

**Annex 3:**  
**Part 1 HIV/AIDS ANALYSIS: AN OVERVIEW OF THE EPIDEMIC IN RURAL ETHIOPIA<sup>1</sup>**

Despite the significance of agriculture in Ethiopia, both economically and in terms of the number of people whose livelihoods are based on farming, the sectoral response to HIV/AIDS has generally been weak. Even though rural prevalence rates are lower than urban rates, the scale of the epidemic requires an urgent response and the agricultural sector has a vital role to play in rural areas. The impact of the disease can undermine development initiatives, diverting attention from productive activities to caring for the sick and surviving the aftermath of the death of key household members. Indeed, if left unchecked, the disease changes the composition of rural communities and the priorities of farming households, thereby making many of the traditional production-oriented extension messages irrelevant.

This paper provides an overview of the status of the epidemic, the policy and institutional environment, and specific responses within rural communities. The dynamics of HIV/AIDS in four pilot learning sites (PLSs) are reviewed, identifying potential sources of risk of HIV infection and vulnerabilities to the impacts of AIDS. Particular attention is paid to any increased risk of infection or vulnerability to impacts arising from market-led agricultural development initiatives. The paper concludes by considering possible implications of the epidemic for the Improving Productivity and Market Successes (IPMS) Ethiopian Farmers Project.

A HIV/AIDS strategy has been developed for IPMS. The major thrust of the strategy falls within the domain of integrating HIV/AIDS considerations into the broad framework of the existing project design (CIDA, 2003). The overall purpose is to reduce the rural population's risk of HIV infection and vulnerability to the impacts of AIDS. Further details are presented in a separate paper (see part 2).

### **1. Status of the Epidemic**

By the end of 2003, it was estimated that 1.7 million people in the country had already died from AIDS and a further 1 – 2.3 million were living with the disease (UNAIDS, UNICEF and WHO, 2004). In addition, it was estimated there are around 700,000 children under the age of 17 who have lost either one or both parents to AIDS. Ethiopia is classified (along with Nigeria, China, India and Russia) as belonging to the 'next wave countries' with large populations at risk from HIV infection which will eclipse the current focal point of the epidemic in central and southern Africa (NIC, 2002). It is estimated that seven to 10 million Ethiopians will be infected by 2010 because of the current high adult prevalence rate, widespread poverty and low educational levels (Garbus, 2003). The dominant mode of transmission is through heterosexual contact (estimated to account for 87% of infections) and mother to child transmission (MTCT) (10% infections) (GoE, 2004).

The national HIV prevalence rate is currently estimated to be 4.4% (UNAIDS, UNICEF and WHO, 2004)<sup>2</sup>. Prevalence rates in rural Ethiopia are estimated to be

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<sup>1</sup> Prepared by Clare Bishop-Sambook, HIV/AIDS Advisor, IPMS (November 2004) with fieldwork support from Gebremedhin Woldewahid in Tigray and Nigatu Alemayehu regarding Oromia.

<sup>2</sup> It is cautioned that this most recent estimate should not be interpreted as a fall in prevalence from the earlier figure of 6.6% but rather a result of increasing the number of sentinel sites from 34 to 66 and changing the method of calculation (MOH, 2004). There is insufficient

around 3%, significantly lower than the average prevalence rate for urban areas of 12.6%. Nevertheless, the rural prevalence rate suggests that nearly 2 million rural people are already infected and a further 5 million rural household members are affected by the disease. There have been substantial efforts by Government to address the disease through a multi-sectoral approach with increasing attention being paid to reaching the rural areas where 85% of the total population reside. Addressing the epidemic is particularly challenging in such a poor country, where annual per capita expenditure on health is in the order of USD 6, including out-of-pocket contributions (CCM, 2004).

The disease is taking its toll on life expectancy (it is estimated that six years will be lost by 2014) and is undermining the country's efforts to reduce poverty, particularly with respect to health, education and rural development. It is estimated that over 50% of government hospital beds are occupied by AIDS patients (GoE, 2004). The increase in tuberculosis cases has been concurrent with HIV progression, with HIV prevalence among TB patients estimated at 40 – 50% (CDC, 2004). The problem of caring and supporting people living with AIDS and orphans has surpassed the capacity of traditional coping mechanisms (GoE, 2004). Since the turn of the new millennium, the Government has recognised that *'investing adequately in HIV/AIDS prevention is now a precondition for virtually all other development investments to succeed'* (GoE, 2001).

