLWHA laity who flock to the holy water sanctuary at Shinkuru St. Michael's, the parish church's Chief Catechist Abba Hailegiorgis also shares how he deals with those who find it objectionable to continue to utilize medication once they arrive at the holy water sanctuary there.

> When people come to the divine from the mundane world, they perceive a whole lot of difference, and rightly so. In the mundane world, innumerable sinful acts take place. When people come into the divine sphere, however, there is no way for such acts to continue to happen. So, the primary reason that people come to us is to repent once they see the error of their ways. When they get here, they pin all their hopes on God and devote themselves to the holy water. They say that they have tried the medication, which is of the

mundane world, and didn't get much out of it, and thus from now on, they don't want to continue taking that. They also tend to relate choosing between the two with the biblical verse that says you cannot serve two masters. This would be a wrong interpretation here because what this verse refers to is the fact that a person cannot engage in righteous acts in the morning and in sinful ones in the evening; that they cannot go to the church in the morning and end up being an idolater in the evening. In general, the verse means that one cannot have one foot in the mundane world and the other in the divine. God doesn't impose anything on anyone. In the days of Adam and Eve, for example, God lets the couple know what rules to observe, as He places the first man and woman in a garden with trees of whose fruits they may eat but forbids them to eat from "the tree of the knowledge of good and evil." Eventually, they choose to eat the fruits God forbade them from eating. The scripture also says, "I place water and fire before you, and the choice I shall leave unto you as to which you extend your hands unto." So, when the faithful approach me and ask me if they should stop the medication, I tell them that they shouldn't because the medication that the doctors give them is made by scientists guided by the wisdom God

> bestowed upon them. For you can never expect the evil one to guide people to discover something that helps humanity, it's self-evident that these medicines are produced with God-given wisdom. Satan is hell-bent on doing things that are harmful and destructive to humanity. We know for sure that medicine can cure illnesses unless the intervention happens at a point where the disease has progressed to an incurable stage. We also know for sure that Jesus is superior to all physicians. Medicine is nothing new to the Christian world. For example, the Apostle Luke himself was a physician. So, when I explain to them that there is nothing wrong with continuing to take their medication while undergoing holy water treatment, they suddenly have an aha moment and carry on with both forms of treatment. Some of them get completely healed; others get better.

In the catechist's rather lengthy explanation of the type of advice he provides the sick persons seeking holy water treatment and accompanying justifications of which some comprise an exegesis of scriptural texts, he clearly draws a line between the mundane and the divine at the beginning and places the biomedical in the former. Then, he proceeds to point out that the biblical verse that proclaims a believer cannot serve two masters gets misconstrued by the faithful seeking holy water treatment as a reference to a state of affairs in which they tap into both the spiritual and

the biomedical treatments at the same time. Yet, in his own elucidation of the verse, Abba Hailegiorgis states that it is meant to be heeded as a restrictive commandment against those who wish to have one foot in the mundane world and the other in the divine. Since biomedicine has already fallen under the mundane world, someone who, after arriving at the holy water sanctuary, continues to take the medication cannot be impervious to a sense of guilt that they are still keeping a foot outside of the divine realm.

By alluding to an apostolic connection that medicine had in the person of the Apostle Luke in the early days of Christianity and tracing the provenance of biomedicine to the divine, and by characterizing it as a source of succor for ailing members of society—a trait that cannot be associated with the sinful mundane world— Abba Hailegiorgis appears to offset the placement of the biomedical in the profane world.

Furthermore, the verse from the apocryphal Book of Sirach about God making choice available for people could also be taken as an allegorical allusion to the two treatment options. With the portrayal of Jesus—who cures through the holy water treatment— as superior to all doctors, the tendency of those on the receiving end of this messaging to forgo the biomedical treatment would simply be reinforced.

The Ethiopian Orthodox clergy are well-versed in the long-established wax and gold trope of speaking in double entendres mostly utilized to avoid being confrontational or offer words of admonition in a more subtle and indirect fashion (Levine, 2014; Girma, 2016). Donald Levine, in particular,

who produced a seminal work on this worldview, indicates its widespread application in the delivery of "esoteric philosophical and religious message" (p. 7). All the same, the catechist, who employs this parlance in his exegesis, reported that his counsel often led to the counselees having an epiphany.

Underscoring the need to observe dogmatic principles when the sick among the faithful undergo medical treatment— as the priorities of the biomedical and religious realms could be at odds with one another—Abba Teklemariam indicates how he lays considerable emphasis on this matter in his counseling:

> In the Ethiopian Orthodox Church, we have some dogmatic principles that cannot be flouted. For example, the Holy Communion and holy water cannot be taken after one has victuals. When it comes to HIV medication, it is the opposite. People have to have food before they swallow their pills. So, we tell the faithful to keep the two apart. They cannot swallow the pills with the holy water like it is some ordinary water. Some would want to undergo holy water treatment only and quit the medication. Only those who are immaculate can successfully do that. Otherwise, we tell all who are taking whatever medication to keep the two apart, that they cannot swallow their pills with the holy water.

But, after they take the holy water, they can have a meal and take their medication. That's what I tell them.

Discernibly, the primary focus in this excerpt appears to be an emphasis on maintaining the order of administering the two treatments, i.e. the holy water first and the medication afterward. Another important point to note is how the clergyman attaches the chances of getting a cure from the holy water treatment to not just having faith in its curative power, but to being immaculate—a state of flawless perfection. Theologically such quality remains mostly aspirational in the sense that the laity continually seek to attain it, but it is an attribute possessed chiefly by deific beings, and those elevated to sainthood.

In what the last two clergymen shared as their regular counsel to PLWHA in their respective flocks, they echoed what others before them accentuated about combining the two treatments, but keeping them apart at the same time. Again, Abba Gebremichael of Entoto Kidane Mehret, who has already become an outlier by saying that the holy water does not completely rid the patients of the virus, raised an issue that none of his colleagues did. "These people need support. Many of them don't have stable housing. The church tries to support them in some ways that it can, but it can only do so much," he observed. Such an observation brings into relief the need for a holistic approach in caring for PLWHA within the church. In *Pathologies of Power*, Paul Farmer (2010) wrote extensively about the plight of the poor in Haiti perpetuated by conditions of perpetual poverty and

oppression marked by lack of access to basic amenities causing and prolonging the plight of AIDS sufferers. The roots of the problem are often traceable to systems of inequities and inequalities in the economic, political, social as well as communicative resources.

One priest, in particular, said when he pointed out what he would tell those who approached him for advice regarding treatment: “The medication wouldn’t work if not supported by the will of God. The medication serves just as a prop, but God can heal without the involvement of anything.” Abba Brook, the head priest at Shinkuru St. Michael’s, has rather taken up a position of theodicy on the matter of healing depicting it as boon embedded in the will of God. In other words, whether the PLWHA faithful chose holy water, biomedical drugs, or some other form of treatment for their condition, without God’s will a cure would not materialize. What exactly does this position entail?

According to Collins Online Dictionary, theodicy refers to “defending the attributes of God against objections resulting from physical and moral evil” (Collins, 2021). Applying this lens to the God’s-will argument or other positions that attribute the disease to sinfulness on the part of the afflicted and thus their eventual inability to command divine intervention, and hence a cure, due to insufficient faith, brings into sharp relief the fundamental concepts of the culture-centered approach: structure, culture, and agency.

The culture-centered framework propounds that cultural members navigate health and illness at the intersection of structure, culture, and agency, as they make sense of their conditions and status within society. In this case, the Ethiopian Orthodox constitutes the structure and its normative modes of sacred treatment, the hermeneutics that informs the health and illness meanings of the PLWHA faithful as well as the positions of the clergy on the treatment choices of the sick among their flock the cultural substrata. Since the focus in the CCA is on marginalized communities such as the PLWHA seeking holy water treatment at various holy water sanctuaries in various parish churches and monasteries across the country, agency becomes paramount in bringing focus to their voices which tend not to make it to mainstream communication platforms. Illness by its nature has the power to invalidate the sick person thereby pushing them to the margins of society and alienating them from cultural and social milieux. Such estrangement, therefore, inextricably engenders not just mere marginalization, but also communication inequalities. In this connection, Claudine Herzlich (1981) provides one of the earliest discussions of this destructive and invalidating nature of illness. She also notes that the overwhelming phenomenon of annihilation of the personal identity of the sick person as a result of social exclusion could at times lead to the denial of the illness itself.

One of the criticisms directed at the dominant biomedical approach to health communication primarily by proponents of the CCA appertains to

the fact that the former serves as an extension of the biomedical model to health. For instance, when public health actors claim the etiologies of certain health problems to be just a matter of mere individual behaviors and choices, they, in effect, vindicate the structural conditions that essentially contribute to those health problems thereby shifting responsibility onto the individual. As such the dominant health communication approach is, therefore, also accused of being complacent for not scrutinizing these claims and positions.

While espousing this standpoint, I would argue here that, in addition to the mainstream power structures, subaltern and cultural structures such as the Ethiopian Orthodox Church—which might as well be viewed as an ideological state apparatus from an *Althusserian* perspective—can equally play a restrictive role. Compared to the dominant power structures, specifically those that Althusser referred to as the repressive state apparatuses, these cultural entities are less conspicuous. This diverts attention from the ways in which they play a restrictive role when it comes to limiting access to certain resources, including healthcare services.

By employing the insufficient-faith or God's-will theodicy, for instance, the church deflects responsibility to the individual believer seeking a cure in its sanctuaries purported as sources of wondrous elixir. A direct parallel in the biomedical approach would be the construction of disease etiologies as caused by an individual's inability to make the right choices in steering clear of the putative causal avenues. Both entities lay the blame at the

patient's door "thereby absolving the status quo of its responsibility to contribute to change initiatives by adjusting the structures and redistributing the resources" (Dutta, 2008, p.111).

Agency is constituted in the ability of cultural participants to challenge and resist the structures that prevent them from realizing a healthful living and finding the cure that they so earnestly seek. Compared to the biomedical framework, it seems that the ecclesiastical realm tenders limited opportunities owing to the theodicy of blasphemy. In other words, challenging the religious treatment modality in any way, shape, or form will be construed as blasphemous by both the clergy and laity in the event a cure fails to be effected.

In the section below, as we explore laity positions, we will take a closer look at how these issues are either foregrounded or backgrounded in their narratives.

Laity Positions

The reality of having to live with a chronic illness such as HIV/AIDS often means that the sick person would need to make a whole host of adjustments in an attempt to adapt to the new modus vivendi. Embarking on this inchoate experience also means that the sick will begin to make sense of the illness, tap into whatever resources that they can access, and as they do, establish and legitimate their positions as part of the illness experience. This, however, does not mean that the process of navigating this reality unfolds without contradictory demands that arise from the

immediate socio-cultural environment. The utilization of a religious frame to make sense of illness—a side that provides a more metaphysical and hermeneutic perspective—could essentially prove to be the source of contradictions. Unlike religion, medicine proves inadequate in its capacity in terms of satisfying this metaphysical need. Such a need increases more considerably when the illness is a chronic one.

Part of the sensemaking process of the illness experience constitutes settling on treatment choices and therapeutics to seek. This almost always occurs as a natural reaction after the onset of a disease in the course of the illness experience. With the absence of a biomedical cure, the afflicted, some of them after giving the extant antiretroviral drugs touted as "lifespan enhancer" a try, couple the biomedical with the spiritual. Interestingly, all of the AIDS sufferers indicated at the time of the interview that they had been receiving both treatments. However, not everyone had the same view of what it meant to combine the two modes of therapy. The names of PLWHA informants have been altered for privacy purposes.

Chuchu who had been diagnosed and living with the virus for over 20 years replied in the below manner when asked how she felt about combining holy water with the medication:

> I believe that God worked through the people who discovered the medicine. Human beings must believe in something. So, I would say that God made this medicine a reality. We lost many people. A lot of my friends are not alive

today. But, I am alive and well today and will be tomorrow, God willing. And when they discover a cure, which I am sure they will, we'll all be cured. When I go to church, cry before my God, and return home, even the dreams I have at night change. It makes me feel a lot better. I am sure if I get tested now, my test will come back negative because the last time I was tested the viral load was found to be very low. Regardless, I am not ready to stop my medication. I don't want to disappoint my God again. That's what many people do. When the viral load drops so low, they will throw out their medication, thinking that it is completely gone. This gives the virus an opportunity to rebound. Many people, especially during the early days, would go to holy water sanctuaries, and eventually, stop their medications. The clergy didn't advise them to stop taking their medications. Once they leave those holy sanctuaries feeling healthy, they would start engaging in undesirable activities and fall sick again. A lot of work has been done on teaching the clergy and now people are taking both HIV drugs and holy water in combination. Many Protestants would also declare in their televised testimonies that they had been cured of HIV, but the virus may just be retreating and hiding only to regain more strength and power. Don't get me wrong: I am

> not saying that God doesn't cure people. As far as I am concerned, the drugs are to be taken for life.

From her explanation, it seems that Chuchu believes a cure would come from the biomedical realm in the future. Contrary to some of the clergy positions above, however, she does not place the biomedical outside of the divine ambit. Chuchu employs the God-as-the-originator-of-both rationalization though she clearly indicates how she utilizes the spiritual treatment as more of a psychological coping mechanism, and not as a source of an eventual cure. While she did not openly express that she did not believe holy water had curative powers, the allusion to friends who did not make it unlike her for not using the medication or perhaps having had access to it speaks to that effect. Like Abba Gebremichael in the foregoing section, Chuchu also appears to believe that the viral load eventually tapers off with faithful adherence to the holy regimen.

Overall, her position reflects an attitude that favors both the biomedical and spiritual therapies with an undertone that reflects the primacy of the former. Still, when asked if she believed the medication had better qualities than holy water, Chuchu fielded the question rather skillfully: "Don't put me at odds with my God. No human being can stay healthy and alive without the will of God." After cleverly dodging the question, she goes on to make use of the God's-will theodicy. Then, she utilizes what I would like to call a transitivity logic where she takes the

makers of the medication out of the picture and characterizes it as a purely divine product just like the holy water:

> So, if I stop taking my medication because I feel healthy, I will eventually become bedridden. It is much more useful for me to stick to both the medication and God to live until it is my time to go, according to the will of the Almighty. It is therefore wise to continue to take this medication that God has created for us until such time when the cure becomes available. Those who stop it are not with us anymore.

In general, the God-as-originator-of-both (holy water and ARVs) frame among the laity has two iterations. The first category constitutes the co-optation of the biomedical into the sphere of the divine through transitivity rationality. In this version, those who are associated with the manufacture of the drugs are still in the picture albeit with their contributions rather trivialized. For instance, Mamité, a 48-year-old woman who was diagnosed with the virus in 2003, had this to say: “It is my belief that God gave the medication to the doctors and they’re just passing it on to me.” In this form of reasoning, the biomedical actors in the person of the doctor are portrayed as passive agents receiving the medication from God and handing them over to those in need.

Exemplified by Chuchu’s quote above, the second type employs a complete elision. So, here, only the biomedical product is mentioned, but

rather than the acknowledgment of those associated with it, we see their origin directly traced back and attributed to the divine. Like Chuchu, Zahara, one of the two Muslim participants, said, “I believe that both of them are from Allah. Allah made the holy water, and the medication; and He is just using them [doctors and other healthcare professionals] as a means or way to cure us.” Interesting to note, of course, is that Zahara has adopted an exclusively Christian treatment and has been persuaded that both the sacred Christian therapy—the holy water—and the biomedical drugs are creations of Allah—the Islamic God. Another equally interesting observation to make: Zahara does not view the Christian holy water as Zamzam, the Islamic equivalent of *tsebel* (holy water). Unlike the holy water prevalent throughout the Ethiopian Orthodox churches and monasteries; however, *Zamzam* only comes from one source: Mecca, Saudi Arabia (Shomar, 2012).

What it means to combine the two treatments meant different things to different participants. For example, Assefu, a thirty-year-old woman who had been living with the virus for eleven years at the time of the interview, argued that the medication and the holy water can never be mixed under any circumstances as they belong to two disparate worlds. To further strengthen her claim, she goes on to back it up with a verse from the Bible.

> The word of God tells us to give to Caesar what is Caesar's and to God the things that are God's. In this instance, what I am giving is myself, but I have to do the giving separately.

> Some people believe that the two shouldn't even mix and prefer the divine to the worldly, but I think if we keep them apart enough, it shouldn't be a problem. But I am not combining the two *per se*. Not at all!

So, in Assefu's interpretation, as long as the holy water is taken in the mornings on an empty stomach as required by church dogma, and the medication in the evenings, it cannot be said that the two treatments are being used in combination. Aberash, a forty-five year-woman who worked as a caregiver at the time, put it more forthrightly. "I drink my holy water in the morning and take my medication in the evening. So, I wouldn't say I am combining the two." This reasoning rooted in spatiotemporal divergence along with other thought processes may have played a crucial role in allaying the tension and conflict that arose as the patients navigated the spiritual and the biomedical treatments.

The youngest HIV sufferer Aregash, who was only nineteen at the time of the interview and said she had acquired the virus congenitally, poignantly described how she came to learn about her health condition after she had lost her mother—the last of her parents to pass on. She maintained that the medication had curative powers and should not be discontinued. Reflecting on her illness career, however, she confessed that her position had not always been in favor of the medication. "I got conflicted about it at first because I have great faith in God. I wanted to stop taking the drugs and take holy water only," she recalled. Orphaned at

a young age, she had to navigate the illness course and surmount some challenging *pons asinorum* along the way as she made sense of her enigmatic ailment in the absence of her parents from whom she had acquired the condition. Regardless of her current position that the medication has the power to cure, Aregash still believed that if she were to rank the two, she would still put the holy water as the number one choice. "I tend to think that the holy water is more powerful than the medication because God created it for us. For me, the medication is of secondary importance." A possible interpretation of this stance is that the unshakable faith in the holy water has been brought to bear on treatment choices and perceptions and that vacillation could occur at any point. In other words, the leap of faith taken forward in order to combine the drugs with the holy water might as well be reversed.

Like Aregash above, other participants were also asked to rank the spiritual and biomedical treatments. Specifically, the questions were not meant for ranking *per se*, but to see if the patients believed the holy water had better qualities than the medication or vice versa. Accordingly, responses fell into three main categories: those that reflected participants' perception of the holy water possessing better qualities than the medication; those that had views contrary to this position, and others that projected something of an abstention whereby they refrained from engaging in an act of stacking up the spiritual treatment against the biomedical.

In the first category, the flexibility with which the holy water could be taken vis-à-vis the medication, which can never be skipped or discontinued once started, its curative power, and its widespread availability were qualities the afflicted laity believed gave the holy water treatment an edge over the biomedical drugs. In particular, Zenebech, a thirty-two-year-old woman who worked as a hairstylist in the capital Addis Ababa, said, "The medication could run out. Its production could stop at any time, but this doesn't apply to the holy water. So, for me, holy water is always my number one choice, but I keep the medication as a backup treatment of secondary importance." Her reasoning for the choice she has made has to do with the reliability of the supply of the spiritual treatment as a never-ending stream whereas the ARVs are thought of as undependable when it comes to lasting obtainability.

In the second set of replies, the PLWHA laity indicated that the medication was superior to the holy water or at least possessed attributes that made them preferable. Assefa, a forty-year-old man who found out about his health condition in 2001, pointed out, for instance, that if there was one thing he would choose the medication for, it was its ability to keep the body intact. Other than that he evinced a firm belief that even entertaining the thoughts of comparing the two treatments would be wrong. While the opinion that the ARVs do not do much besides keeping the body intact appears to be counterintuitive, the implication is that they do not cure the sick of the viral disease. Others were more upfront in their

assertions. Zeleka, a thirty-year-old woman who identified herself as HIV/AIDS counselor and educator, said that before she had started the medication eleven years ago and just relied on the holy water treatment, she would frequently go back and forth to the hospital, but this was not the case anymore after she embarked on the antiretroviral treatment. Though she never considered quitting the holy water, Zeleka made it clear that the medication was her number one go-to therapy. An army veteran who had been living with the condition since 2001, Goshu, 35, was probably the only one of the participants to say that he would rather quit the holy water than the medication because he believed that the medication was meant to control the virus and its spread in his body.

The majority of the laity fell into the third category, refusing to engage in juxtapositional appraisals of the two treatments. Either foregrounded or backgrounded in their explanations was the insinuation that such an act constituted an affront to the sacred— sacrilege or blasphemy. "Trying to entertain the thought itself is, for me, slighting the sacred divine gift from the Holy Savior. I cannot dare to be this irreverent," said Almaz appearing to be rather irritated by being asked that question itself. Almaz, 36, did not recall when exactly it was that she had been diagnosed with the virus but said it had been more than a decade ago. Interestingly, as irate as she sounded for being asked to compare the holy water treatment to the ARVs, Almaz did not object to tapping into both forms of treatment to manage not just HIV/AIDS, but all other types of illnesses. Most others just dodged the

question and went on to state that they were both holy water and ARVs were given to man by God or comparing and contrasting the two would be like comparing apples and oranges, if not worse, since something man-made cannot be compared to a creation by the Almighty God.

Finally, before turning to the discussion of the portrayals of the issue in the media, let us look at what the laity considered to be the best treatment for HIV/AIDS. In this case, they were not comparing the biomedical to the spiritual, but picking whatever course of treatment that they believed was the most suitable for treating their health condition. Intriguingly, only one member of the laity chose only holy water as the best treatment. Even for Aberash, 45, who was professionally a caregiver, holy water was secondary, and in a way tied to what she indicated to be her first pick. “The best treatment for me is to have a job, a livelihood. I want to leave home in the morning and come back at the end of a workday.” She then went on to say that she would never rely on the medication for a cure because she had absolute conviction that her cure would be brought about by the holy water. Her assertion that having a job—a reliable means of living—falls under the meaning of health as work, to which we will turn in the next chapter.

Besides the available treatments of ARVs and holy water, like Aberash above, Zenebech also gave a less expected answer. The best treatment for HIV/AIDS for Zenebech meant education. In her opinion, the antiretroviral treatment has at best camouflaged the conspicuous physical

manifestations in the patients as a result of which others have become less prudent. At the time of this study, there was a growing concern that the pandemic was reaching epidemic proportions in Ethiopia after years of a noticeable drop in new cases, a claim supported by research (Mirkuzie et al., 2021).

Then again, there were those who suggested that the medication along with the holy water or some form of divine providence as the best course of treatment to pursue to manage the illness. Halima, one of the two Muslim participants, for instance, said this: “For me, the best treatment is the medication, plus Allah.” Along similar lines, Mulu, a forty-seven-year-old woman who sold wax candles at Shinkuru St. Michael’s, also observed that the medication worked well with the grace of God. Most others opted for both holy water and biomedical drugs. At least three of the participants recommended the medication only without recourse to some form of divine remedy. This, however, does not in any way mean that they stopped believing in the power and curative potential of the holy water, but exposure to messaging that stressed the pressing need to adopt the medication as well as their own experience throughout their illness career may have led them to assume this position.

Holy Water and ARVs in the Media

In this section, we will briefly look at the depiction of the holy water treatment and the AIDS drugs in various media types. On the basis of their affiliation, the media were divided into three categories, namely church-affiliated, PEPFAR-affiliated, and conventional media. The conventional group further bifurcates into domestic and international subdivisions.

Church-affiliated Media. Included in the church media materials are reports and in-house communication in the forms of pamphlets, booklets, YouTube videos, as well as T-shirts emblazoned with campaign messages that purport to bring around laity members who opt for the holy water treatment only. Most of the media content was produced by the Church's HIV/AIDS Prevention and Control Department, set up under its Development and Inter-church Aid Commission in 2000.

One seminal document that laid out the Church's five-year strategic plan from 2004-2009 was put out by the Church's HIV/AIDS Prevention and Control Department. It primarily focused on prevention and control and left out the treatment component, however. At this point, ARVs were not available as HIV treatment, and holy water was the number one treatment route. So, it was a bit bewildering not to see that included in the church's strategic plan to curb the spread of HIV/AIDS at the official level while the afflicted members of laity availed themselves exclusively of holy water at the time. Though PEPFAR was launched in Ethiopia in 2004, it did

not seem to have started to work with the church until 2007. In later publications, such as the ones obtained from the Church's Child and Family Affairs Organization, founded in 1973, PEPFAR appears as the principal funder. Later on, in 2019, treatment was included as a key component when a clergy training manual was published in collaboration, also with financial backing from PEPFAR. In the part that addresses the nexus between the holy water treatment and the biomedical drugs, emphasis was laid on utilizing both in combination in the manner in which both the laity and clergy reflected in the preceding section. While the need to observe church dogmatic principles in tapping into both treatments was accentuated, interestingly, as one would expect, the holy water treatment was not depicted as a curative in this manual.

In terms of the central messages in the communication materials, the issue of compatibility between the biomedical and religious treatments was of principal focus. From tracing the provenance of the biomedical to the ecclesiastic realm, citing the Apostle Luke as one of the earliest physicians in the New Testament, to the use of the poultice of figs as a treatment for the old testament prophet Hezekiah's boils after another prophet, Isaiah, put forward the recommendation, all sorts of biblical verses were used to justify that tapping into the medication while on holy water treatment does not run counter to the Christian faith.

In the New Testament verse, the Apostle Paul mentions Luke *en passant* in his Epistle to Colossians: "Our dear friend Luke, the doctor, and

Demas send greetings" (Holy Bible, New International Version, 1973, 1978, 1984, 2011/2012, Colossians, 4:14). This verse has often been drawn on to reinforce the position that medical doctors have roots in the Church. Not that there is a dearth of medical doctors who are practicing Orthodox Christians whose testimony the church could tap into, but because the Holy Bible commands much more authority and reverence vis-à-vis the physician. However revered the physician may be, he/she is no equal to a canonized saint.

With reference to the medication, figs pulverized into poultice prescribed by the Prophet Isaiah in 2 Kings appeared as the most prevalent biblical story used in all forms of church communication to highlight that old nexus: Then Isaiah said, "Prepare a poultice of figs." They did so and applied it to the boil, and he recovered (Holy Bible, New International Version, 1973, 1978, 1984, 2011/2012, 2 Kings, 20:7).

Another, second most prevalent biblical message that also pertains to the origin of medicine in the ecclesiastic realm comes from the apocryphal book of Sirach, a book that is only found in the Old Testament of the Orthodox Bible.

> He gave medical knowledge to human beings so that we would praise him for the miracles he performs. The druggist mixes these medicines, and the doctor will use them to cure diseases and ease pain. There is no end to the activities of

> the Lord, who gives health to the people of the world (Holy Bible, Good News Translation, Sirach 38:7).

These and other verses were frequently interspersed in sermons and other church-related media geared toward faith members afflicted with HIV/AIDS in an attempt to make them utilize both the spiritual and biomedical treatments. Imbued with these and other similarly-themed biblical verses, the church-related media materials appeared to encourage the concerned laity to adopt the ARVs, but at the same time, they also made sure to incorporate language that the two had two disparate purposes: holy water as a curative and ARVs as a palliative just meant to fight off what are commonly referred to as opportunistic infections.

PEPFAR-affiliated media. While technically PEPFAR does not own any media outlets *per se*, its partners have their own communication platforms in the form of websites and online blogs. Some of them declare this affiliation upfront whereas others may not disclose the relationship. In general, media pieces put out by these partner entities present the biomedical push as a roaring success that lifted "uncultured" people who held "outlandish" beliefs out of misery. The framing borders on what is usually referred to as "White saviorism" in postcolonial and development critique at times (Sondel et al., 2019). In one pamphlet produced and circulated for a media roundtable on the issue of holy water treatment, the very first sentence reads: "In recent weeks international news teams have

been making their way up to the church and Holy Water shrine at Entoto to report on a story that, to *Farenjis*, seems both bizarre and deeply alarming." In Ethiopia, in everyday parlance, the word *Farenji* is used in reference to a Caucasian person. It could perhaps be the equivalent of *Mzungu* in Swahili-speaking East African countries, and *Gringo* in Latin America, albeit not pejorative. Such discursive formulations essentially infantilize (Sastry & Dutta, 2011) the "Other", a characterization that depicts the postcolonial subject in jejune terms thus justifying the need to control and dominate (Hall et al., 2013; Said, 2019). According to Sastry and Dutta (2011), the juxtaposition of "primitive" versus "modern" with regard to health constitutes a common frame and line of inquiry in the postcolonial approach to health communication.

I-TECH, an entity established and run by the University of Washington's Department of Global Health at Seattle, Washington, and TheBody, an extension of a digital media platform known as Remedy based in New York and Virginia, are the two PEPFAR implementation partners that have put out some stories on the subject. The abbreviation I-TECH stands for International Training and Education Center for Health. Neither has a presence in Ethiopia, though the latter has offices in much of southeastern Africa, including in neighboring Kenya.

"Hope" and "success" were the most predominant and recurring frames in the I-TECH narratives. Anchored in a holy water setting at Tsadkane St. Mary's Church, these stories feature capacity building and

empowerment, in addition to miraculous recuperation of the AIDS-afflicted beneficiaries against the backdrop of ineffectuality and hopelessness of the indigenous “Other”. In addition to the biomedical success in helping patients regain vitality, the articles also contain claims of having eased the burdens of stigma and discrimination at this location. From my observation during my visit, PLWHA pilgrims at the holy water sanctuary declined requests for interviews primarily fearing stigma and discrimination. The only participant, who after hours of dithering agreed to do the interview, revealed that stigma and discrimination had always been rife at the site. During the interview, she kept looking over her shoulders fearing that someone might overhear our conversation. Mulu said her daughter was healed after God had spoken to her in her dream, but she kept her status private in order not to hurt her daughter's matrimonial prospects. It could be argued that a conversation with one participant would not be representative of the circumstances prevailing at the time, but the overall disinclination of the pilgrims constitutes a telltale sign of widespread stigma and discrimination. While this was a different location, the claims that these PEPFAR-backed programs have led to success in assuaging stigma and discrimination against the PLWHA faithful at the said holy water sanctuary needs further scrutiny.

The TheBody article carried a rather dramatic headline, “Ethiopians Trade Holy Water for AIDS Drugs,” utilizing a narrative frame that lacks subtlety and paints an entire population in the country with the same

broad brush. In the lead of the story comes a patronizing and disdainful representation of not just the practice of holy water treatment, but the entire belief system.

> Ethiopia is slowly embracing antiretrovirals (ARVs) to treat HIV/AIDS, following years in which superstitious views of the disease dominated, and affected people often shunned drugs in favor of holy water as a curative. In Ethiopia, Orthodox Christians represent the largest religious group. To them, holy water has the power to heal, and it is bathed in as well as ingested. (TheBody, 2012)

The representation of the indigenous, cultural healing system as "superstitious" can be understood as a form of symbolic violence in order to necessitate the control and intervention of the biomedical. As Dutta-Bergman(2005) and Lupton (1995) observe, alternative ways of understanding and dealing with health and illness have been widely deprecated owing to their lack of access to epistemological loci and positions within which knowledge is formulated and eventually disseminated.

In general, it is through such portrayals that neoliberal global health interventions which masquerade as altruistic medical humanitarianist ventures create and expand destinations for the business schemes for the global pharmaceutical and medical industries in the so-called Global South. The monolithic notion of global health itself seems to be anchored in

the assumption that sociocultural boundaries do not exist and that there is a uniform, universal understanding of healthcare, which, obviously, is not the case.

Conventional media. Included in this category are domestic and international mainstream outlets which have published a piece on the issue of HIV/AIDS treatment. Two state-owned television channels known as Ethiopian Broadcasting Corporation (EBC) and Fana TV ran a program each on the utilization of AIDS drugs. EBC's segment was produced by a health show with a phone-in format for viewers to phone up the host with questions to which a medical doctor or some other health expert then provides answers live on television. The show is titled □□□ □□□□ (*t'enawo bebetwo*), an Amharic phrase which could be roughly translated as "Your Health in the Comfort of Your Home''.

The global narrative surrounding the palliative HIV/AIDS medication sometimes draws on the biblical story of the coming back to life of Lazarus—what also came to be known as the Lazarus effect. This biblical allusion is often made to highlight the power of ARVs to enable the HIV/AIDS afflicted person to live longer than they normally would. While this was the most pronounced frame in the interlocutions between the host and the medical experts featured as guests of the show, there to answer any and all issues on the subject of HIV/AIDS treatment, the viewers who called in with queries mostly sought to know about ways they could attenuate the side effects of the medication. They all raised what is referred

to in medical terms as lipodystrophy, also known as lipoatrophy, a condition that leads to the loss or accumulation of fat in certain areas of the body (Abel & Thompson, 2017; Schumaker & Bond, 2008). The callers complained of how their emaciated faces devoid of fat that once plumped up their cheeks or unsightly fat growing on their napes made them overly self-conscious and lack confidence in their looks. In the call-ins, the callers do not stay on the line for any follow-up questions or clarifications.

After posing their questions to the host, they are told to hang up the phone and wait for the answers. So, as such, the format is not conversational. Among the questioners, one woman brought up a different kind of loss: the medication made her lose her periods before she turned thirty. She reported to have been on medication for sixteen years, and as a result of this side effect could not have children. The health experts do not offer much counsel and remedy to the side effects other than stating that side effects are part of the medication-taking experience, and that no medication comes without side effects. Overall, they—the health experts—offered hope that the next generation of AIDS drugs would not have such disfiguring side effects. As a matter of fact, hope is considered to be one of the central elements in the narratives of the chronic illness experience, which, as Arthur Frank (1995) theorizes in his book *The Wounded Storyteller*, is positioned in the narratives of restitution.

Interestingly, the call-ins are punctuated by discussions of issues that affect strict adherence to biomedical drugs, but holy water does not

come up as one such issue. Adherence has been widely studied and side effects found to be one of the main factors that hindered PLWHA’s uninterrupted medication taking, particularly, the lack of recognition and concern on the part of healthcare providers (Bagus Arisudhana et al., 2019; Browne et al., 2019; Johnson et al., 2010). Nguyen et al. (2007), for instance, draw attention to the importance of attending to ARV-related challenges the HIV-afflicted individual's experience within the local socio-cultural context. Consequently, any discussion about ARVs and adherence issues in the Ethiopian context could not be complete without factoring in holy water treatment.

The second television item produced by Fana TV was a video that featured a panel discussion by various stakeholders, including religious leaders from the Islamic faith and evangelical churches. Jointly organized by the Ethiopian National HIV/AIDS Prevention and Control Office (HAPCO) and the television channel, the panel discussion features discussants who deliberate on the topic of adherence to HIV/AIDS medication and factors affecting it. As in the previous material, noticeably missing in this discussion is a representative from the Ethiopian Orthodox Church among the participants. Even though the influence of spiritual healing as it relates to HIV/AIDS is the top agenda and leaders from the evangelical Christian denominations and the Islamic faith responded to some of the issues raised, the Orthodox Church, not only the largest Christian denomination

but also the largest religious group in the country, has no representation nor is any explanation offered for this rather conspicuous absence.

As this absence is in the limelight, so is Dr. Aster Shewaamare's presence. Dr. Shewaamare, who was one of my interviewees in the interlocutions I had with medical experts, is a veteran physician dedicated to antiretroviral treatment (ART) at the Zewditu Hospital, one of the main state-run healthcare centers in the capital Addis Ababa. She appears in both videos as the leading specialist in this area of medical practice. In fact, one PLWHA participant pointed out the doctor's omnipresence during the panel discussion and attributed it to her caring personality and that stigmatizing doctors and healthcare workers elsewhere shone the spotlight on her. The patient also signaled deep-seated stigma and discrimination facing PLWHA even in healthcare settings in the country. Along with holy water treatment, stigma and discrimination in all areas of social life has been pointed out as one of the leading causes affecting strict adherence to the drugs.

Among the international conventional media outlets, the Associated Press and a local NBC-affiliated television station known as *Wave 3 News* in Louisville, Kentucky, published video stories that focus on the practice of holy water in the Ethiopian Orthodox Church. In the former, it appears in a juxtaposition with the biomedical treatment reported from Ethiopia, at the original ecclesiastical setting where efforts to disseminate AIDS drugs at the holy water spring was met with fierce resistance. The latter appears to

acquaint the domestic U.S. audience with the uniquely Ethiopian Orthodoxy experience that drew the faithful from far and wide. Though healing was part of the reporting, it was not particularly related to HIV/AIDS *per se*.

In the Associated Press (AP) video uploaded to AP Archive, an AP YouTube channel with 3.95 million subscribers, on July 21, 2015, the holy water treatment and the biomedical appear in a juxtaposition that features both patients and authorities from both camps. The video is titled "Orthodox priests claim to be able to cure HIV with holy water." YouTube flagged the post with an automatically-generated disclaimer by the CDC that defines HIV and cautions that if not treated the virus causes AIDS. Interestingly, the caveat does not seem to catch the claim that HIV/AIDS is being cured outside of the biomedical realm contained in the material that prompted the admonition. Nor does it say that the treatment that is currently available does not cure the afflicted of the malady.

The video begins with a shot of a priest walking toward a holy water ritual hall, followed by a multitude of congregants, and then a line of men passing along jerry cans filled with holy water into the ritual hall. A group of women who appear to be naked except for their underwear are doused with the holy water by clerics clad in waterproof overcoats. Then, a female HIV/AIDS patient named Tirunesh Bizuneh appears on the scene. “"I am receiving the holy water here, and not taking medicine, because I believe it will help me more and I want to go back home soon. You know, when I first

came here I was not able to walk by myself. But look at me - now I can," she said.

Another patient who hails from Woliso, a town in the western part of the country, speaks: "I come from a town called Woliso and I've been coming here for more than a year. I prefer to use the holy water; I don't want to take the drugs and I really feel I am getting better." This is followed by Father Gebremedhin who is shown going through file folders in his office. He explains, "You can see that we have many documents from hospital patients - those who have come here with certificates indicating that they are HIV-positive. We document their cases here in this file folder before and after holy water treatment. We don't accept their papers if their documents do not have the proper official seal of the hospital and the doctor's signature. Each folder you see here with all these files is just set aside for one hospital and others for others. That's just to say we have one folder per hospital. When they are cured with holy water, we publish some patients' certificates with photographs, which show that they were once HIV-positive but are now negative. We print that information in our yearly publication."

The next footage was shot at St. Paul's Generalized Hospital, one of the leading public healthcare facilities, also in the capital Addis Ababa. After a wide shot of the entrance to the hospital, an HIV/AIDS specialist Dr. Anteneh Anduale is shown walking toward his office. Asked about the conflict between the holy water treatment and ARVs, the doctor says:

> We have patients who come here for ARV (antiretroviral) treatment but who also go to the St. Mary's Church in Entoto hoping to be cured by the holy water. Some people have told me that there are a few priests who are forcing them to stop taking the drugs because they say they—the medications—are evil. We are negotiating with the priests, trying to tell them to stop this coercion. It looks like they might be starting to listen because we hear that some are stopping, allowing people to use both holy water and drugs.

Monitoring and Evaluation Adviser from UNAIDS Tatiana Shoumilina speaks next. "In a country with 77 million of population and with the infrastructure that is not strong, with still some areas being hard to reach by any means, it is not easy to deliver messages. You cannot in one go educate everyone."

In the closing scene, priests swing thurible around a group of men in underwear waiting to be aspersed with holy water, followed by a clip in which women are shown being exorcized, and in another a priest beating the soles of a woman's feet with a wooden cross as she screamed and flailed about is put on.