## **2. Policy and Institutional Framework for Addressing HIV/AIDS**

The Government has been active in addressing the HIV/AIDS epidemic. Details about the policy and institutional frameworks for addressing HIV/AIDS, including the role of the national and regional HIV/AIDS Prevention and Control Offices (HAPCOs) and AIDS councils, and the Ethiopian Multi-sectoral AIDS Programme (EMSAP), are presented in Appendix 1.

The recent Strategic Plan to Combat HIV/AIDS Epidemic, 2004 – 2007 recognises that community mobilisation and empowerment is essential for an expanded, sustained and effective response to address the disease (GoE, 2004). However, it is acknowledged that extremely limited attention has been paid to involving rural communities in this process.

## **3. Responses in the Agricultural Sector and Rural Communities**

### **(i) Institutional**

To date, the response by the lead agencies working in the agricultural sector, namely MoARD, the regional agricultural bureaux, and the Ethiopian Agricultural Research Organisation (EARO) has generally been weak. They have each appointed one member of staff as the HIV/AIDS focal point, a task which they perform in addition to their existing duties, and, in MoARD, a small task force has been created. The regional HAPCO secretariats assist the sectoral bureaux, including agriculture and cooperatives, to mainstream HIV/AIDS into their work and develop action plans. In SNNPR, full-time specialist HIV/AIDS focal points have been appointed in 11 regional bureaux, including agriculture.

Some initiatives are underway and have the potential to contribute to various aspects of HIV/AIDS prevention, care and mitigation activities. They are often supported by

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evidence to indicate there has been a substantial behaviour change, especially among the youth, to result in a 2% decrease in prevalence.

EMSAP funding through the HAPCOs. Activities include awareness raising about HIV/AIDS for MoARD, regional bureaux and *woreda* staff, agriculture Technical Vocational Education and Training (TVET) college staff and development agents (DAs); and a forthcoming HIV/AIDS impact assessment study in agriculture<sup>3</sup> which will be conducted in 26 *woredas* from seven regions (including all four IPMS regions).

## **(ii) Agriculture TVET and FTC curriculum**

There are no specific courses addressing HIV/AIDS in the agriculture TVET curriculum. HIV/AIDS awareness has been raised among staff and students at the colleges through drama, posters and video programmes by NGOs and HAPCOs. Anti-AIDS clubs are also active in the colleges. However, identifying and understanding HIV/AIDS issues in the agricultural sector and its implications for the work of the extension service is not yet a formal part of the curriculum. Under the initiative of the HIV/AIDS task force in MoARD the possibility of developing a new agriculture TVET curriculum for HIV/AIDS is being considered. A manual has been prepared for DAs in Amhara by the BoARD in Bahir Dar and another one is in the process of preparation for DAs in Tigray. In SNNPR, the BoA together with the regional HAPCO, is integrating HIV/AIDS and gender issues into the curriculum for Farmer Training Centres (FTCs) and a training of trainers course has been conducted for *woreda* staff to train DAs. An HIV/AIDS manual is also being published by MoARD HIV/AIDS taskforce for DAs.

## **(iii) Cooperatives**

The cooperative sector offers a route for reaching the farming community but has not been fully exploited. At Ferro primary society, Dale, for example, there has been awareness raising among the board members by VOCA-Ethiopia but not yet among the broader membership or employees at the coffee washing stations. Cooperatives may also be used as an entry point for mitigation, care and support activities in communities, for example, by developing income generating activities, savings, gender awareness, livelihoods diversification, or using the social fund to provide care for orphans. In SNNPR the possibility of establishing an anti-retroviral treatment fund to enable farmers to access health care treatment is being explored (an example of such a scheme working in Addis Ababa is described in Box 1). Cooperative shops and milk collection points could be used for the social marketing of condoms. Dairy cooperatives could distribute information leaflets about HIV/AIDS to their members along with the fortnightly payments for milk.

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<sup>3</sup> The overall objective of the study is to generate information for a detailed understanding of the actual and potential impacts of the HIV/AIDS epidemic on crop and livestock farming in Ethiopia and identification of appropriate responses. Specific objectives include identifying channels through which the impacts of HIV/AIDS on agriculture are transmitted; the impact on farming and livestock production and the long-term implications; the possible impacts on the provision and effectiveness of the agricultural extension programme and DAs; gender dimensions of the epidemic; and informing policy and intervention measures (MoARD, 2004). CIDA has appointed a part-time consultant to liaise between MoARD's HIV/AIDS task force and the consultancy firm which will undertake this assignment.