On the whole, the reporting and framing put to use by the AP in this item could be said to be fair and balanced. While a tinge of exoticization (Dutta, 2008) could be deciphered, appearing to have been enacted through the juxtapositional placing of the two healing systems against each other.

As such the errancy of the "Other," local system, was put before the dominant, hegemonic system so in closing authorities representing the latter could administer a stern rebuke. The doctor's assertion that the clergy at the Ethiopian Orthodox Church may have now begun to listen speaks volumes about the positions and dynamics of power. As Dutta (2008) further argued, such discursive and communicative construction "legitimizes the flow of power from the centers to the peripheral positions in the margins" (p. 169).

In the local NBC-affiliated television station known as *Wave 3 News* of Louisville, Kentucky, one notices a similar framing of exoticization in the coverage of an Ethiopian Orthodox Church with a holy water spring. The *Wave 3 News* segment shows the faithful coming from far and wide, from all across America, and even from as far as Canada due to the popularity of this holy water site. The story also presents short clips with testimonies from those attending, who express their initial disbelief when they learned about this holy water spot in America. The journalist also adds that typically holy water is found in Ethiopia, and the reason this one is attracting so many believers is that it is a rarity in the U.S. The journalist also adds that it is powerful after presenting words of testimony from those showcased in the news piece. The report also indicates that the archbishop of the Ethiopian Orthodox Church traveled to this site in order to bless it. Those who are naked and being doused with holy water are shown with

their faces blurred and no breasts of women zoomed in on unlike in the AP video above.

In their testimonies, the faithful who appear in the news footage claim to have witnessed people getting cured of serious ailments ranging from blindness to cancer. One believer from Canada says he had Parkinson's disease and was unable to walk when he came in, but now he did not need his wheelchair anymore. The wheelchair is shown wrapped in a plastic case and deserted outside the church. The news item is titled "Rare Ethiopian holy water draws thousands to Louisville '' and was uploaded to the reporter Jobina Fortson's YouTube Channel.

In the main, the reporting does not do much more than depict the church and its spiritual treatment practice as some sort of newfangled exotica imported to the center from the periphery in an "othering" fashion. However, it does not seek to call into question the claims of healing put forward by the faithful or present it juxtapositionally against the biomedical. The absence of this frame of reference in this reportage could be explained by the fact that the church and its "anti-scientific", non-biomedically aligned healing system are located within the center itself, and therefore could not be framed in a way that would make it appear to necessitate intervention—a move that serves as an entry point for neoliberal control and exploitation elsewhere in the Global South.

CHAPTER V

MEANINGS OF HEALTH AND ILLNESS, TREATMENT DECISIONS, AND THE VOICE OF THE BIOMEDICAL WORLD

In this chapter, the ways in which the devout PLWHA in the Ethiopian Orthodox Church, who seek treatment in the form of holy water, among other things, make sense of health and illness would be examined. As the PLWHA laity constantly navigate the ecclesiastical as well as the biomedical realms, the chapter also draws on perspectives of healthcare professionals. As Freidson (1995) aptly observes, "the priest determines what is holy and who is profane; the doctor what is normal and who is sick"(p. 206).

On the grounds that the devout PLWHA straddle the two disparate healing systems and tap into both treatments, it would be insightful to include the viewpoints of the representative figures of each establishment. Clergy positions on using the biomedical and the spiritual treatments, as well as the counsel they offered the PLWHA faithful were presented in the previous chapter. Further, positioned in this nexus, the PLWHA laity has to follow counsel given to them from both sides, which at times prove to be clashing, as they make treatment decisions. In taking stock of these issues, we respond to three research questions, namely, RQ 3: How do AIDS patients conceive of health and illness in general? RQ 4: How are treatment decisions made?; and RQ 5: Where do health professionals stand on the tension between the two healing systems?

The experience of living with a chronic illness such as HIV/AIDS takes on a palimpsest of meanings as the afflicted individual navigates through the particularities of an altered reality. In this process of navigation, the afflicted individuals engage in making sense of not only their own life trajectories, but also often competing health cosmologies that inform the interpretations of their health conditions and the treatment decisions they arrive at. It is possible for a person to put multiple interpretations on an illness experience all of which could be at play simultaneously. Aside from the predominant and mainstream biomedical model, focusing on local contexts where various cultural and religious communities construct their illness experiences at the nexus between the global and the local cosmologies provides a unique perspective.

In interaction with the biomedical, the realm of religiosity and spirituality situated in the local cultural context undergirds the identity of believers and what health and illness mean to them both at an individual as well as collective level. Engaging with cultural members as such, therefore, affords us an insight into the various ways in which health and illness are made meaningful on the basis of cultural rationalization and understood through the lived experiences of cultural participants (Lupton,1994).

As members of the Ethiopian Orthodox Church who are living with HIV/AIDS resort to the holy water treatment while on modern medicine, but at times giving up the latter in favor of the former, they go through the

process of negotiating health meanings at the intersection of religion and culture. Given the chronicity of this illness, the patients go about their daily lives with an ever-present precarity that vacillates between health and illness. This oscillatory ebb and flow, and the frequently receding line between the two states along with the incessant search for a cure constitute the illness narratives. As Arthur Kleinman (2020, p. 15) puts it, “Illness has meaning; and to understand how it obtains meaning is to understand something fundamental about illness, about care, and perhaps about life generally.” It also means understanding the worldview that underpins treatment choices, especially in the case of a chronic illness for which modern medicine has no known cure.

The interpretations of these meanings are not a decidedly solitary undertaking. Often those who crisscross the patient’s private terrain, including family members and practitioners take on the feat for a variety of purposes. Drawing on the culture-centered approach which espouses the centering the voices of the subaltern participant (Dutta, 2008) through dialogical engagement, I, therefore, put to use semi-structured in-depth interviews with 21 AIDS patients to extricate illness narratives for interpretation and eventual co-construction of health and illness meanings.

Health Meanings

Health as Faith

In the local cosmology, health is usually foregrounded in everyday conversations as something that comes as a boon tied in with the will and grace of God. It is weaved into everyday greetings whereby a regular salutatory “are you well?” is returned with “(I am well), thanks be to God” among Ethiopians. Generally, interlocutors just say, “thanks be to God” regardless of their actual health status at the moment in time they return the greeting. As I greeted each participant, this was the format in which the exchanges occurred except for the case of the two Muslim participants who basically used Allah in place of God. Zahara, one of the two Muslim women who used Christian holy water for treatment, stated:

> To be healthy means to live in an abundance of Allah’s grace. To have the full presence of Allah in your life, which means that He can protect you from all evil. Shaitan, the evil one, makes us yield into various sorts of temptation so we fall short of Allah’s grace, and eventually, Allah is the ultimate provider of health. Illness is oftentimes the consequence of sinning and falling short of Allah’s glory, for without the will of Allah not a single strand of our hairs will be affected.

By framing health as the complete antithesis of illness, Zahara construes illness as the absence of divine providence. According to her, one

leads a healthy life as long as one does not fall out of what she calls Allah's grace. A total lack or a dwindling supply of this grace constitutes a cause of illness. In this frame of reference, both health and illness are located in the realm of the divine, and the strength of one's faith seems to determine which physical state of mind one could be in at a given time. While Islam and Christianity are mostly antagonistic, it was interesting to find a Muslim participant undergoing a treatment that is almost exclusively Christian.

Not only did Zahara believe in the curative power of the Christian holy water, but her narratives reflected her immersion in biblical texts. Both the Quran and the Bible remark on the place of the will of God in the life of the faithful in general. However, the language pertaining to hair in her excerpt above can be traced back to the Bible. Zahara depends on her Christian neighbors to get her holy water from churches and monasteries they frequent and does not visit the sanctuaries herself, unlike other participants. *Zamzam*—the Islamic version of holy water—is less ubiquitous as one has to travel to Mecca, Saudi Arabia, in order to get blessed by it (Siraj et al., 2019). Zahara places complete faith in the Christian iteration thusly.

For Chuchu, a founder and leader of a local PLWHA sorority known as Lucy Positive Women's Association for women living with the virus in the capital Addis Ababa, to be healthy entails total devotion and supplication to God. "When I go to church, cry before my God and return home, even the dreams I have at night change. It makes me feel a lot better. I am sure if I

get tested now, my test will come back negative, because the last time I was tested the viral load was found to be very low," she notes.

Piety and devoutness, which also includes undergoing holy water treatment, she believes, are essential in maintaining health and bringing about the eventual cure from the debilitating illness. As a matter of fact, she states with confidence that she may have already been cured at the time because her viral load was shown to be dwindling during her last medical test. Like Zahara, Chuchu also underscores the place of the will of God in maintaining one's health. "No human being can stay healthy and alive without the will of God. But, there are things that we as people need to do and fulfill. Nothing happens against the will of God." Chuchu attributes the dropping of the viral load in her bloodstream—as she claims to have learned during her last medical check-up—to the will of God, but also to her piety, which she alludes to in her explanation of the part that people can play for divine intervention. In her view, the medication was also manufactured because it was the will of God. With this rationalization, Chuchu believes that stopping the medication would be an affront to God.

The perception that falling short of maintaining strict adherence to the medication nearly amounts to a form of blasphemy against God could be put down to the construal that hinges on the God-as-originator-of-both frame of reference discussed in the preceding chapter, used widely in PEPFAR-backed messages aimed at attaining the takeup and eventually

lasting compliance with the biomedical treatment. This was not found to be a ubiquitous attitude among the rest of the informants, however.

Health as Work

In the illness experience of the chronically ill, maintaining a reasonably healthy status that makes it possible for the afflicted to participate in everyday life activities requires some amount of work on the part of the sufferer. That is to say that the ill individual must put in some effort physically or mentally to sustain the ever-precarious health to stay reasonably active. The other iteration in which health is being construed as work emerged more widely in the interlocutory engagements I have had with the holy water-goer PLWHA.

Embodied in their experiences are political and economic forces that define access to the daily desiderata in their lives or lack thereof. It is as they attempt to escape from poverty at home that some of them go through a system of medical diagnosis and screening for employment abroad that they come to discover their HIV/AIDS status. Most had their eyes set on employment as domestics in the Middle Eastern and Gulf states. Such destinations particularly include Dubai, Beirut, Riyadh, Aman, Abu Dhabi, Doha, Sana'a, and Cairo, among others, with the trend exponentially growing due to increased globalization and neoliberal economic policies. The plight of those who make it to these popular destinations has been well documented by human rights organizations and researchers alike (Human Rights Watch, 2020; Fernandez, 2018; Katherine Carter & Judy Aulette,

2016; Amnesty International, 2021). Even in the presence of such an abundance of reports of abuse and egregious rights violations perpetrated by employers in these destinations, there has been an uninterrupted exodus of mostly female aspirants, including to war-torn places such as Yemen. The yearning to leave the country and get to these "employment utopias" persists even after the women know full well that they cannot go as a result of their HIV status.

For instance, Chaltu,36, who worked as a cleaning lady for Amanuel Hospital, one of the major public hospitals in the capital, said, "If I were healthy, I would get a job in the Middle East and give my kids a better life. I hope that I will do that one day if I become well again, God willing." Suffused with hope against hope, Chaltu's words echo determination and optimism that ties her future ability to work for a decent living in the putative dreamland. That ability, however, entirely hinges upon the prospects and likelihood of regaining her health.

Not only does she view health in terms of her inability to gain employment abroad, but she defines health as the ability to have a job. Here is how she distinguishes between health and illness: "To be healthy means to have a job, have healthy social relationships with others, and not be bedridden. To be ill means not to be able to participate in or excluded from forms of social interaction, and to be bedridden." In Chaltu's explanatory account, health becomes equated with a job or the ability to work.

As a PLWHA, she does not appear to mark herself as unhealthy due to the presence of the HIV virus in her bloodstream. Eventually, it is due to her unemployability and inability to secure a decent job as a result that she employs to determine her status. Similarly, Abebech, a thirty-year-old woman, who volunteered for services at St. Paul's Hospital, another major state-run health establishment in Addis Ababa, offers an analogous explanation. "To be healthy means to be able to work and provide for your family. For example, I am healthy because I can do these things as any healthy person would, thanks be to God." Though Abebech was just volunteering, probably for a nominal allowance for her services, the fact that she had that opportunity to do a little something had an impact on how she viewed herself.

Essentially, it is not about having a well-paying job, but being an actively-productive citizen, able to participate in the socio-economic aspects of the lifeworld that serves as the definens in the construal of health here. The phrase "as any healthy person would" in Abebech's explanation above reveals the thought process behind her meaning-making, stacking herself up against others who do not have her health condition. As such, she does not quite think of herself as unhealthy, but only less healthy, perhaps, in contrast to others who fall into a category she deems healthy. This interpretation of health as a continuum and not as dichotomy coincides with a well-documented critique of the World Health Organization's (WHO) most authoritative definition that defines health as "a state of complete

physical, mental and social well-being" (The Lancet, 1946, P. 1; Card, 2017).

Another interesting point to note in Abebech's explanation is how she views one's ability to maintain what she refers to as "healthy social relationships"—something that was not commonly echoed by others. The individual exists as an integral part of the social world whereby the performative experience of both health and illness are interwoven into the prevailing social system so much so that the individual becomes social and the social individual in nearly all areas of life. The ability to participate in the economic activities in this milieu or lack thereof as a result of an illness condition becomes an integral part of the illness career.

Interestingly, besides being viewed as health, work also gets equated with the best treatment. For Aberash, the forty-five-year-old caregiver, who, in addition, sells things on the street to scrape a living, having a job constitutes the primary form of treatment. "The best treatment for me is to have a job, a livelihood. I want to leave home in the morning and come back at the end of a workday." What is even more interesting, she ranks it higher than the divine holy water treatment in its usefulness in treating her health problem, making a noteworthy distinction between a treatment and a cure. In her discernment, Aberash views work as the primary treatment and holy water as the primary cure for her health condition. In her daily struggles to make ends meet going back and forth between street vending and her caregiver role, health thus becomes saturated in the context of

health and the pursuit of maintaining the status of "health citizenship" in the social world (Yamasaki et al., 2017; Geist-Martin, Ray, & Sharf, 2002).

A quote from Woletemariam, a forty-six-year-old woman who was self-employed, sums up the import of the notion of health citizenship: "My health condition has taught me what it means to be a social being when you're healthy and when you are not." Indubitably, stigma remains part of the illness experience with a blemishing disease such as HIV/AIDS, besides the debilitating effects of the condition resulting in an inability to work or exclusion from participation in various aspects of the social world.

Health as Serostatus and Therapeutic Position

It is with the administration of a diagnostic serological test that the seropositivity of an individual for HIV/AIDS gets determined. This nosological event puts an end to all speculations over what may have gone wrong with the individual supplanting all conjectures and attempts at an explanation. The most authoritative and more-or-less sure-fire detection mechanism undergirded by biomedical technology establishes this status. As such, therefore, it is in the realm of the biomedical that the meaning of health is assigned and ratified. For the afflicted, it constitutes a stride in the continuing quest for meaning. Since it is the doctor who confers this meaning at this juncture, a diagnosis could be said to be more of a story of disease delivered in the language of medicine rather than a story of illness related by the patient (Jutel, 2011).

However, the doctor, the harbinger of this story, is not acting on his own, but represents the social institution of medicine and thus engages in the process of social discovery which in turn leads to the beginning of social construction (Brown, 1995). Brown further points out that “other components of social construction such as the experience of illness, decisions regarding treatment, and social understandings of what constitutes outcomes follow” (1995, p. 38). The negotiation of the meanings of health falls within the category of the illness experience in this social constructionist rubric.

Several PLWHA defined health by applying such parameters. For instance, Chuchu proffers this description in her elaboration of what it means to be healthy: “A person is healthy only when he/she gets tested and knows his/her HIV status. Otherwise, they might feel healthy today, sick tomorrow, and healthy again the next day…until one day, they remain bedridden.” Not only does health become articulated in the domain of diagnosis, but serostatus comes to be the sole determining factor of health status. In other words, seronegativity for the HIV virus gets equated with being healthy for PLWHA post-diagnosis. From this standpoint, HIV/AIDS is not just another malady to watch out for; it rather epitomizes health like no other. It seems to automatically obviate all other health conditions regardless of their chronicity or acuteness.

In the local parlance, the Amharic phrase *rasin maweq* (□□□ □□□)—which could roughly be translated as ‘knowing oneself’ or ‘to self-

discover'—has been used exclusively in reference to getting a diagnosis for HIV/AIDS. Nowhere else do we hear or see this phrase applied in the context of talking about being diagnosed with a disease, in spite of the acuteness, chronicity, curability status, or even the level of social significance such as stigmatization. In Chuchu's account above, referencing the vacillation between wellness today and illness the next day alludes to this need for self-discovery. This self-discovery leads to social discovery, situating health at the nexus between lay discovery, social discovery, and disease discovery performed primarily in the biomedical realm.

Once clinically determined that a person has the HIV virus in their bloodstream, the natural next step becomes seeking out therapeutic remedies on the part of the afflicted either prescribed by the doctor or in this case holy water treatment provided by the Church. Naturally, the church does not tout holy water to AIDS sufferers, at least not as much as the biomedical establishment does, but the faithful seek it out and tap into it believing in its curative powers. In the articulations of health by the participants, this therapeutic phase and the struggle to sustain one's health post-diagnosis emerge. "To be healthy means to take your holy water and medication without quitting one or the other. As much as I believe in the power of the holy water to heal, it wouldn't make sense for me to drop the medication and stick to holy water only for I believe that God made

them both," Kawessa, a thirty-five-year-old female AIDS activist who was diagnosed with the virus in 2010, observes.

Treatment is a large part of Kawessa's activism often geared toward raising awareness about combining spiritual and biomedical treatments, and access to the latter, in particular. Hence, her conception of health as adherence to both the biomedical and religio-spiritual remedies. Several other respondents also shared this definition of health locating wellbeing in the ability to strictly adhere to treatment and with the right dosage. Interestingly, most referred to the biomedical treatment in their explanatory accounts of what it means to be healthy, often mentioning its restorative potency. For instance, Halima, the Muslim participant, noted, "To be healthy means to take one's medication on time. People can even have children free from the virus now. That is what they told us at the health center."

Health as Mindset

Another commonly expressed meaning of health locates wellbeing in the psyche of the afflicted individual, maintaining that a non-pathologizing self-perception, even in the presence of a chronic illness such as HIV/AIDS in one's body constitutes health. Positive thinking has been widely researched in psychology, particularly in what emerged in the 1950s, and often referred to as positive psychology and the psychology of health. Such research has established that positive thinking or maintaining a positive mindset; adopting a more perseverative perspective has been associated

with some positive health outcomes for both healthy and sick individuals (Aspinwall & Tedeschi, 2010; Aspinwall & Tedeschi, 2010). Mainly, it is the salutogenic orientation—as opposed to a pathogenic coherence—that subsumes it under the psychology of health, which also intersects with positive psychology.

The very onset of an illness itself is known to trigger a deep search for meaning, especially in the religio-spiritual realm for people of faith. In fact, religious participation and subscription to spiritual *weltanschauung* have been linked to enabling the afflicted to decipher the meaning of loss that ensues the onset of an illness career. For Mamité, the forty-eight-year-old housewife, who found out about her health condition in 2003, health is but a function of one's worldview: "Health is something that is in your mind; something that is reflected in your worldview. If you don't have a worldview, and an outlook on life that is not positive, then you are not healthy." In this case, providing the basis for the worldview, of course, and undergirding that meaning is her religious belief. I would like to argue here that the hope and optimism that emanates from religion and spirituality, and belief in the holy water, together with the biomedical drugs, could very well aggregate to make the illness experience take on such a meaning.

With the cumulative effect drawn from the aforementioned three domains, the patient musters hope and optimism which in turn, as a coping mechanism, allows for a boost in the locus of control. In his critique of the notion of health as a locus of control, Dutta (2008) points out the

existence of Eurocentric bias in health psychology that constantly characterizes cultures in Europe and North America as having and promoting internal locus of control whereas those in Asia, Africa, and Latin America get consistently labeled as externals, meaning exhibiting external locus of control. Internal locus of control refers to healthful outcomes ascribed to individual behavior and agency whereas an external locus of control implies the individual believes external circumstances—forces beyond his or her control, in other words—determine his or her health, including belief in God, for instance.

Contrary to claims that it is only those from cultures believed to exhibit internal locus of control that leads to health benefits vis-à-vis those in cultures with a putative external locus of control, these explanations reflect the existence of a trait that is primarily associated with the former in most of the psychology of health research. In fact, it is such framing of the cultures in the Global South that serve as one of the bases for neoliberal health interventions in these destinations, most of which, as Dutta (2008) argues, do not end up being success stories.

Illness Meanings

Needless to say, it is the absence of health or the state in which something, usually a disease, poses a threat to it that health comes into focus. The meaning of health itself tends to be a bit elusive, but an illness or the presence of a disease is widely construed to be its antithesis. WHO, the world's highest authority on the issue of health, has defined health but

has not so far come up with one for illness. If anything, its definition of health mentions disease, but not illness. Nevertheless, in everyday parlance, the two tend to be used synonymously.

Imbued with social and personal meanings, illness runs the whole gamut of the sick person's life, especially so when it is chronic. An illness career, thus, becomes a deeply semiotic journey throughout which the chronically ill becomes, as Kleinman (2020) observes, "the interpreters of bad and good omens." Some of such interpretations lead to mythologies of self-deception and transcendental self-perception anchored in religio-spiritual and cultural realms. As such it helps bring under control the unwieldy natural phenomenon of chronic illness that throws into disarray, not only the life of the chronically ill but that of those in their inner circle.

Consequently, delving into the patient's illness narratives and illness meanings emanating therefrom puts into perspective the illness experience, casting the patient both as "the experiencer" and "assigner of understandings"—to use Cassel's (1979, p.203) distinctive turn of phrase. While most of the illness meanings have been expressed as the antitheses of the foregoing health meanings, not all of them could be characterized as such.

Illness as Bedriddenness

Illness often reduces the sick to be stuck in bed and remain inactive for a lengthy period of time, which could at times be permanent. It means that they cannot engage in routine everyday activities required of them nor

maintain their social roles during this state of inactivity. “To be ill means to be bedridden and rely a hundred percent on others for food, drinks, even getting in and out of bed, let alone working or participating in society. As long as a person can work and take part in social activities such as going to the church, visiting the sick and comforting the bereaved, why would they even call themselves ill?” wonders Woletemariam, the self-employed forty-year-old woman who lived as a PLWHA for almost a decade. Her explanation, besides being her own reflection on illness, also stems from a rather conventional normative understanding of what constitutes being ill in the larger Ethiopian society, which is that the definition of illness presupposes confinement to bed. This phrase has also turned up in a couple of earlier accounts and explanations by others. Whereas the experience and interpretations of each patient remain unique, those interpretations do not unfold in a vacuum away from the influences of social, cultural, religious etc. backgrounds.

Since illness robs the sick person primarily of activity and autonomy, as Herzlich (1981) notes, it essentially renders them somewhat worthless. As a result, even when illness kicks in, people tend to resist the label until they can no longer do that once the illness confines them to bed. Mulu, the live-in candle wax vendor at Shinkuru St. Michael’s holy water sanctuary, does not just characterize illness as being a state of being confined to bed, but she speaks of being comatose in her account.

> Anyone who can get up and walk around is healthy. In other words, if you are not bedridden, you are healthy. All those people you see walking around…they may seem healthy, but you don't know what they may be covering up underneath their clothes. There are a lot of people who wouldn't go public with their health status. I may not be healthy, but I have witnessed many otherwise healthy people die. I am still around. You don't have this [HIV] virus doesn't mean you are not going to die. I was hospitalized for eight months once. I was carried away off the holy water site on a stretcher twice. Now I'm fine. So, I would say to be ill means to be bedridden and comatose.

Ambulatory incapacity caused by an illness along with falling into a coma as a result thereof appear as central meanings Mulu assigns to illness in this case. However, she goes on to blur this signification by pointing out that it all comes down to who has revealed or concealed the information about their health status. As someone who has been comatose twice herself, as she also reveals in the above excerpt, Mulu draws on her experience of witnessing deaths of "ostensibly healthy" individuals whom she says she outlived despite being chronically ill. From her narratives of illness experience emerge meanings that reflect struggles of sensemaking and reconstruction of the self. Constantly assessing how she stacks up

with others deemed healthy individuals in society appears to have led her to her apprehension of illness as being bedridden and comatose as such.

Illness as Mindset

This conception of illness is the flipside of the meaning of health discussed in the preceding section whereby health becomes constituted in the realm of positive psychology. Put differently, it is the construal of illness that ascribes illness to the sick person's "undue" emphasis on being sick, which in turn purportedly keeps the subject in this state, thus dislodging and superseding health. This ascription emerges in Zenebech's explanation:

> …similarly, to be ill means to be in a constant mental frame that keeps telling the person that they are ill. If that person can get out of this cycle of illness-oriented mentality and convince themselves that they are healthy and well, they can work and be in charge of their life, chances are, they will start feeling healthy for as long as they forge ahead with this mindset.

While not everyone expressed their subscription to this particular meaning of illness, the faithful who locate their health in the realm of the religio-spiritual, do resort to not dwelling on their illness as a coping strategy when health happens to be at a premium. As health becomes anchored in the divine domain undergirded by a near-denial mental concentration on being and becoming healthy, straying from this mindset is

believed to put the sick person back in the illness territory. Total faith in God and the holy water interlaced with pious hope constitute an effective coping mechanism. Interestingly, the defiance includes avoiding thinking about the treatments being received for the illness, barring the holy water treatment, of course, as could be noted in Abeba's account below.

> Illness is a mindset. If I really emphasize my illness all the time, think about all the treatments, then I will end up being ill. However, if I, while aware of my condition, keep telling myself that I am healthy, even though I am in this treatment or that, I will be healthy. When I say treatments, I am not including the holy water treatment because it is not your ordinary therapeutic solution to this problem. It is a divine cure given to us by God Himself. The reasons for which I am taking the medication and those for which I am sticking to this holy regimen are far from each other. With the medication, I know pretty sure that I won't be cured. This is not the case with the *tsebel*—the gift from the Holy Savior—the holy water. I know for a fact that I will be cured by the holy water.

As could be deciphered from the above excerpt from Abeba, the holy water treatment by virtue of its location in the divine realm, is accorded the status of an elixir, perhaps with a capital 'e'. This rationalization seems to enable the patient to continue to brood over the divine treatment and

utilize the biomedical treatment despite forcing her attention from it to a level bordering on disavowal. With the onset of illness sets in a loss of self—what Herzlich(1981) refers to as illness as destructive—in her discussion of illness meanings. Abeba reported having gone through such a loss of self when she discovered her health condition, and as she sprung back from the doldrums, she seemingly moved away, at least mentally, from the pathological path that thrust her into this nadir of despair and despondency.

Illness as Therapeutic Position

Therapy in whatever form is a natural sequel to the onset of an illness. As it becomes part of the illness career, it takes on personal significance for the sick person to an extent where it becomes synonymous with illness. The afflicted individual assumes the "sick role", as Herzlich (1981, p.104) further notes, part of which entails adherence to a therapeutic regimen, whether it is prescribed by a traditional healer, a medical doctor who exacts much more formal and strict institutional anticipations, especially with respect to adherence. In addition, we have a spiritual form of treatment provided by the church—overseen by the clergy. It is, therefore, at the intersection of all of these approaches to treatment that the PLWHA laity grapple with making sense of their illness experience. This is reflected in this excerpt from Chuchu below.

> To be ill is to not be cautious enough to actively follow your treatment regimen and be a bit devil-may-care about one's

> health, indulging in harmful practices such as doing drugs, drinking, etc. to the detriment of one's health. For example, it's been 21 years since I was diagnosed with HIV. However, I try to stay away from things that would affect my health; I take care of my family, make sure I adhere to my treatment and consult with my doctor should any issues arise, and follow her advice in all that I do. Some people may not care to adhere to their treatment regimen, and instead, become addicted to things like hashish or khat. These addictions then set them in a never-ending cycle of illness and recovery, making them go back and forth to the doctor all the time. That's how I'd like to describe what it means to be ill.

At the center of the above explanation by Chuchu, who has been a PLWHA for over two decades, lies the issue of adherence and abstinence from what she referred to as addictive substances and behaviors that are deemed to be detrimental and non-constructive in the treatment process. Patently, adherence here exclusively relates to modern medicine. Going back and forth to the physician as a result of not sticking to the regimen the doctor puts the ill person on comes to define illness. Such lay constructions of illness are punctuated and interspersed with biomedical language because essentially illness narratives, and thus meanings draw on the patient's lifeworld as well as the voice of medicine. Interactions with

the clinical realm yield grist for patient's illness narrative and definition-making, which complements and comprises illness meanings that emerge at this juncture.

Notably, Chuchu's therapeutic meaning centers the social and institutional enactments of what I would like to christen good therapeutic citizenship and the disruptions thereof alluded to but not fully accounted for in her account. As an AIDS activist, Chuchu had many years of experience working with those in the health profession as she traveled around from place to place creating much-needed awareness in curbing the spread of the pandemic. This may have led to the individual-blame bias that emerges from her explanation. Individual-blame bias has largely been associated with biomedical theory and praxis which entirely lay blame at the patient's door for not maintaining health or complying with physician orders and thus fall ill as a result, without accounting for socio-cultural factors.

Due to overexposure to discursive spaces where the rhetoric that blames the marginalized AIDS sufferers caught up in various forms of structural violence, its language percolates through Chuchu's explanatory account. A number of social forces contribute to illness and suffering. The powerful forces which dominate the communicative and material resources determine what gets circulated and normalized in the public domain through their hegemonic power. Structural violence comes in all forms of its manifestations, including co-opting resistive potentiality through

rhetorical hegemony. The perception that an individual falls ill because their own lack of caution and devil-may-care recklessness coming from members of such a marginalized group indicates the success of the hegemonic enactment of the biomedical discursive manufacture of consent.

In *Pathologies of Power*, Farmer (2010) cites such things as addiction, lack of housing, and employment, *inter alia*, as consequences of structural violence that interfere with adherence to the treatment regimen. This is essentially an act of erasure—an elision of the real origins of pathology.

As Dutta (2008, p.167) also rightly points out, "Violence is played out through the acts of erasure, through those communicative acts which silence the voices of the marginalized and place them at the peripheries of the socio-cultural system." All in all, it is through the co-optive rhetoric that the subaltern are kept in this therapeutic position which they eventually equate with what it means to be ill.

Treatment Decisions

It is a universal human experience to seek out some sort of therapeutic solution after being diagnosed with a health condition. The diagnosis may not necessarily be a laboratory-based biomedical investigation conducted to get to the bottom of what may be causing the dis-ease in the individual. Instead of a visit to the doctor's, people may first and foremost on the basis of signs and symptoms they are experiencing conduct an auto-diagnosis, so to speak, so as to determine their health

problems. Whether it is based on a hunch, an auto-diagnosis, a folk healer's interpretations, or of those around the sick individual such as family members, friends, or co-workers, the immediate sequel becomes what to do about it. While the remedial course taken is often one that leads to a total cure, in the case of chronic illnesses such as AIDS, it does not do much more than merely staving off the damaging effects of the condition. In the typical medical encounter, the practitioner dictates the terms and courses of treatment with little or no attention given to the patient's perspective.

Patients' health and illness meanings, which we discussed in the foregoing section, along with explanatory models they utilize in making sense of their medical predicaments are known to have a significant bearing on the decisions they make with regard to treatment. Such decisions may or may not involve those in the patient's inner circle, clergy, or the physician and other healthcare professionals. In contrast with patients suffering from acute illnesses, those diagnosed with chronic illnesses such as HIV/AIDS have been shown to be much more actively involved in treatment decisions (Toombs, 1993). We will now turn to treatment narratives in an attempt to take a closer look at how the PLWHA laity who are currently availing themselves of both the biomedical and holy water treatments make various decisions with regard to these and other treatment modalities available to them in the socio-cultural milieu.

In the initial medical encounter where the physician constructs out of the patient's illness narrative an anamnesis—a case history—used as a primary input in the diagnosis process, emerges a prescription or a recommendation of some sort. This medico-centric approach has been largely accused of marginalizing the patient, stripping them of agency in the treatment decision-making process. While this is an important observation, and the medical practitioner does truly wield considerable clout, patients could mount stiff resistance to treatment regimens or recommendations at times. Mulu, the forty-seven-year-old woman PLWHA at Shinkuru St. Michael's, said this about her outright rejection of the doctor's prescription at the time of her initial diagnosis.

> When I first went to see the doctor about my condition, they prescribed me some medicine. I threw it at the doctor. I got pissed off after I had been told that it was meant to help me live longer. And I was like who are you to tell me you'd help me live longer with this stupid thing! I strongly believed that I would be completely healed by the holy water and didn't need their "longer-life" medicine. Only the almighty God decides how long any person lives on this earth.

Given the authority and influence the doctor has, not just over the patient, but in society in general, Mulu must have plucked up considerable courage to react the way that she did to her very first prescription after being diagnosed with HIV/AIDS. A rhetorical disconnect between the

physician and the patient lies at the heart of this dispute. The Amharic phrase □□□ □□□□□ /idmeɪ mɑːrɑːzəmɪə/ whose literal translation into English could yield something like “age lengthener” constitutes the prime culprit in this regard. Oddly, out of palliative drugs, this term has only been used in reference to AIDS drugs even though there exist a wide array of chronic illnesses for whose treatment only palliative care remains to be the sole approach. To the ear of a devout believer such as Mulu, this reference borders on the blasphemous as she indicates in her reaction that it was an encroachment on the divine.

Though the patient decided to seek help in the biomedical realm first, in this case, she did not go through a positive experience. I would argue here that it would help a great deal to take the patient’s religious and spiritual history in addition to the illness anamnesis as the religious views that a patient holds easily bleed over into and affect the outcomes of medical care. Whereas spirituality and religiosity are understood to be universal human phenomena, there are variations among members of a given society as well as between societies. For instance, in comparison with the Ethiopian society at large, Americans tend to be less religious. Still, in one study that focused on 200 inpatients in North Carolina and Pennsylvania, 94% pointed out that spiritual health was as important as physical health while 77% wanted their physicians to address their spiritual concerns (King & Bushwick, 1994). Owing to the dearth of similar studies in the Ethiopia context at this time, much could not be said in this

respect, but were a similar study was to be carried out, the stats would definitely be much higher.

By and large, such findings are indicative of the need for the integration of spirituality into the clinical care of the chronically ill in particular as patients make sense of health and illness in spiritual terms. Spurred on by the deep dejection she experienced at her initial clinical care, Mulu left her hometown of Shakiso— a small town in southern Ethiopia where she resided at the time—in search of better care. In her next destination, which was in the capital Addis Ababa, she received a more-or-less similar treatment at the Tuberculosis Treatment Center. An instantiation of the medication as a choice between dying and staying alive was how she was talked into embarking on her regimen here. Mulu's decision to accede was not driven by her satisfaction with the service and care afforded her at the center, but her realization that her search for better clinical care was an exercise in futility.

On the other extreme, another patient reported that her doctor engaged in corporeal violence toward those who did not heed his prescriptions, recommendations, and admonitions. Interestingly, the thirty-year-old female PLWHA, who worked as an HIV/AIDS counselor and educator herself, did not think the doctor was in the wrong at all. Zeleka had this to say:

> The health facility where I was first diagnosed had this physician who would even resort to physically punching

> patients if they were not following his advice out of genuine concern for their health. He was like a father to us. He's such a good person for me. Some people took their medication out of fear of not being issued with a reprimand by him.

The doctor's use of coercive measures is a bit out of the ordinary. With the enormous hegemonic power concentrated in the hands of the physician reflected in the authority and control exerted over anyone seeking clinical care, but also in the larger society without the need to resort to coercion, one would think that there is no need for the physician to employ any violent tactics to force treatment on the patient. All the same, the patient speaks favorably of the physician's comportment, expressing her perception of him as a father disciplining his children. Needless to say, dealing with some intricate medical problems for both the patient and the doctor could lead to an altercation. Still, the resolution of such a dispute would not naturally include the very person meant to care for the sick—the physician—punching the care-seeker. Viewed from the standpoint of medical morality, this would be deemed lacking in ethical demeanor if not reflective of outright depravity.

In the current medical practice, the ethos of clinical care establishes a fundamental departure from medical paternalism, advocating for a much more patient-comes-first, patient-autonomy-based approach. This translates into patient self-determination and the establishment and

protection of more rights and freedoms. For instance, supporting this principle, Freidson (1995, p. 23) writes, "...the survival of medical practice depends upon the choice of laymen to consult it. Choice to consult cannot be forced; it must be attracted." Friedson's point may only be partially true in the Ethiopian context because the physician as could be construed from Zeleka's account can force not just a consultation but can also enforce treatment decisions with corporeal violence—the most extreme form of medical paternalism. Such a form of paternalism could be put down to the extant socio-political dispensation that does not uphold such liberal ideals as freedom and individual choice. Pugnacity of the physician would lead to fear and trepidation of the patient, which will in turn result in what Deez (1992) refers to as "discursive closure" (p. 189). Deez defines discursive closure as "the denial of the right of expression, denying access to speaking forums, the assertion of the need for certain expertise in order to speak, or through rendering the other unable to speak adequately." As a result of this discursive closure, whatever care afforded the patient after discounting their voice becomes rather lacking because, as Toombs (1993) aptly puts it, "to bypass the patient's voice is to bypass the illness itself" (p. 28), and thus the treatment for the illness.

From the culture-centered analytic lens, this discursive closure of the patient occurs at the nexus between structure, culture, and agency. The patient is essentially rendered devoid of agency in the juncture where culture and structure overlap. Structural amenities enable the physician to

enjoy clout and leverage over the patient along with a cultural orientation that bestows unbridled power on the biomedical figure whose abuse could result in such extreme manifestations as inflicting bodily harm. In addition, it also highlights how the biomedical ethos and the entire biomedical model which is touted as being universal and acultural fails to hold up in a non-Western context.

Apart from the foregoing treatment decisions that appear to be positioned on the two extreme ends of the overall treatment decision-making continuum, other decisions take place prior to the medical encounter. An important step in the quest for the restoration of health after the onset of an illness could begin with embarking on a journey to assess all the available avenues of healing and treatment. As they make these decisions, patients may seek out information from those around them, including family and friends. A fellow patient who has been afflicted with the same illness and has been traversing that treacherous path could become someone to turn to for guidance. Aberash, the forty-five-year-old caregiver, who moved from Dire Dawa, a city in the eastern part of the country, to the capital in search of treatment, reflects on her experience when she was diagnosed with the virus before sixteen years.

> My brother arranged for me to meet with another woman living with the virus. "We're in the same boat," she told me. "I have long given up on life and sold most of my personal effects." One day she took me to Alert Hospital. They told

> me that my CD4 count was really good. I started a new job as a daily laborer on a construction site. I did a lot of heavy lifting work. As a result, my CD4 count dramatically fell. I fell sick. My brother took me to the hospital. They asked me about my new job and suggested that I change it because it really affected my CD4 count. They also recommended that I start medication. They arranged for me to get my medication from the nearest health post to my residence.