### **Box 1: Role of cooperatives in health insurance**

One best practice encountered during an ILO study of 450 women working in micro-enterprises in Addis Ababa has been support for them to form savings and credit co-operatives, with technical and skill upgrading programmes. A separate health association (similar to health insurance) associated with the cooperative collects money from members (Birr 1 per week) and covers all their medical expenses. In addition, members help the sick with their housework and business on a rotational basis, if necessary.

Source: ILO (2004)

#### **(iv) Micro Finance Institutions**

Micro finance institutions (MFIs) vary with regard to loan recovery practices in the event of the death of the borrower. For example, in Sidama MFI, 1% of the principal is paid as insurance against the death of the borrower, releasing family members from responsibility for repaying any outstanding debt. Other MFIs (such as Omo MFI in Dale and Dedebit Credit and Saving Institution in Atsbi Wemberta) do not operate such a scheme and family members are responsible for loan repayment if the borrower dies.

#### **(v) Activities at community level**

A wide range of community and civil society organisations are responding to the epidemic, particularly in urban areas (HAPCO, 2003), including:

- *Kebele* HIV/AIDS committees: usual structure through which communities organise HIV/AIDS interventions in their localities. Most of the funding is through EMSAP and is only available in EMSAP-supported *woredas*.
- *Edirs*: traditional societies providing support during burial to the deceased's family. In many places they have expanded their role to address HIV/AIDS, with and without the support of EMSAP funds.
- Anti-AIDS clubs: highly motivated and innovative youth groups present in most communities, running their activities using their own initiatives and resources.
- Associations: various such as the commercial sex workers association in Afar, virgin girl association in Amhara, and the association for deaf and disabled.
- Faith-based organisations: all religious organisations play a significant role in addressing HIV/AIDS, forming coordinating offices, designating focal points and integrating HIV/AIDS into their routine activities.
- NGOs: vary by region, playing a special role in reaching more difficult communities.
- People living with HIV/AIDS (PLWHA) associations: the major ones are Dawn of Hope and Mekdim, with central and regional branches.
- Private sector: Ethiopian Employees Federation, Confederation of Ethiopian Trade Unions and the Chamber of Commerce are active in workplace activities.
- Community outreach: house to house visits and coffee ceremonies by peer educators in urban settings.

Activities in rural communities are also moving forward. In particular, the use of community conversations for stimulating behavioural change is generating some very tangible results (UNDP/BDP, 2004) (Box 2). The methodology was originally developed in Alaba by KMG and is now being promoted by UNDP<sup>4</sup>. Although the agricultural extension network represents one of the largest resources for reaching

<sup>4</sup> Community conversations are being applied in other *woredas* in SNNPR (with HAPCO support), Amhara, Oromia and Tigray (by WFP including Wukro *tabia* adjacent to Atsbi Wemberta).

scattered rural communities, it was noted during the Mid Term Review of the Ethiopian HIV/AIDS National Response 2001 – 2005, that little use had been made of it (HAPCO, 2003). The potential of DAs is gradually being mobilised: for example, in Alaba *woreda* DAs who have been trained in HIV/AIDS issues, raise awareness in the farming community whenever an opportunity arises and train contact persons from the community to spread the message among their friends. EMSAP emergency funds are used at *kebele* level for teaching farmers, helping PLWHA and supporting orphans.

**Box 2: Community conversations**

Community conversations are being used as an entry point for stimulating behaviour change through providing a forum for community discussion about HIV/AIDS risks and transmission, paying particular attention to cultural aspects which are contributing to the spread of the disease. Trained members of the community facilitate the conversations over a period of 18 months. Outcomes in communities in SNNPR include increased use of pre-marital testing and the cessation of female circumcision and other harmful practices. In Gurage, where men traditionally migrate for one or two years in search of work, their wives are asking them to be tested for HIV when they return home for holidays.

*Source: Field notes*

**(vi) Health infrastructure**

**Voluntary counselling and testing (VCT) centres:** VCT plays a key entry point for treatment, care and support, and prevention. Demand for HIV testing is high in rural areas but the facilities are limited. At present there are around 175 VCT centres in country, of which 20% are in the zonal towns and rural areas. It is planned to increase the number of rural-based centres and expand the facilities to do CD4 count and viral load testing, in order to complement anti-retroviral therapy.