Aberash's brother had some contribution in the treatment decision-making process because he connected her with someone who was suffering from the same illness. It was this connection—not a family member—who talked her into going to the hospital for treatment. Patients tend to exhibit a natural affinity toward fellow patients vis-à-vis others, including family and friends sometimes, due to the intenseness and profundity of the illness experience over which they form a strong bond. Aberash's connection, the woman she talks about in the excerpt above, greeted her with an acknowledgement that the two were in the same situation, and then went straight into sharing her story with her, including the sense of despair and despondency she experienced at the onset of her illness career. This shows the storied nature of health communication and the power of stories as they function as conduits for the flow of health and illness meanings, which in turn lead to exploring treatment options.

As Dutta (2008) observes, “It is through their understandings of health choices and treatment options that individuals come to make decisions about the prevention and treatment of illness” (p. 107). In this connection, he further introduces what he refers to as the “dialogical turn” propounded by the culture-centered approach, which focuses on the foregrounding of the voices of cultural participants—voices that typically remain silenced in the dominant health communication discourse. A sense of camaraderie develops as sufferers of chronic illness share their illness experiences. These fellowships often lead to the formation of a support group that serves as a voice of the sick, but also have an impact on coping, prevention endeavors as well as treatment decisions of both in-group and out-group members.

Additionally, such support groups act as anchors and exemplars for the cultural members. Counsel and treatment recommendations that arise from within the support group tend to be heeded and adhered to rather consistently. Chuchu, who presides over one such support group herself, shares her own experience in this regard.

> It was upon recommendation by my colleague Zewdu at *Tesfa Goh* that I began my treatment at Zewditu Memorial Hospital. Up until today, that’s where I go for my treatment. It was only when I had my daughter that I had to go to the Gandhi Memorial Hospital because of defective equipment at my hospital.

Mutual information and support characterize support groups of individuals who come together because they are going through the same difficult circumstances—HIV/AIDS in this case. As discussed in the foregoing chapter, *Tesfa Goh,* Amharic for dawn of hope, was one of the pioneer associations of HIV/AIDS sufferers, which started out as a small support group of about ten. Zewdu, a PLWHA man who was in charge of the association for many years, shortly became a household name across the country due to his frequent media appearances on HIV/AIDS awareness-creation, prevention, and treatment programs. Chuchu's treatment recommendations came from this quasi-celebrity support-group leader, and it is evident from her testimony how adherent she has been. We may not extrapolate too much, but it would be safe to argue that such social support groups have a lasting impact on treatment decisions and negotiations on members. This is consistent with the below assertion made by Yamasaki et al. (2017).

> Sometimes people would rather receive social support from individuals who are outside their inner circle of family or friends (weak ties versus strong ties)". Weak-tie support is sometimes perceived as more useful than strong-tie support because it can offer diverse points of view and information, present less risk when disclosing information, offer objective feedback, and require less role obligation than support provided from close personal relationships (p. 258).

Narratives of treatment decision-making are also suffused with the assessment of the innovation attributes—from the perspective of the diffusion of innovations theory—drawing a comparison between the divine and the biomedical modes of treatment. Assefa, the forty-year-old, self-employed man, engages in such rationalization: “If you stop the medication, there may be consequences. You may seriously damage your health. You may lose a body part. If you stop taking holy water, nothing like that will happen to you. You can stop it today and resume it tomorrow without any problems.”

Drawing on his experience of tapping into both forms of treatment, Assefa portrays the biomedical as vindictive, as it were—an entity that inflicts corporeal harm should one decide to skip it even for a single day, installing a therapeutic regime that commands complete submission. On the other hand, the divine treatment stands in stark contrast: the patient can decide to stop and take it up again without stinting. In addition to the relative advantage attribute, this also means that the biomedical does not make the grade in terms of trialability and observability as well. Even as they reap health benefits from it, patients feel ensnared in this “malevolent” biomedical therapeutic regime which seems to have Jekyll and Hyde tendencies, in a manner of speaking.

It was while he was undergoing another rigorous treatment, after having been diagnosed with tuberculosis, that Assefa found out about his HIV status. When his tuberculosis proved intractable, his doctors

recommended that he get checked for the virus: his worst suspicions were confirmed. Grabbing his test results, Assefa made a beeline for a holy water sanctuary. He did not waste time considering the doctor's treatment recommendations.

> Even before starting the medication, I knew full well, because I have seen first-hand the damaging side effects they had on people, that they were not the best. I met patients who were on those AIDS drugs. There are phases…in the long run, they turn you into something else, but I guess folks just keep taking them because living is always preferable to dying. I went directly to my faith's sanctuaries, holy water sites. I still go today. Even if I take the drugs, I still believe that my primary source of cure is the holy water. If I skip taking my holy water for a single day, I feel that something significant, a part of me is missing. I don't stay for days or weeks, because I have to eat, and in order to eat at least one loaf of bread a day, you need to work. But, I tell you, there is nothing like holy water.

In the above excerpt, Assefa makes it clear that he believes the holy water will cure him and not the medication. With an a priori reason based on the vicarious experience of fellow patients, he developed an aversion to the medication. All the same, he knew he would have to utilize it for

effective management of his health condition. In the final analysis, it is not just the belief in the curative power of the holy water treatment that the PLWHA faithful factor into their treatment decisions, but also what they know before embarking on the biomedical treatment.

While the primary focus in this project is on biomedical and spiritual treatments, a third therapeutic destination also exists in the form of what is usually referred to as traditional medicine. As the traditional healers are often church-educated, it is not uncommon to see an overlap between the traditional and the spiritual, which typically include holy water, holy mud, but also holy oil and holy honey at times. Some patients criss-cross all the three treatment options over their illness career, depending on the magnitude of the illness as this varies from time to time. The traditional treatment option could be the first one that patients turn to even after being prescribed modern medicine. Assefu, the thirty-year-old woman who worked as a hospital records assistant, says that was her first stop for treatment. She relates her experiences, and turns and twists as follows:

> There was this traditional healer at Shiro Meda (a neighborhood in the northwest of the capital Addis Ababa). Because I am the youngest child, my mom would do anything for me. The healer asked for one thousand birr (about $50 then) in advance. My mom gave me the money, and I went back to the healer. He offers me a potion which has lemon juice in it. It looks all very green. A whole glass

> of lemon juice goes into it. I was prescribed to drink this every morning on an empty stomach for one week. In the morning after drinking the potion, the healer also recommended that I drink milk within forty minutes of drinking the potion. Since I started medication at the time, I would take this in the morning and the medication in the evening. I went to his place every morning to get my brew. As time went by, I began having symptoms of gastritis. When I told him about those symptoms, he said this was because his medicine was working and that I would be free from the virus soon. Because I had a strong yearning to become completely healed, I thought he was telling the truth. I believed him. And, alas, I have really bad gastritis to this day.

It is manifest in Assefu's explanation that she fell victim to some quack medicine which she hoped would give her the cure that she was so earnestly looking for. The realization that the extant biomedical treatment does not bring about a cure underlies her decision to search for one in the traditional realm. At this juncture, even as she realizes that the traditional healer's remedy caused further detriment to her health and not the contrary, Assefu remained resolute in her belief that the concoction actually restored her health. Since the healer does not have a means to

carry out a test to determine her seronegativity, Assefu goes to the hospital to have the test done.

> So, I went back to the Police Hospital to get checked for the virus. I was holding the icon of Our Lady. The nurse asked me what it was for and I said I was going to be free from the virus soon. And she was like what are you talking about? She drew my blood. This was after my mom paid two thousand birr ($100 at the time) to the healer. So, when I told my mom that nothing had changed, she said, "Don't worry, I will send up a votive prayer to St. Gabriel." So, I gave up on this treatment and went to St. Mary's at Addis Alem (24 miles away from Addis Ababa) for holy water treatment. I stayed there for three months. When I arrived at the holy water spring, it was the fast of the Dormition of Our Lady, and therefore, during those days of fast, sixteen days total, I didn't take the medication.

Setting her mind on the quest for a cure, Assefu meandered through the therapeutic triad: traditional, spiritual, and biomedical. Once she knew that the biomedical was just simply there to placate the virus and not completely rid her of the virus, she turned to the traditional. When she finally walks out of the traditional into the biomedical, she has every faith in the healer that his treatment cured her. In a rather uncommon move, Assefu takes along a religious appurtenance to the hospital—an icon of St.

Mary. According to the teachings of the Ethiopian Orthodox Church, St. Mary, along with other saints is believed to play a decisive intercessory role, and is thus held in the highest possible form reverence, but also worshiped because she ranks in the top due to her divine maternity. This confluence of the therapeutic triad marks a kind of *terminus ad quem* in her journey of exploring treatment options, bringing the preternatural and the supernatural to bear in the biomedical realm.

Tapping into the local-healer remedies tied in with the *miracula* of saints in the form of an icon, Assefu seeks to obtain verification for her cure. Not only did the verification not confirm her faith and hopes, but the icon she brought into the biomedical space as her faith prop was not received well. Encouraged by her mother, Assefu pursues the spiritual treatment further and goes on a pilgrimage for three months during which she quits her medication. Yet again, this decision was primarily made as a result of not finding a cure in the traditional therapy. The role of her mother in Assefu's decision-making cannot be underestimated, nonetheless. In addition, the ineffectiveness of the treatments she has been receiving up until the confluence point is taken into consideration. It appears that she was not ready to settle for anything palliative.

Overall, Assefu's case, in particular, serves as a classic example of how patients make their decisions regarding treatment options. Over the course of the illness, the ebb and flow of the malady constitutes one of the forces behind those decisions. In practical terms this would mean electing to

choose this therapeutic option or that and opting out of an ongoing regimen as Assefu did during her three-month sojourn at a holy water sanctuary. These decisions mean different things to the physician and the patient. Obviously, on the patient's side of things, it simply indicates an incessant quest for a cure while on the biomedical side of things, it is perceived as a rebellious act of defying or not heeding the recommendations of the doctor—non-compliance or lack of adherence.

The Voice of the Biomedical World

The exploration of the meanings of health and illness would not be complete without the inclusion of the voice of the biomedical world—the healer's perspective. Besides the obvious collision of the religio-spiritual treatment modality with the biomedical at the heart of this study, the illness narratives that constitute the grist for the co-construction of health and illness meanings and the clinical anamnesis straddle both the patient's lifeworld and the biomedical world. In the latter, however, these illness narratives tend to get truncated. As the medical sociologist Waitzkin observes illness narratives are continually interrupted because "the patient's story may not contribute to the doctor's cognitive process of reaching a diagnosis; the patient's version of the story may be confusing or inconsistent; telling the story may take more time than is perceived to be available or parts of the story may create feelings that are uncomfortable to the doctor, the patient or both" (1991, p. 28).

In this section, the extent to which the interactions that take place within the realm of the biomedical encounter provide opportunities and possibilities or limits to the patients' lifeworld will be discussed. The social construction of the physician as the licensed authority with almost exclusive power over the healing of illnesses makes them, and by extension the biomedical model, a force to be reckoned with. According to Foucault, and several scholars he has influenced (Lupton, 1994; Shilling, 2012), the body remains under constant "medical gaze"—a term Foucault (1973) himself used.

Drawing on Jeremy Bentham's notion of the panopticon from the early nineteenth century—a system of surveillance enabled by an architectural design that made it possible for a single security guard to watch all the inmates within the structure—unbeknownst to the latter—which Foucault later on popularized as a symbol of social control that could be extended to just any area of life, and not just the prison system. Armstrong (1987) likens the prisoner under surveillance in the panopticon to the patient under the stethoscope, an emblem of the biomedical authority of the doctor in the medical encounter. "The prisoner in the Panopticon and the patient at the end of the stethoscope, both remain silent as the techniques of surveillance sweep over them. They know they have been monitored but they remain unaware of what has been seen or heard" (p. 70). Due to the imbalance of power between the voice of medicine

and the voice of the lifeworld put on by the patient, the latter often gets drowned out and silenced by the former.

By adopting the culture-centered approach through dialogical engagement with these powerful actors, I will explore the nexus between structure, culture, and agency as they play out in the enactment of healing from the standpoint of the physician who plays a pivotal role within the doctor-patient dyad. Besides the dyadic relationship that involves the doctor and the patient, how polymorphic interactions among the traditional, the religio-spiritual, and biomedical play out in the discursive realm of biomedicine would be the focus of attention. More specifically, the discussion centers on the health care professionals' encounters with patients with a marked preference for holy water treatment, communication strategies and avenues they utilize and the extent to which they listen to claims put forward by patients, and finally their views on the dissemination of biomedical AIDS drugs at holy water sanctuaries situated on ecclesiastical grounds.

Encounters with Patients with Preference for Holy Water Treatment

Religious proscriptions could be at odds with medical prescriptions posing a challenge for the health care practitioner to pursue the therapeutic agenda with those making use of their services. In the case of the Ethiopian Orthodox, no scriptural and dogmatic interdictions that explicitly prohibit biomedical treatment exist. Yet, the faithful afflicted with HIV/AIDS have shown time and again preference for spiritual treatments

such as holy water, holy mud, or the sacrament of unction. Of course, of all these and other forms of treatments offered and available in the ecclesiastical realm, holy water remains the most popular. While this spiritual treatment does not constitute the only factor that contributes to the lack of adherence to the biomedical treatment for the malady, it is an issue that has become too uncomfortably conspicuous in the overall HIV/AIDS therapeutic landscape in Ethiopia to escape attention.

Commenting on the general trend of this preference for holy water treatment among the PLWHA community in the Ethiopian Orthodox Church, almost all of the health care professionals indicated that compared to the early days more and more patients had adopted the medication even though the problem still existed. Hiwot, a thirty-year-old physician with over six years of experience dealing with PLWHA at the Zewditu Memorial Hospital, where she worked as the hospital's ART team physician, recalled her interactions with a patient who had intentions of refraining from the medication until after she [the patient] sojourned in a monastery for holy water treatment. That the medication cannot be discontinued, not even for a single day, is what the physicians tell the patients. According to Hiwot, the patients may appear to accept the recommendations and prescriptions during the medical consultation, but once they walk out of the physician's office, those recommendations may end up not being heeded. In cases where the patient appears non-compliant during the medical encounter, they are given a referral to their spiritual advisers.

> Priests in the Ethiopian Orthodox Church have come a long way from their earlier position on the matter and now teach the faithful that they can combine the biomedical with the spiritual. So, we count on them. Compared to us doctors, patients are very likely to adhere to the recommendations of their spiritual advisers. It is important that they hear it from them instead of us. What matters is that they believe in the medication. At the end of the day, patients open up more to their spiritual fathers, and when we cannot agree on certain things, we refer them to their spiritual advisers.

From this physician's explanation, it appears that the critique against biomedicine that patients' religious faith, belief in miracles, and reliance on God's will are often not magnified in the medical setting could not be sustained. The patients' belief in the spiritual treatment gets validated in the physician's referral to the spiritual realm with the perspicacity that challenging the patients' claims would be counterproductive to the therapeutic endeavor. Yet, there is no guarantee that the spiritual figure would go along with the health care provider's recommendations. Patently, the biomedical expert places implicit trust in the ecclesiastical domain for the enactment of their counsel under priestly obedience in this case.

Such modus operandi, however, does not constitute the sole approach that health care providers utilize to deal with patients who reject combining the two treatments. Taye, another medical doctor, a fifty-one-year-old male

general practitioner who led the ART unit at Addis Ketema Health Center, relates his own experience handling similar cases.

> Toward the beginning of the ART treatment, I remember this devout man who really believed that biomedicine is of the devil. He believed that he could only be cured by holy water. We tried all we could to explain to him that it is not. We used ART case managers to follow up with him and try all they could to bring him around. In the meantime, matters took a turn for the worse: his CD4 count took a nosedive, and his viral load built up. Then he developed some deadly infections and passed on. So, we lost him. More recently, there was this lady. She had consistently been adhering to her medication. Then for nine months, she stopped the medication and disappeared. When she returned, she was quite ill. She developed TB and brain infections because her CD4 count drastically dropped. She had to be hospitalized for more than two months before she was finally discharged. The reason she disappeared for those nine months was that she decided to go to a holy water sanctuary, which she said was far away from Addis Ababa. Now she could have taken the medication when she was leaving, but she believed that it would be an affront to

> God to seek a cure from His house, and at the same time look elsewhere.

As shown in the above excerpt, in the Addis Ketema Health Center, ART case managers are responsible for monitoring and counseling patients. In this service orientation, referral to the patient's spiritual advisers does not appear to be part of the overall service orientation. According to the physician, in addition to case managers, they also have a group working as adherence supporters whose primary responsibility—teaming up with ART case managers—constitutes the maximization of adherence to medication. "We usually identify patients at the risk of sliding into poor adherence, among whom we have patients who have a history of switching to holy water." So, the female patient, whom Taye identified as the most recent case, seems to have escaped the notice of the ART case managers and adherence supporters.

Another veteran physician at the Zewditu General Hospital, with sixteen years of experience treating PLWHA patients, observes that very few of her patients would seek her advice on whether or not they could put their medication on hold during their pilgrimage to holy water sanctuaries. Her observation chimes in well with what King & Koenig (2000) remark, "Although both patients and physicians agree that spiritual well-being is important, they usually do not discuss spiritual well-being in clinical situations" (p. 58). Not all the clinicians I interviewed had this experience.

Drawing on his personal practice and dealings with PLWHA who had proclivity for holy water treatment, an internist and infectious diseases specialist at the Addis Ababa University's Black Lion Specialized Hospital, Wondwossen underscores the importance of reminding patients during all consultations that the medication does not conflict with the holy water treatment. According to the physician, regardless of constantly broaching the subject in his clinical consultations with the PLWHA, some rank-and-file members of the clergy would advise the patient against combining the two treatments. He believes that there exists a lack of consensus between the top echelon of the church leadership and the lower-level clergy, in particular, on whether the PLWHA laity can utilize the biomedical and spiritual treatments in combination. This is in keeping with what Mork (2008) found: that lower-level clergy, who constitute the majority in the ecclesiastical structure, did not believe holy water should be used together with AIDS drugs.

Communication Strategies, Avenues, and the Voice of the Patient

In the clinical encounter, successful communication with the patient from recording the anamnesis to the disclosure of diagnostic results and consequent therapeutic decisions and prescriptions goes a long way in establishing a harmonious doctor-patient relationship. Within the domain of healthcare, patient-centered care has been recognized as an important aspect of quality care (Institute of Medicine, 2001). Newell and Jordan (2015) characterize patient-centered care as "care that is respectful of and

responsive to individual patient preferences, needs and values, and ensuring that patient's values guide all clinical decisions. Patient-centered care encompasses the 'individual experiences of a patient, the clinical service, the organizational and the regulatory levels of health care" (p. 77). Needless to say, healthcare essentially centers around the patient, and as such the phrase patient-centered itself sounds a little out of place. The concept was only introduced as recently as the 1980s (Greene, 2012).

Given the chronic and stigmatizing nature of HIV/AIDS, taking into account the needs and values of the patient, in particular, as indicated in the definition of patient-centered care above, and adopting patient-centered communication with an approach that incorporates patient views would also contribute to quality care. As such, it would also transcend the limits of the conventional medical approach built on a more paternalistic relationship between the physician and the patient, making it more of a partnership. In practical terms, this would mean that more time and attention need to be devoted to the patient. Hiwot's position and experience as shown in the excerpt below reflects this.

> Our job is not just to get them started on the medication and make sure that their prescriptions get refilled. We go beyond that and engage in really intimate conversations with them. Like I said before, you cannot force a patient to be on a particular medication. They must consent to do that. In dealing with chronic illnesses such as HIV, it's

> important for the health professional to be in close consultation with the patient. Here at the ART team, we're allowed more consultation time per patient compared to other out-patient departments. On average, we spend half an hour of consultation with each patient and sometimes, even more, depending on their cases and the issues they're facing. It is not enough to prescribe and dispense the medication.

The institutional arrangement by the hospital in which it has allotted more consultation time for the clinicians interacting with the PLWHA constitutes a move in the right direction toward patient-centered communication. Every session of the patient-clinician interaction would be such that the patient would be afforded a reasonable opportunity to share their lived experience, which is believed to reflect the reality of the patient's illness in its immediacy (Toombs, 1993). Each visit thus provides the clinician with the most recent aspect of that experience. Long and in-depth medical consultation has been identified as a hallmark of patient-centered care leading to increased patient satisfaction (Sohn et al., 2019; Gross et al., 1998). Satisfaction with communication in the doctor-patient encounter has also been linked to greater compliance.

Acknowledging the patient's cultural background, religious values and needs becomes paramount in the clinical communication endeavors as well. In this connection, speaking about her own experience of in-person

consultations with the PLWHA, with specific reference to cases where lack of adherence to medication becomes the main sticking point, Hiwot has reported the extent to which she broadens the usually one-on-one consultation, and asks the patient to bring in the person who advises the patient to quit the biomedical treatment and switch to holy water. After the physician engages in conversation with the third person and the patient, a consensus eventually emerges. Essentially, this is an act of entering the patients' lifeworld undergirded by empathic listening aimed at helping the patients make sense of their suffering. Usually, doctors are blamed for lacking that empathic listening, and only listening for aspects of patients' illness narratives that could be easily translated into the disease state—a putatively objective scientific construct.

Besides the primary means of communication, face-to-face interaction, the healthcare practitioners put in place regular means of communication to follow up with the patients. Telephones constitute one such channel of communication. The modus operandi for all the health institutions treating PLWHA is to require two phone numbers when they arrive as new admissions. Keeping and getting two numbers means that the patient would be tracked via the primary phone number, but the second number would be used to communicate with an emergency contact who could be a significant other, parent, sibling, or a relative who knows about the patient's condition. Before placing any calls to the emergency contact and sharing any private information about the patient, the patient must grant

full and express consent for such communication to take place. When telephone communication fails, the clinicians rely on an army of community volunteers who go from door to door to check on the PLWHA who become unreachable.

As long as the patient continues to take calls or the emergency contact handles the calls, the door-to-door option is not taken. According to the clinicians, sometimes the person on the receiving end of those calls tells them to stop calling because the patient has purportedly been healed. After several attempts, the patient may come around, sometimes ineluctably, after an acute relapse of an opportunistic infection. Two issues complicate the door-to-door option: exorbitant and ever-increasing rent forcing many of the PLWHA out of city limits and rendering them inaccessible; patients feeling uncomfortable disclosing where they live for fear of stigma and discrimination. They fear that if their landlords find out, they might evict them. In finding a way around this obstacle, the doctor at the Addis Ketema Health Center said that they would resort to a spy-like tactic whereby they arrange for someone to go to the patient's apartment on the sly just to know where they are located.

As a communication strategy, the practice of secretly following an unsuspecting patient around to find out their residential address becomes ethically questionable. Buoyed up by the helplessness of the PLWHA and with the power and prestige accorded the profession, the medical practitioner cites having the patient’s best interest at heart. In essence,

however, the professional is not empowered to coerce the client into treatment regardless of the nature of prevailing circumstances at a given time. Regardless of the claim that it stems from a well-intentioned belief that has taken into consideration the patient's good, it appears to be a misguided approach to keep these vulnerable individuals under watch without their express consent. Besides being unethical, it is likely to end up complicating matters and harming the patient. In his book *The Wounded Storyteller*, Arthur Frank (2013) observes, "One of our most difficult duties as human beings is to listen to the voices of those who suffer. The voices of the ill are easy to ignore because these voices are often faltering in tone and mixed in message…listening is hard, but it is also a fundamental moral act" (p. 25).

Looking at this through the culture-centered-approach lens brings into focus most importantly the issue of agency. It is through the omission of the voice of the patient and ignoring their complaints of the discomfort of disclosing their residential address, in this case, that the clinical powers that be enact a surreptitious communication strategy that jeopardizes the patient's prospects of life and work. Stigma and discrimination directed at the patient arise from the socio-cultural setting. Nevertheless, in the medical encounter and consultations, these issues remain off-limits. Oftentimes, medical practitioners feel that addressing issues that stem from the social context fall outside of their prerogative. However, that lack of attention to the social context with such an excuse contributes to the

protraction and eventual exacerbation of the contextual problems. In this connection, my position ties in with the criticism that instead of resorting to the medicalization of such matters in most cases or bypassing them as is true with this case, the health professionals could use their clout to stem such sources of social distress. With the notion of empathetic listening which remains integral to patient-centered communication, responsiveness to patient concerns also becomes paramount.

Viewed from the social constructionist perspective, the medical encounter constitutes a platform whose participants bring different views of the same problem. Sociological and anthropological scholars have drawn an important distinction between disease and illness, referring to the former as physiopathological abnormalities and the latter as denoting the lived experience of the sufferer (Kleinman et al., 1978). According to Lupton (2012), the primary concern from the social constructionist standpoint is not so much about these two different states, but essentially the social interactions, including those that take place during the medical encounter, in the backdrop of the socio-cultural context. From this viewpoint, it could be argued that within the Ethiopian context, contrary to the widely held position within the biomedical practice that patient privacy has to be protected, the doctors' decision to employ the clandestine approach to keep a close watch on the patient may not constitute a violation. In a collectivistic cultural context, the façade of a collective identity gives the physician a considerable leeway and greater authority over the patient as

what constitutes health is situated not in the individual, but in the collective.

Health Professionals' Positions on the Dissemination of ARVs at Holy Water Sanctuaries

The antagonistic reaction against the push to disseminate HIV/AIDS medication at the Ethiopian Orthodox holy water sites in parish churches and monasteries across the country lies at the heart of this study. In the foregoing chapter, the findings generated a discussion on the positions of the clergy and laity. That discussion, however, would not be complete without the inclusion of the views of the health care professionals who interact with both the PLWHA laity and their spiritual advisers. In terms of religious affiliation, two of the five medical practitioners identified as Protestants whereas the rest indicated that they belonged to the Orthodox denomination.

None of the health practitioners espouse the idea of distributing HIV medication at holy water sanctuaries. Their unanimity in disapproving this approach is not grounded in the same interpretation per se, however. Nearly all of the practitioners provided religious justification emphasizing that such a move would amount to an encroachment thereby undoing all the gains that have been made over the years toward a treatment modality combining the spiritual and the biomedical. "It might seem innocuous if you think in terms of improving and increasing availability and access to medication, but it could have a number of unintended consequences,"

Markos, the ART nurse with fourteen years of experience, observes. One such consequence could be discrimination against people seen with medication on holy water grounds because some among the faithful at these locations consider that an act of blasphemy. Additionally, following the PLWHA to these holy water sites with a treatment they did not view favorably in the first place would end up pushing them even further away. Another clinician, the primary care general practitioner with a decade of experience working with the PLWHA, noted that this would make the patients become more suspicious causing them to think that there is an ulterior motive behind all of this.

In lieu of attempting to disseminate the medication at holy water sites, the medical practitioners put forward suggestions of approaches they believed would be less controversial. The most common recommendation has to do with setting up a dispensary or a clinical stall of sorts in the vicinity of the holy water springs rather than putting it up on ecclesiastical premises. With PLWHA not always being comfortable with revealing their HIV status primarily owing to stigma and discrimination, a caveat against this proposal is that it may not work that well as closeted patients are very unlikely to avail themselves of such a service. In this regard, Markos shared: “People come from the regions to receive their medication from a health institution here in the capital just for the sake of privacy.” Navigating the capital city without running into an acquaintance or a friend due to the sheer enormity of the city in terms of area and population size

makes it a safe haven for those hoping to escape the prying eye of the inquisitive onlooker.

In the interaction between structural and cultural elements, having been robbed of agency, PLWHA who have to resort to this clandestinity do so by traveling away from the comfort of their hometowns, often for hundreds of miles. Dutta (2008) maintains that various actors communicatively construct and circulate the rhetoric that brings into being the stigmatized identity. As a result of the omission of the patient's agency, there emerges a communication hiatus, rendering the patient voiceless and muted.

Foucauldian and social constructionist scholars who have widely researched surveillance medicine and have introduced the concept of the "community gaze", an offshoot of the Foucauldian notion of the "clinical gaze" which primarily refers to biomedicine's power and control that evolved from its focus on the individual patient to encompass those who may be at risk in the community (Larkin, 2011; Conrad, 1992; Armstrong, 1993; Armstrong, 1995). I wish to rework this notion into a somewhat different iteration in reference to the societal panopticon that scouts out those with stigmatized illnesses such as HIV/AIDS. In the biomedical realm, the physician and other clinical staff may be diagnosing and treating the putatively biological signs and symptoms of an illness, but the discursive interpellations are all grist for the mill in the social construction of illness and eventual consequences in the community gaze applied to

individual members to single out those who are deemed invalid and thus stigmatized as a result of a particular illness.

Lastly, offering a counterproposal that suggests educating the faithful and the clergy as an approach that would lead to more success was put forward by the internist and infectious diseases specialist at the Black Lion Hospital. This is not a new approach *per se* and has been put to use perhaps since the outbreak of the pandemic, but the recommendation here is to continue to do that as opposed to dispensing medication at holy water sanctuaries. In his explanation, the physician points to the lack of access to the holy water sites as they are often found in hard-to-reach localities. The notion of "hard-to-reach-ness" itself and its application in various realms including in health communication and health policy initiatives has been rather controversial. One of the most common criticisms its use prompted has to do with the general tendency to gloss over its various nuances as it could mean different things in different contexts (Mackenzie et al., 2012). In fact, in this case, the physician has indicated that the hard-to-reach entities are not the patients *per* se, but the holy water sites—the geographic locales. Since these holy water sanctuaries are located in far-flung areas by design as a metaphoric representation of the separation and detachment of the sacred from the profane, it can be said that it is structural and cultural.

At the intersection of structure and culture, the PLWHA who seek treatment at these destinations are stripped of agency. Embedded implicitly

in the idea of “hard-to-reach-ness” is the adoption of one-way communication (Lupton, 1994) in the sense that the reaching is constructed to be unidirectional whereby those who are being reached are pictured as lacking the capability to reach back. Agency, qua agency, cannot be attained in the presence of such communication inequality. From a diffusion of innovations standpoint, a lack of compatibility between the biomedical and the religio-spiritual manifested in the seclusion and inaccessibility of the latter becomes evident. In turn, this also complicates the trialability of the dispensation of the biomedical drugs at the holy water sanctuaries from all of these angles.

CHAPTER VI

CAUSAL EXPLANATIONS AND NARRATIVES

This chapter presents causal explanations and narratives that emerged in the conversations held with the clergy and the devout PLWHA. It goes without saying that the biomedical establishment operates within an explanatory model anchored in the germ theory that traces the origins of HIV/AIDS to a viral agent, and thus there was no need for the inclusion of the biomedical perspective in this discussion. As such the analysis, therefore, responds to RQ 6: What dominant causal explanations of the AIDS epidemic emerge in the health and illness narratives?

Illness narratives and explanatory accounts that do not dovetail neatly with the physician's etiological theory anchored in pathophysiological morbidity usually get thrust aside in the biomedical realm though they make up a crucial part of the patient's illness experience. Kleinman (2020), who is a physician by training himself, remarks how in medical training would-be doctors are taught to discount the patient's illness narratives and explanatory accounts. In the clinical encounter and the communication that occurs therein, the explanatory models (EMs) of patients and practitioners interact, and when they are markedly disparate, affect treatment choices. An extension of the patient's illness meaning, the quest for an explanatory model is an essential part of the hermeneutic journey. Illness brings about disruptions in the life of the patient. These disruptions and dislocations set off a chain of ontological

questions as to what caused the illness, why the patient, why now, and so on and so forth.

Regrettably, the foregoing questions do not get entertained within the biomedical realm as they fail to make the grade within the framework of the germ theory—its most basic EM. With this void, the afflicted continue the quest to find answers to those deeply existential questions elsewhere. For the PLWHA faithful in the Ethiopian Orthodox Church that "elsewhere" happens to be in the ecclesiastical realm. In this hermeneutic and ontological trajectory, the pondering of these existential issues in the backdrop of religious and spiritual explanatory framework leads perforce to the treatment choice that is consistent with it. As Shyu et al. (2010) maintain, the explanatory models people subscribe to determine the solutions and treatments they seek or recommend to those struck with the malady around them.

However, that does not mean that there exists a direct correlation between the belief in the typifying constructs of causality and the treatment modality sought. Additionally, the capricious nature of chronic illness and the meanings it takes on throughout the illness career of the chronically ill continues to shape the explanatory accounts. The sufferers could give up on this treatment or that or decide to combine various forms of remedies as they journey through the sickness. Consequently, the illness experience comes to be punctuated by interludes of recuperation and decline. Such capriciousness is not always explainable. The lack of explanation

notwithstanding, this enigmatic nature of the illness itself takes on considerable significance for the patient. Kleinman (2020) aptly observes, “Physiological aspects of chronic illness shape explanatory models and the meanings they encapsulate” (p. 68).

Not only do the illness narratives and explanatory accounts of causation and cure evolve with the vagaries of the illness, but out of the interaction and interpenetration among various competing EMs, emerges a hybrid model. Constructed from conflicting sources at times, such as the biomedical and the religious, this lay model does not constitute or substitute reality *per se*. It does, however, create order out of the chaotic chronic course of illness. Reflective of the individuals’ health beliefs, the explanatory accounts of the holy-water-treated PLWHA and those of their spiritual fathers need to be studied to determine the possibility of reaching an integrative locus between the two treatment modalities.

With this orientation, thus, we will focus in this chapter on the ways illness narratives and causal accounts of illness emerge in the discursive constructions of the PLWHA laity and the clergy in charge of the ecclesiastical premises where the former avail themselves of the spiritual therapy. In other words, we shall examine the ontological and hermeneutic basis that underlie the stories through which the PLWHA laity account for their illness experience in juxtaposition to clergy etiological beliefs. In so doing, my goal is not to come up with some inflexible EMs as such or to

generalize that the clergy or the laity will always subscribe to this or that explanatory format.

As the patients oscillate between the biomedical and the ecclesiastical, their encounters in both of these realms with powerful agents in the person of the physician in the former and the clergy in the latter lead them to a state where they experience an inability to choose between or reconcile the spiritual and biomedical treatments. By drawing on dialogical engagements carried out with both clergy and PLWHA laity, I wish to bring to light lay accounts of illness causation—as opposed to those that draw on biomedical expertise—situating them in the ecclesiastical encounter vis-à-vis the biomedical encounter.

Clergy Causal Explanations

Depending on the relationship and the amount of power wielded by the recommender, the recommendation could constitute a prescription or even a commandment. Some might argue against the latter suggestion, but the clergymen in the Ethiopian Orthodox Church are viewed as divine beings: monks more so than priests. Observing this status of the clergymen, Kaplan (1984) writes:

> By living an 'angelic life', the holy men became like angels, divine Messengers believed to be capable of both conveying and influencing divine will…Such a mediatory role was of tremendous importance in Ethiopia where a pious Christian was primarily concerned with gaining the favor of

> an immediate figure such as an angel, Mary, or a holy man, rather than appealing to a remote and unreachable God (p. 82).

In my conversations with the clergymen, divine commination was frequently cited as the cause for HIV/AIDS. The antidote for that divine retribution becomes realized by divine will in the performative ritual of holy water aspersion on sacred ecclesiastic grounds presided over by a priest or through private consumption if one chooses to fetch the holy potion in a receptacle. Explaining the causes of HIV/AIDS, Abba Hailegiorgis, chief catechist and preacher at Shinkuru St. Michael's, a popular destination for the faithful who are afflicted by the illness, said, "Firstly, it is caused by fornication. Our church teaches people to not commit fornication. The Apostle Paul in his Epistle to Corinthians discusses this subject in considerable detail."

Abba Hailegiorgis then gets into the specifics of the verse and concludes with the assertion that not heeding against the dangers of adultery and fornication and violating teachings of the apostle that to avoid the perils of fornication every man and woman should be married amounts to a cardinal transgression. And, according to Abba Hailegiorgis, this transgression constitutes the primary means for the transmission of HIV/AIDS. This does not, however, mean that he does not recognize that there exist other modes of transmission. Of secondary importance, in Abba's view, are things like sharp objects that when shared could expose

one to contracting the illness. This perspective must have been picked up from the biomedical explanatory model that situates causality in blood-borne viral transfer.

Whereas Abba Hailegiorgis' characterization appears to be rather subtle and allusive, Abba Enkuselassie, a hierarch at Shegolé Kidane Mehret, puts it more bluntly:

> Now if, according to the word of God, a man remains faithful to the woman he's married to and vice versa, there is absolutely no way that they can contract this malady. Sinning against God in that sense is the only way people can get it, which means this mortal sin draws the wrath of God. That's what our church teaches, and that is what I believe the cause of the malady is.

Unlike Abba Hailegiorgis before him, Abba Enkuselassie stops short of even acknowledging that there are other ways people could contract the disease. As the quote above indicates, he does not just believe that "sinning against God" by way of engaging in extramarital sex constitutes the primary means through which the disease spreads, but the sole mode of transmission. Another clergyman, Abba Enkuselassie's colleague and subordinate at the same parish church, Abba Teklemariam states:

> HIV/AIDS is caused when people go against the word of God that orders each man to stick with one woman and each woman with one man only and commit fornication. It is a

> punishment meted out to those who don't follow God's commandments. Another thing that might contribute as a rather marginal secondary cause is exchanging needles and sharp objects. The primary cause, however, is sexual intercourse or fornication.

In contrast to his superior, Abba Teklemariam makes a distinction between fornication—which he also calls the primary cause as does Abba Enkuselassie—and exchanging needles and other sharp objects which he believes plays second fiddle to sexual intercourse. Discursively important to note is also how Abba Teklemariam uses the more neutral parlance "sexual intercourse" vis-à-vis the more nuanced term: "fornication." Neither the hierarch of his parish church Abba Enkuselassie nor the chief catechist and preacher at Shinkuru St. Michael's, one of the most popular destinations for the devout PLWHA, if not the most, in the country, Abba Hailegiorgis, engage in this seemingly simple act of semiosis.

Interestingly, the top hierarch at the parish church and Abba Hailegiorgis' superior Abba Brook employs the most neutral language in his explanation of the causes: HIV/AIDS is primarily transmitted through sexual intercourse and sharing sharp objects. Besides avoiding the condemnatory language, Abba Brook does not seem to distinguish between primary and secondary modes of transmission. In fact, as various studies have shown, heterosexual sex remains the principal means for the transmission of the disease in the sub-Saharan Africa region (Kharsany &

Karim, 2016; Hunter, 1993; Bastien et al., 2011). Like Abba Brook, Abba Gebremichael, a clergyman who presides over holy water aspersions at Entoto Maryam, a parish church where all the controversy over the dissemination of AIDS drugs at holy water springs began, does not apply the sinning-against-God frame in his causal explanation.

As a matter of fact, Abba Gebremichael says he finds the cause of the disease puzzling and hard to pin down. “I have come across cases where within the same family the mother has the virus along with one of the kids, and then the father and the other kid are free from the virus. How do you explain that?” In Abba Gebremichael’s view, the punishment-for-sin explanation is not convincing because he believes that people today commit rather venial sins compared to older generations. Rather, he believes some sort of evil spirits that possess people cause the disease. In the same vein, Abba Hailegiorgis also offered a similar causal explanation: “In our church, we believe that all illnesses be it HIV/AIDS, flu, gastritis, cancer, etc. are manifestations of the evil one: Satan. These are all ways in which Satan manifests himself. None other than Satan causes illnesses.” In a study they had conducted in Tanzania on faith leaders’ attitudes toward treatment options, Roura et al. (2010) found that several faith leaders believed that the syndrome is caused by evil spirits which can be exorcized.

In general, it would be fair to argue that the use of the more lenient term that is devoid of a condemnatory undertone in reference to patients

would have a constructive contribution toward shaping and building an exculpatory discourse on PLWHA. In this connection, Susan Sontag (2013), for example, posits that vilification of a patient follows the perception of the illness itself as particularly malevolent and implacable in nature. Not only do such representations have implications for treatment choice in the sense that it would mean once labeled "adulterer", "fornicator" and thus "sinful", one should seek cure primarily in the divine and ecclesiastical realm through the confession of sins and utilizing the sacred treatment offered by the church. Moreover, in portraying the sick as particularly "sinful" who committed unforgivable turpitudes deserving of punishment in the here and now, the clergymen assign these individuals to a condemned category. This would also in turn expose them to stigma and discrimination both in the church and outside. Many of the PLWHA faithful indicated that stigma and discrimination remain widespread.

In *Health Communication and Faith Communities*, Derose and Kanouse (2011) argue that such frames were commonplace earlier on during the course of the pandemic as faith leaders across the world put an altogether literal interpretation on the matter. Generally speaking, this may be true, but the fact that these spiritual leaders still look at the illness through the wrath-of-God or punishment-for-sin frame indicates that such a conclusion could not be drawn in this case. To reiterate, the application of the wrath-of-God frame in the causal explanation of the clergy points to structural conditions that deny the devout PLWHA of human agency

(Dutta, 2008). Such an appellation also constrains the sick to primarily seek spiritual remedies, primarily in the form of holy water.

Due to communication inequality that emanates from the power asymmetry in the ecclesiastical encounter, the devout AIDS sufferers are in no position to express their disagreement or contest this interpellation ascribed to them by the figures that are believed to speak on behalf of God. In this regard, it could be argued that the PLWHA are accorded better communicative space and power in the biomedical encounter than they are in the ecclesiastical encounter in relative terms. The PLWHA live on the margins of society as chronically ill persons (Kleinman, 2020; Dutta, 2008), and any health communication efforts that aim at improving their therapeutic outcomes need to take into consideration the communicative aspects of their marginalization as well. Cogently summing up a scenario where health campaigns forge ahead without taking stock of these issues, Dutta (2008) observes, "their voices typically remain unheard, as experts at the center continue to plan and implement interventions targeted at them" (p.64).

Laity Causal Explanations and Narratives

The onset of chronic illness such as HIV/AIDS brings with it a growing sense of precarity of the health of the afflicted person due to unrelenting pathological mechanisms that underpin it. Causal explanations occur as the chronically ill scrambles for meaning and set out on an arduous hermeneutic journey without a clear and definite road map.

Following an illness episode, a natural sequel occurs as the patient sets off on a quest to trace the pathological event to a source that caused the ill health. Figuring out the causality is just one part of an EM though perhaps the most important one. Points at issue range from questions pertaining to—besides pondering the causality—the would-be trajectory of the illness, treatments the patient opts for, or those that get recommended to the sick individual by those around them, etc. Having discussed the most prominent causal explanations of HIV/AIDS put forward by the clergy in the foregoing section, let us now turn to the causal explanations and narratives that emerged in interlocutions with the devout PLWHA.

Substance Abuse, Unsafe Sex, and Promiscuity

When asked to name what they consider to be the primary cause of their illness, the PLWHA pointed to an assortment of causal agents in their explanatory accounts. Sometimes their narratives feature a sequence of events with one thing leading to the other, with the latest occurrence or condition reckoned to be the immediate cause. Such a pattern is particularly observable in causal narratives of the PLWHA that locate causality in the nexus between substance abuse and engaging in unprotected sex with multiple partners. In her explanatory causal narrative, that is what Aberash, the forty-five-year-old caregiver who moved from Dire Dawa, the country's second-largest city, to the capital foregrounds.

> Where I lived in Dire Dawa it's customary to chew Khat. Anyone who doesn't do that is looked down upon as some kind of rube. Chewing Khat is usually followed by a binge-drinking bout. I was with this guy after we had parted ways with the father of my child. At the time, HIV/AIDS was not something that many people talked about. So, my knowledge about it was really limited. We would have unprotected sex. I had absolute trust in him even though I would hear rumors about him sleeping around. I thought there was no truth in the rumor. I naively thought he was in love with me and would never sleep with other women. Some people even told me that he had married a prostitute and divorced her after they had a child together and that he could give me an STD. I didn't even exactly know what that meant. It was too late when I found out that he had been sleeping around the whole time. So, I'm pretty positive that I got it from him.

In the above excerpt, Aberash draws causal links between chewing chat, binge-drinking, and sexuality without moral stricture. She alludes to having gone through a divorce, but without a doubt imputes contracting the virus to the post-divorce stage of her life. Interestingly, she does not look back beyond her post-divorce sexual relationship. In fact, research has shown that divorce makes women more vulnerable compared to men

(Larkin, 2011). Poverty and economic insecurity usually impel women to engage in quid pro quo sexual relations as they take on this brunt of hardship onto their shoulders. Filled with remorse at her gullibility and general lack of awareness of STDs, not just HIV/AIDS at the time, Aberash revisits that chapter of her life. Albrecht et al. (2003) maintain that causality eventually boils down to two components, namely temporality, and determination. A social causation of illness, divorce as a social phenomenon does not often get recognized as a factor for women's vulnerability to ill health in neither the biomedical nor the ecclesiastical realms. It could be argued here that this omission has led the respondent to settle on events that occurred after the divorce in terms of temporality. In other words, it has not been stressed enough to make into the patient's narrative schema regardless of constituting an important nodal point in the genesis of the illness. Critics of the dominant biomedical approach to health have pointed out time and again that it engages in the systematic omission of the social and cultural context that undergirds the health and illness conditions of the patient (Airhihenbuwa, 2007; Lupton, 1995; Dutta-Bergman, 2004).

Another participant relates her account of how she contracted the virus and positions her causal explanation in the context of a familial discord resulting from unfulfilled filial expectations and its unfortunate aftermath. Zenebech, the thirty-two-year-old hairstylist, recalls with an elaborate

flashback the moment when she disclosed to her parents and siblings that she had flunked her tenth-grade national exam.

> My parents called me different names. I decided it would be best for me to be independent of them. So, I ran away from home. I came to the capital and started working as a prostitute in a hotel. It was while working as a prostitute in that hotel that I contracted this illness. As a young girl, I didn't think much about the consequences of my actions.

Dubbed the oldest profession in popular parlance, rather euphemistically, prostitution has always been viewed as a risky, disease-ridden line of work. It is primarily entered into by women and girls like Zenebech above mostly as a last resort to eke out a living. While these women and girls understand that they run the risk of contracting HIV/AIDS by being involved in prostitution, health promotion efforts targeting them have not had much success as they reportedly do not heed the messaging. In her book entitled *African Women's Unique Vulnerabilities to HIV/AIDS*, Linda Fuller (2015) writes, "For street kids, sex has many meanings—money, comfort, status—and even where they know about AIDS they commonly disregard its message" (p. 71). In the excerpt above, all the three attributes emerge in Zenebech's explanatory account. Running away from home means that she does not need to depend on her parents anymore—independence means a change in status. And, of course, the comfort associated with sex goes without saying, which gets performed in

exchange for money. A teenage schoolgirl, disappointed because she did badly in an ultimately decisive exam, was not able to find that comfort when she returned from school with that terrible news. The fact that she did not come home to a consoling family environment constitutes a turning point. It is thus important to not overlook the social contexts of illness and scrutinize causalities down to the familial level, the basic unit of society.

In discursive constructions of medical knowledge, prostitutes, who are predominantly women and girls in every society, are portrayed as conduits of sexually transmitted diseases in the backdrop of moralistic discourse. Such social constructions and interpellations leave out the sociocultural context within which sexual practices and behaviors are enacted. Dutta (2008), for instance, observes that health promotion campaigns promoting safe sex and condom use decontextualize the problem "when condom use is singularly promoted without regard for elements of the structural context" (p. 53). Etiological illness narratives, therefore, bring to light these otherwise overlooked structural conditions that engender social vulnerabilities.

Sexual promiscuity, a notion often conflated with prostitution, also emerged in the causal narratives of the PLWHA. Characterized by indiscriminate sexual encounters, this is what the clergy designate as fornication in their representations of causality. Rhetorically, both terms have discriminatory and condemnatory undertones. In the Ethiopian context, in the discourse on sexuality and relationships, one may come

across instances where the two are used interchangeably. A notoriously promiscuous person could be referred to as a prostitute. Since the utterance of these words inherently constitutes a moral judgment, the person so labeled could face social consequences, including stigma and discrimination. Still, fornication carries a much more pungent connotation and tends to be applied more often in religious contexts as opposed to secular settings. Interestingly, however, □□□ /*zimut*/, the Amharic word, which is used as an equivalent for fornication, covers a much wider ground, semantically speaking, referring to all forms of sexual immorality, including adultery.

In the final analysis, when the clergy employ this word in their causal explanations, they do so from a frame of reference that encompasses a whole gamut of practices considered acts of sexual immorality, including promiscuity and prostitution. Nonetheless, the PLWHA laity does not make use of the term in its explanatory account. As a result of the ecclesiastical explanatory locus of blame and divine punishment, the devout PLWHA are bound to be seeking a cure in the spiritual realm.

Trails of Structural Violence

Structural violence as a theory was initially propounded by the Norwegian sociologist Johan Galtung in the 1960s but was later widely popularized by the American physician and medical anthropologist Paul Farmer (Galtung, 1969; Farmer, 2010). In his book *Pathologies of Power,* Farmer meticulously pieces together anthropological accounts of how tacit

and overt workings of social, economic, political, cultural, etc. nature negatively impact the health experiences of those who live on the margins of society in Haiti, thereby exposing them to all sorts of illnesses, death, and violence. Through these thorough biographical sketches of the victims of structural violence, he illustrates how a panoply of social forces and processes work together and rob the subaltern of agency.

During my interlocutory engagements with the devout PLWHA, some of their explanatory narratives point to instances of structural violence. When asked what she considered to be the primary cause of her illness, Chuchu, for instance, offered the following rationalization.

> I think the primary cause is the murder of my father. My father was a geologist who was with the Ministry of Mines during the military regime. He was well educated, and a very respectable man. He was also the chairman of our county at the time. His only crime was that he spoke up and mobilized the community against the extrajudicial killings of many young men and women by the government where we lived. I was just a little girl, but I remember times when he would just walk out into the streets, with only a t-shirt on, and holler. When the powers that be killed my dad, my mom was pregnant with the ninth child. They didn't even let us take his body. My mom was denied her right to claim my dad's annuity payments. They didn't even let us mourn

> his death. We went through a lot. My mom suffered a great deal raising nine kids on her own. When I got to my teenage years, I wanted to keep up with the fashion of the time and dress up like my agemates. My mom couldn't afford that. I would therefore sleep around with a lot of men for some sort of quid pro quos.

In her elucidation, HIV, as the commonly known etiologic agent for AIDS does not appear to be foregrounded. Instead, Chuchu puts down her current predicament to the havoc wrought by the country's military regime, commonly referred to as the Derg. Upon overthrowing the imperial government of Haileselassie in 1974, the military junta promised to represent the marginalized subaltern populations of the country. This façade of emancipation and egalitarianism did not last long as its true colors showed soon and it resorted to violence to suppress any and all forms of dissent. As Girma succinctly sums up the spirit of the time, "Its dictatorial stance coupled with the infamous Red Terror painted the Dergue as a monster that consumes anyone and everyone who comes in its way" (Girma, 2016, p. 158).

It was in this spate of violence unleashed on the populace by the hegemonic military elites that Chuchu became fatherless. Not only was she robbed of a father, but her entire family was traumatized for the authorities went as far as denying them the right to give the family's paterfamilias a decent burial and a period of mourning his violent demise. Worse yet, her

widowed mother was left without the necessary means to raise Chuchu and her eight siblings after the family was bereaved of their breadwinner. Caught in the resultant destitution and poverty trap, the teenage Chuchu begins to offer sexual favors to meet her needs and consequently gets infected with the virus. It is within this socio-political nexus that she positions the etiological events leading to her present health condition.

Within the patriarchal structure and hegemonic constructions of normative male sexual comportment, women's experiences become gendered. Social inequalities so created in turn engender differences in the level of risk of infection. Even in the presence of condoms, women's financial disadvantage and intimate partner violence get in the way of women's ability to practice safe sex. Masculine promiscuity is widely tolerated and perceived to be reflective of male virility and sexual prowess whereas girls are expected to remain *virgo intacta* before marriage, and entirely faithful to their husbands once married. This particularly emerges in the causal explanations of Mamité, the forty-year-old housewife, as she also attempts to establish the primary cause of her illness.

> My primary suspect would be my husband because I knew he slept around. I would hear rumors that he had a mistress, but because I didn't want to cause trouble in my marriage, I never confronted him about it. Therefore, I chose not to listen to what was being said in the neighborhood

> rumor mill. I was of the belief that it was okay and more befitting when men slept around than when women did.

As Toombs (1993) succinctly sums up, "…causal explanations are a direct reflection of a particular lifeworld" (p. 104). Sociocultural constructions of masculinity in Mamité's lifeworld have provided the script for her perception of what it means to have an extramarital affair as a man vis-à-vis as a woman. It, thus, constitutes a tacit, and less conspicuous form of structural violence that constrains women's health, thereby increasing their vulnerability to deadly diseases such as HIV/AIDS. Their subaltern position within these structural circumstances that portray men's promiscuity as permissible takes place at the intersection of culture, structure, and agency. The complex interplay between the dynamics of culture and structure, thus, by overemphasizing uxorial faithfulness and timidity even as she is cognizant of risky spousal behavior, constrains her agency.

In this connection, Farmer also remarks that 'the distribution of AIDS is strikingly localized and non-random; so is that of human rights abuses. Both HIV transmission and human rights abuses are social processes and are embedded, most often, in the inegalitarian social structures, which I have called structural violence," (Framer, 2010, p. 230). Farmer and his colleagues also underscore in a 2006 study that interventions that aim at enhancing the agency of the poor would dramatically cut down their risk of exposure to HIV infection, a position I also concur with.

Furthermore, my observations are in no way a contribution toward the traditional depiction of Third World women in international health communication as a wretched collective waiting to be emancipated by being subjects of intervention. Nor is this a denial that issues of such nature do not exist. Important to note here is the fact that structural and cultural transformations occur everywhere, albeit slowly, and that interventions ought to scrutinize structural causes of illness instead of desocializing them to deflect responsibility onto the victimized individuals themselves. This constitutes another layer of structural violence: violence by omission (Farmer et al., 2006).

Most of all, the cursory scrutiny of the causal explanations and narratives has revealed the existence of a marked discrepancy between the clergy and the laity. Causal explanations and explanatory models make up an integral part of the illness experience. While patient understandings and beliefs of what caused their illness primarily comprise the biomedical model of retroviral transmission and social determinants of health, the clergy largely put it down to fornication and adultery. It could be argued that both refer to essentially the same state of play in referencing transmission through sexual intercourse, but I would argue otherwise. At the rhetorical level, fornication and adultery carry a condemnatory overtone. Not only that, but it also predetermines the treatment modality for the illness so acquired that the sick person has to undergo.

Concluding Thoughts

Explorations of the health and illness narratives of the faithful PLWHA in the Ethiopian Orthodox Church as well as dialogic engagements with the clergy and healthcare providers who are in charge of the spiritual and biomedical realms the PLWHA traverse, respectively, uncovered a panoply of health and illness meanings. Understanding these health and illness meanings, in turn, leads to getting a clearer picture of their construal of explanatory models, the illness trajectory as well as treatment preferences. Illness can be construed as a locus of communication through which nature in the form of pathogens, society, and culture simultaneously articulate various formulations. The natural has, since the advent of modern medicine, fallen under the purview of the biomedical whereby the healthcare practitioner primarily in the person of the doctor, as the leading authority in the detection of disease and determination of its eventual course of treatment, plays a redemptive role.

Occurring at the nexus between the patient, the health practitioner, and socio-cultural institutions, illness is also a cultural phenomenon. Religious establishments are one group of such sociocultural institutions with far-reaching impacts on all aspects of the faithful's life, including in the area of health, illness, and curing. Orthodox Christianity has been a dominant influence in the Ethiopian socio-cultural landscape for millennia since its official establishment in the 4th century A.D. Its followers were

found to be the most devout of any Orthodox Christian population in the world in one Pew Research Center study (Diamant, 2020).

Modern medicine was formally introduced into Ethiopia only during the latter half of the 19th century. Even after the introduction of Westernized medicine, the Orthodox Church has maintained a central place in offering its followers who are ill a spiritual solace primarily in the form of holy water treatment. The holy regimen promises cure even when the biomedical treatment does not. Consequently, the religio-spiritual treatment vies with the biomedical so much so that it diminishes the latter in the eyes of the faithful who seek remedy for their illnesses in the sacred springs due to the putatively superior redemptive power it purports to wield. For both the clergy and laity, even when approving of receiving both treatments in combination, the biomedical seems to play second fiddle.

Posing as a custodian of tradition and custom, the church has so far maintained some distance away from modernity such as manifest in its avoidance of the use of modern hymnal instruments. The rejection of modern medicine could be said to be yet another expression of the Church's relationship with modernity. Notwithstanding such a rejectionist stance, a marked shift toward the adoption of the biomedical therapy was readily discernible from the health and illness narratives articulated by the participants. Within the ecclesiastical realm, no disease falls into the status of chronicity. It is simply antithetical. Thus, not only the palliative

pharmaceutics but also the nosological frame of reference utilized by the two systems prove incompatible.

In particular, the clergy do not embrace the biomedical designation of incurability for HIV/AIDS much more vehemently than the laity. The antiretroviral medication as a public health innovation, therefore, does not appear to make the grade in the divine domain from the diffusion of innovations standpoint. Appraised on the basis of innovation attributes, namely, relative advantage, compatibility, complexity, trialability, and observability, it falls short. Of these attributes, relative advantage, compatibility, and complexity have been found to facilitate the adoption of a given innovation (Tornatzky & Klein, 1982).

Specifically, the first two have been indicated to determine whether an innovation gets adopted while complexity was identified as the most prominent deterrent of the process. In view of this observation, besides being viewed as a profane presence in the divine sphere, the medication neither possesses a relative advantage over the holy water treatment nor is it compatible with it in order to be used as a combined treatment. In other words, the holy water treatment is believed to bring about a complete cure whereas the medication simply alleviates symptoms. With this perceived advantage, one would expect that the devout PLWHA would exhibit a proclivity toward primarily utilizing spiritual therapy. While this is still true, it would also be fair to conclude, at least tentatively, that a shift toward combining the two treatments is evident.

In the local health cosmology, constructions of health and illness, as expressed through the health and illness narratives of the cultural participants, show to-ings and fro-ings between the biomedical and the spiritual treatments. The social construction of the holy water treatment as a panacea in the spiritual realm anchors the faithful in this ecclesiastical territory, especially when the medical condition for which a cure is being sought is chronic. Social construction is essentially a political process with structural and cultural elements embedded in it. The followers of the Ethiopian Orthodox faith constitute a culture, in this case. As Dutta (2008) observes, "Culture is conceptualized in terms of a space that brings individuals into a community" (p. 80). The beliefs and dogmatic practices of the Church are enacted, and structural processes acted out within this very space. Put differently, the holy water springs located throughout the ecclesiastical spaces of parishes and monasteries serve as symbols representing the creed.

At the intersection between structure and culture, the devout PLWHA are stripped of agency more so in the ecclesiastical realm than in the biomedical. Due to the sacred nature of the former, resistance remains beyond the bounds of possibility particularly due to the fear of blasphemy. For instance, the kind of outright rejection of prescription medication put up by one of the patients during a doctor-patient encounter could never occur in the divine realm.

In addition to religious institutions, the media also play a key role in mediating social and cultural experiences, including health and illness. More often than not, the mainstream media are accused of thriving on the coattails of the biomedical contributing to the erasure of marginalized, subaltern voices. Much of what makes into the media draws on the biomedical model, with most other ways of dealing with health and illness either absent or juxtaposed as “superstitious” and “unscientific”. One interesting finding in this study is the ways in which the media present drastically differently the holy water treatment on the basis of the locale of reporting. Reporting from the autochthonous provenance back in Ethiopia takes on a much more deprecatory tenor as opposed to one done from the United States. In the case of the former, an apparent intention of setting up the stage for and legitimizing a possible neoliberal health intervention could be readily deciphered. In other words, it is by the virtue of its location in the Global South that the holy water treatment becomes the target of global health intervention. Dutta (2016) writes, “Experiences of health are closely intertwined with the organizing of economics and politics: locally, nationally, and globally” (p.18). Media frames used by PEPFAR implementing partners, thus, locate “hope” and “success” in the backdrop of PEPFAR-backed biomedical intervention juxtaposed against the “despondency-ridden” nature of the spiritual therapy.

Such discursive constructions of the West and the rest are employed in the domain of global health overtures almost exclusively targeting the

postcolonial economic periphery of the Third World to create “points of dominance” (Dutta, 2008, p.11). In Foucauldian terms, these rhetorical interpellations of subaltern communities and cultures accomplishes postcolonial governmentality. In their postcolonial appraisal of PEPFAR’s policy articulations, Sastry and Dutta (2012) deconstruct the discursive constructions of the Third World spaces in terms of backwardness, spaces for the enactment of American altruism through the delivery of ARVs as modern biomedical technologies in an attempt to save the primitive Other. These depictions commonly appeared in the media coverages. Furthermore, the omission of the local healing system and the suppression of the grievances of the chronically ill about psychosomatic impairments wrought by the biomedical drug were also evident.

By and large, exploring the health and illness meanings through the narratives of the cultural participants helps to understand how the socio-cultural context shapes and influences the meanings of health and illness. It is on the basis of these culturally and socially germane constructions of health and illness that cultural members act and make their treatment decisions. Exploring and highlighting these meanings and centering the voices of the cultural members chips away at existing communication inequalities and subalternity of cultures in the Global South in general and of African cultures in particular, bringing them to the mainstream health communication discursive realm which is currently dominated primarily by the dominant biomedical approach.

Respect for local cultural practices and modus vivendi, especially when they are considered sacred goes a long way in conducting successful health interventions. Culturally sensitive and linguistically appropriate messaging is also paramount. Besides the symbolic violence perpetrated against the holy water treatment in discursive constructions that denoted the spiritual treatment as "superstitious" in the aforementioned media depictions, the introduction of the biomedical treatment into ecclesiastical sphere was also seen as an insensitive move. A substantial majority of participants from the clergy, laity, as well as healthcare practitioners, did not approve of such an overture.

On the sacred premises, the presence of the biomedical gets perceived as defilement. In her book *Purity and Danger,* Douglas (2015, p. 49) writes, "Religion has always been bedeviled by medical materialism." In addition to being perceived as a profane presence in the divine sphere, the claims of putative superiority to the spiritual treatment, even as it serves a palliative purpose, remains at odds with the curative status of the holy water as well as the designation of HIV/AIDS as a non-chronic condition. The belief that the twain shall never mix abounds in the health and illness narratives of the devout PLWHA as well as in those of their spiritual fathers.

Dogmatic proscriptions of the Ethiopian Orthodox Church dictate that holy water and the medication be ingested separately. During conversations with the clergy, they noted that the sacred treatment can be

“taken together with the ARVs but separately”, which means that the two should be administered “unconnectedly”. When making treatment decisions, the laity consults with the clergy as to which treatment option they should take up. As they do, they heed the recommendations and prescriptions they receive from the *Abba* more than those of the physician. The health professionals themselves admitted to deferring to the *Abba* on matters pertaining to treatment decisions.

One of the controversial pronouncements made by the late Patriarch of the church Abune Paulos in 2007 during a PEPFAR-led campaign effort was that the devout PLWHA can swallow the ARVs with the holy water. None of the clergy who participated in this study espoused this position. In fact, the late archbishop has been accused of having been co-opted by the American agency, betraying the Church’s principles. Generally, there is a conspicuous lack of consensus on this matter, especially in the lower echelons of the church. PEPFAR’s use of co-optation and discursive obfuscation of donor-recipient relationship in a way that portrays it as if it were a democratic alliance between equals devoid of power and control appears to be a widely utilized strategy (Sastry & Dutta, 2012). While PEPFAR-Ethiopia prides itself on having increased treatment coverage in the country (PEPFAR, 2021), the controversy remains. By and large, a cultural sensitivity approach, and not co-optation and obfuscation would lead to more success in this regard.

In the final analysis, clergy causal explanations situate HIV/AIDS in the realm of the divine, mainly putting it down to the wrath of God. Given the power these spiritual figures wield, and the amount of sway they have over treatment decisions of the devout PLWHA, it would be beneficial to work more closely with them. Adopting a polymorphic approach, an approach that recognizes the existence of varied systems of healing and allows the sick to seek an assortment of treatment modalities consistent with the individual's worldview and availability of resources would be apt in addressing the prevailing sticking points between the two healing systems. Since the presence of the biomedical in the ecclesiastical realm was not well received, a reverse overture whereby health establishments let the clergy assume chaplaincy can be envisaged. In this connection, it would be useful for the physician to conduct both medical and faith anamnesis upon admittance of the patient.

Notwithstanding the foregoing recommendations, from the culture-centered perspective, health and illness narratives of the PLWHA faithful point to structural and cultural conditions within and outside of the ecclesiastical realm that pose constraints to their agency. Discursive constructions of the etiology of the illness that position it within the frame of God's wrath or deserved retribution for sin relegates them to the status of subaltern subjectivity and marginalization. Owing to this position of subalternity, the PLWHA faithful are also communicatively subdued as they

can in no way dispute the interpellations accorded them in the ecclesiastical encounter.

As chronically ill individuals suffering from a stigmatized condition, they are already on the margins of the society. Co-constructions of health and illness meanings through the CCA, by centering the voices of the PLWHA faithful within the Ethiopian Orthodox Church, a community that exists on the peripheries of the mainstream society, helps offset the existent communicative inequality. In addition, it opens up entry points for social change by creating opportunities for discursive disruptions of the status quo that are embedded in local social and cultural norms and mores, often undergirded by hegemonic structures which in turn lead to changes in health-related policy decisions.

Limitations and Considerations for Future Research

Taking into account the overall trajectory of this study, I would be remiss if I did not reflect on the main limitations I experienced at various junctures while undertaking the project. Given the stigmatizing nature of the health condition, accessing the PLWHA and getting them to share their story was an enormous challenge. Had I not utilized snowball sampling, it would have been impossible to obtain any participants. One downside to this is that due to participants being members of a close-knit network of individuals, the sample becomes a somehow biased subset of the total population.

Time and financial resources were also limited. In terms of coverage, parish churches and monasteries in the capital Addis Ababa and its environs were included, but if the said resources were not so severely insufficient, more faraway locations in the regions could be incorporated. In effect, the analysis is limited to this geographic location and findings cannot be extrapolated into generalizations. Future research endeavors could delve into this issue at such far-flung localities as this element of geography could result in an interesting hermeneutic nuance.

Though PEPFAR-sponsored media messages were analyzed, the voice of the agency through its representatives was not included. The study could have benefited from that addition. As one of the most powerful players in the area of HIV/AIDS prevention and treatment globally, PEPFAR brings its influence to bear in this domain.

However, anchored in the culture-centered approach to health communication, the focus of this project was more on the subaltern target: the cultural community on the receiving end of its global health communication interventions, with an inflection point that came when the introduction of biomedical drugs into sacred, ecclesiastical spaces was rejected and deemed defilement of the divine by the profane.

APPENDICES

APPENDIX-A ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome

AP: The Associated Press

ART: Antiretroviral Treatment

ARVs: Antiretrovirals

CCA: Culture-centered Approach

CDC: Centers for Disease Control and Prevention

EM: EXplanatory Model

EOTC-DICAC= Ethiopian Orthodox Tewahedo Church-Development and Inter-Church Aid Commission

HIV: Human Immunovirus

MINI: McGill Illness Narrative Interview

PEPFAR: The U.S. President's Emergency Plan for AIDS Relief

PLWHA: People/Person Living with HIV/AIDS

UC: University of California

UNAIDS: The Joint United Nations Program on HIV/AIDS

APPENDIX-B INTERVIEW GUIDE FOR PATIENTS

Interview #______________

Date_______/_____/_______

Welcome and thank you for your participation today. My name is Gubae Beyene and I am a doctoral student at the University of Oregon conducting research for my dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Communication and Media Studies. The interview will take about 30 to 60 minutes and will include 8 questions regarding your experiences. I would like your permission to tape-record this interview, so I may accurately document the information you convey. If at any time during the interview you wish to discontinue the use of the recorder or the interview itself, please feel free to let me know. All of your responses are confidential. Your responses will remain confidential. The purpose of this study is to increase our understanding of HIV/AIDS patients' treatment preferences.

At this time I would like to remind you of your written consent to participate in this study. I am the responsible investigator, specifying your participation in the research project: Exploring Attitudes and Beliefs about Antiretroviral Drugs and Christian Holy Water in Ethiopia. You and I have both signed and dated each copy, certifying that we agree to continue this interview. You will receive one copy and I will keep the other, separate from your reported responses. Thank you.

Your participation in this interview is completely voluntary. If at any time you need to stop, take a break, please let me know. You may also withdraw your participation at any time without consequences. Do you have any questions or concerns before we begin? Then with your permission, we will begin the interview.

Demographic Information

Age_________________

Sex_________________

Religious affiliation______________

Professional Background____________________

Section 1. INITIAL ILLNESS NARRATIVE

1. According to you, what does it mean to be healthy? What does it mean to be ill?
2. When did you experience your health problem or difficulties (HP) for

the first time? [Substitute respondent's terms for 'HP' in this and subsequent questions.] [Let the narrative go on as long as possible, with only simple prompting by asking, 'What happened then? And then?']

3. Can you tell us what happened when you had your (HP)?

4. Did something else happen? [Repeat as needed to draw out contiguous experiences and events.]

5. If you went to see a helper or healer of any kind, tell us about your visit and what happened afterward.

6. If you went to see a doctor, tell us about your visit to the doctor/hospitalization and about what happened afterward.

6.1. If you went to see the doctor, were you prescribed any medication?

7. If yes, are you currently taking that medication in combination with holy water?

7.1. How do you feel about combining the two forms of treatment?

7.2. How did you make your treatment decision?

7.3. Do you think that the medication has qualities better than those of the holy water treatment? In what ways?

7.4. Do you think the holy water treatment has qualities better than those of the medication? In what ways?

Section 3. EXPLANATORY MODEL NARRATIVE

8. Do you have another term or expression that describes your (HP)?

9. According to you, what caused your (HP)? [List primary cause(s).]

9.1 Are there any other causes that you think played a role? [List secondary causes.]

10. Is there something happening in your family, at work, or in your social life that could explain your health problem?[If the answer to #10 is Yes, then ask Q.11]

11. Can you tell me how that explains your health problem?

12. What does your HP mean to you?

13. What usually happens to people who your HP?

14. What is the best treatment for people who have your HP? Why?

15. Is your (HP) somehow linked or related to specific events that occurred in your life?

16. Can you tell me more about those events and how they are linked to your (HP)?

Section 4. SERVICES AND RESPONSE TO TREATMENT

17. During your visit to the doctor (healer) for your HP, what did your doctor (healer) tell you that your problem was?

18. Did your doctor (healer) give you any treatment, medicine, or recommendations

to follow? [List all]

19. How are you dealing with each of these recommendations? [Repeat Q. 18 to Q. 19 as needed for every recommendation, medicine, and treatment

listed.]

20. Are you able to follow that treatment (or recommendation or medicine)?

21. Before deciding on your current treatment modality, were you able to give other forms of treatment a chance?

22. Which one did you find simple to follow or adopt? Why?

23. Were you able to observe results for each of the treatments you tried? [If yes, ask the length of the trial period and types of results observed]

24. How did you decide on the best treatment for your HP?

25. What other therapy, treatment, help or care have you sought out?

26. What other therapy, treatment, help or care would you like to receive?

Section 5. IMPACT ON LIFE

24. How has your (HP) changed the way you live?

25. How has your (HP) changed the way you feel or think about yourself?

26. How has your (HP) changed the way you look at life in general?

27. How has your (HP) changed the way that others look at you?

28. What has helped you through this period in your life?

29. How have your family or friends helped you through this difficult

period of your life?

30. How has your spiritual life, faith, or religious practice helped you go through this difficult period of your life?

31. Is there anything else you would like to add?

APPENDIX-C INTERVIEW GUIDE FOR CLERGY

Interview #______________

Date_______/_____/_______

Thank you for agreeing to be interviewed for this study. My name is Gubae Beyene and I am a doctoral student at the University of Oregon conducting research for my dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Communication and Media Studies. The purpose of this research is to better understand relevant attitudes and beliefs about antiretroviral HIV/AIDS and holy water treatments, especially focusing on the decision patients make to participate in either or both treatments. As a clergyman, you are likely to have had laity who dealt with these issues. The thoughts that you share will help us gain an additional perspective on the matter.

We realize that you are very busy and have many other things that you could be doing with your time, so I really appreciate your agreeing to do this. We're interested in your honest opinions, so please feel free to say what's on your mind.

Before we begin, I wanted to remind you that I brought a digital recorder so that I don't miss anything you say. The discussion will last about an hour; there are several questions to cover, so at times I may need to move us along. Also, I ask that you do not discuss what we talk about in this room after the interview is over. Remember that you do not have to answer any question that

you are uncomfortable with, and most importantly, there are no right or wrong answers.

OK, let's get started. I'd like to begin by asking you to introduce yourself. Give me your first name, age, professional title, and years of experience in your current role.

1. In your opinion, what causes HIV/AIDS?
2. In your opinion,what is the most effective treatment for HIV/AIDS?
3. Do members of the laity who are HIV/AIDS sufferers consult you regarding the kind of treatment they should seek for their condition? What do you tell them?
4. What is your position on the complementarity of holy water and IRV treatments for HIV/AIDS patients?
5. Is this what your position has always been or has it shifted over time? If it has, tell me how and when?
6. Do you believe that members of the laity who suffer from HIV/AIDS should be free to choose the type of treatment that they deem most effective? Why?
7. How do you feel about ARVs being disseminated at holy water sites?
8. As a clergyman, do you teach the laity about treatment modalities for HIV/AIDS? How?
9. When members of the laity with this problem come to you for advice, what recommendations do you make? Why?

10. Is there anything that you would like to add?

APPENDIX-D INTERVIEW GUIDE FOR MEDICAL PROFESSIONALS

Interview #______________

Date_______/_____/_______

Thank you for agreeing to be interviewed for this study. My name is Gubae Beyene and I am a doctoral student at the University of Oregon conducting research for my dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Communication and Media Studies. The purpose of this research is to better understand relevant attitudes and beliefs about antiretroviral HIV/AIDS and holy water treatments, especially focusing on the decision patients make to participate in either or both treatments. As a medical professional, you are likely to have had patients who dealt with these issues. The thoughts that you share will help us gain an additional perspective on the matter.

We realize that you are very busy and have many other things that you could be doing with your time, so I really appreciate your agreeing to do this. We're interested in your honest opinions, so please feel free to say what's on your mind.

Before we begin, I wanted to remind you that I brought a digital recorder so that I don't miss anything you say. The discussion will last about an hour; there are several questions to cover, so at times I may need to move us along. Also, I ask that you do not discuss what we talk about in this room after the interview is over. Remember that you do not have to answer any question that

you are uncomfortable with, and most importantly, there are no right or wrong answers.

OK, let's get started. I'd like to begin by asking you to introduce yourself. Give me your first name, age, professional title, and years of experience in your current role.

1. How frequently do you come across patients that are conflicted about treatment choice?
2. What is your position on HIV/AIDS patients who opt for holy water treatment and reject ARVs?
3. What is your experience dealing with HIV/AIDS patients who do not adhere to medication and prefer holy water instead?
4. What are some of the claims they make in supporting their choice of treatment?
5. To what extent do you listen to their side of the story?
6. What strategies, if any, do you use in order to persuade them to adhere to the biomedical treatment?
7. What channels of communication have you used? Which one(s) would you consider most successful? Why?
8. How do you feel about the idea of disseminating IRVs at holy water sites?
9. Is there anything that you would like to add?

APPENDIX-E INFORMED CONSENT (SAMPLE)

UNIVERSITY OF OREGON

Consent for Research Participation

Title: Exploring Attitudes and Beliefs about Antiretroviral Drugs and Christian Holy Water in Ethiopia

Researcher(s): Gubae Beyene, University of Oregon

Researcher Contact Info: gubaeb@uoregon.edu

You are being asked to participate in a research study. The box below highlights key information about this research for you to consider when making a decision whether or not to participate. Carefully consider this information and the more detailed information provided below the box. Please ask questions about any of the information you do not understand before you decide whether to participate.

Key Information for You to Consider
• **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to participate or not. There will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or discontinue participation. • **Purpose**. The purpose of this research is to better understand relevant attitudes and beliefs about antiretroviral HIV/AIDS and holy water treatments,

especially focusing on the decision to participate in either or both treatments, feelings about the beliefs of important peers, family, or community leaders.

- **Duration.** It is expected that your participation will last somewhere between 1-2 hours.
- **Procedures and Activities.** You will be asked to express your views and feelings, as well as experiences regarding antiretroviral drugs and holy water as treatments for HIV/AIDS, by way of answering questions posed by the researcher.
- **Risks.** There are no reasonable foreseeable (or expected) risks in this study.
- **Benefits**. There are no direct benefits to participation. This study advances health communication research.
- **Alternatives.** Participation is voluntary and the only alternative is to not participate.

What happens to the information collected for this research?

Information collected for this research will be used as part of academic research. However, your name or other identifying information will not be used in any published reports, conference presentations about this study.

How will my privacy and data confidentiality be protected?

We will take measures to protect your privacy including storing the information collected on a password-protected computer. All electronic information will be coded

and secured using a password protected file. Once transcribed, the audio records will be deleted.

What if I want to stop participating in this research?

Taking part in this research study is your decision. Your participation in this study is voluntary. You do not have to take part in this study, but if you do, you can stop at any time. You have the right to choose not to participate in any study activity or completely withdraw from continued participation at any point in this study without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your relationship with the researcher or the University of Oregon.

Will I be paid for participating in this research?

You will not be paid for taking part in this research.

Who can answer my questions about this research?

If you have questions, or concerns contact the research team at:

Gubae Beyene

+251-9120-51881

gubaeb@uoregon.edu

An Institutional Review Board ("IRB") is overseeing this research. An IRB is a group of people who perform independent review of research studies to ensure the rights and welfare of participants are protected. UO Research Compliance Services is the office that supports the IRB. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Research Compliance Services

5237 University of Oregon

Eugene, OR 97403-5237

(541) 346-2510

STATEMENT OF CONSENT

I have had the opportunity to read and consider the information in this form. I have asked any questions necessary to make a decision about my participation. I understand that I can ask additional questions throughout my participation.

I understand that by signing below, I volunteer to participate in this research. I understand that I am not waiving any legal rights. I have been provided with a copy of this consent form. I understand that if my ability to consent or assent for myself changes, either I or my legal representative may be asked to re-consent prior to my continued participation in this study.

As described above, you will be audio-taped during the interview.

I consent to participate in this study. I agree to the use of audio-recording.

______________________________ ________________________________ ________

Name of Adult Participant Signature of Adult Participant

Date

Researcher Signature (to be completed at time of informed consent)

I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

______________________________ __________________________________ _________

Name of Research Team Member Signature of Research Team Member

Date

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