**Anti-retroviral (ARV) therapy:** The Government's Policy on Anti-Retroviral Drugs Supply and Use was approved in May 2003 and, since July 2003, the initiative on low cost ARV has been implemented (CCM, 2004). By mid June 2004 it was estimated that 4,500 adults with advanced HIV infection were receiving ARV therapy whereas it was estimated that around 200,000 are in need of treatment (UNAIDS, UNICEF and WHO, 2004). Ethiopia is one of the countries to benefit directly from the WHO/UNAIDS '3-by-5' initiative (3 million people to receive ARV by 2005 globally). A system of cost sharing with a very minimal payment (minimum contribution of USD 0.23) is to be introduced. The money raised will be used as seed money for the National HIV/AIDS fund (which will be one mechanism for providing nutritional support to people for ARV treatment and to include more patients for therapy) (CCM, 2004).

**Prevention of Mother to Child Transmission (PMTCT):** In 2001, it was estimated that over 200,000 children under the age of five had been infected with the virus. In 2003 PMTCT services were established in four hospitals on a pilot basis.

**Health extension agents:** Government outreach to rural areas is being substantially strengthened by the appointment of 20,000 health extension agents to be appointed at *kebele* level to work under the regional health bureau. The agents (high school leavers with one year's training) will be trained in all aspects of primary health care services, with special attention on HIV, tuberculosis, malaria and first aid. There will be two agents per *kebele*, mainly women, and they will work closely with DAs.

#### 4. Sources of risk of HIV infection in the PLSs

The following two sections focus on the dynamics of HIV/AIDS in the PLSs. This section explores the principal sources of risk of infection at the PLS level: the urban hinterland, bridging populations who move between high risk urban and lower risk rural communities, activities specifically associated with agricultural marketing, and cultural norms and social traditions within communities.

##### (i) Urban hinterland

In order to examine the dynamics of HIV/AIDS in rural areas, it is essential to place rural communities in the context of their urban hinterland. The disease is well established in many of the principal regional towns throughout the country, where prevalence rates typically range from 10 – 20% (Table 1). The extent to which the farming community interacts with this high risk environment (and engages in unprotected sex with infected people) will have a major bearing on the development of the rural epidemic. For example, the high urban prevalence rate in Amhara is mirrored in the high rural prevalence rate of over 5%.

**Table 1: Rural and Urban HIV Prevalence Rates by PLS**

PLS	Regional HIV prevalence rates (%)		Nearby site-specific data on HIV prevalence rates (%)
	Rural	Urban	
Atsbi Wemberta, Tigray	2.8	12.4	Mekelle HC 9.3; Adigrat HC 7.4; Atsbi HC 6
Fogera, Amhara	5.2	15.5	Bahir Dar HC 20.2; Bahir Dar Hospt 16.9
Ada'a Liben, Oromia	1.8	10.3	Adama HC 10.8
Dale, SNNPR	2.3	9.1	Awassa HC 8.8; Dilla Hospt 12.1

HC = health centre, Hospt = hospital  
Source: MOH (2004)

Ada'a Liben differs from the other three PLSs in that it has Debre Zeit, a sizable town with over 100,000 population, in the middle of the *woreda*. Hence, it has a high risk urban centre immediately within the *woreda*. The town hosts airforce and military camps, factories, colleges and secondary schools all of which draw people in from many different parts of the country with different behavioural norms.

##### (ii) Bridging populations

There are several potential bridging populations who may carry the virus from urban areas into rural communities:

- seasonal migrant farmers: seasonal migration during the quiet months in farming is a long established tradition in parts of the country. For example, male farmers in Amhara migrate from rural areas to work as daily labourers in the construction industry in Bahir Dar, or on the major transport route from Addis Ababa through Bahir Dar to Sudan, or building the new agriculture TVET colleges. Many leave their wives in the villages and take on a new wife in their new residence.
- skilled migrants with dual livelihoods: these men work as farmers during the season and in non-farm work in town, as carpenters or masons, during the summer months;
- long term migrants: male farmers from the densely populated central highlands in SNNPR migrate to Addis Ababa or to farms and plantations in the Awash valley and Dire Dawa for one to two years, leaving their families at home and returning

occasionally for holidays. In Atsbi Wemberta there has been a tradition for young men in particular, to migrate for work in Saudi Arabia but it is less common today;

- long distance livestock traders: men spend several weeks moving their cattle from Borena through Arsi on their way to the market in Addis Ababa;
- long distance salt traders: men spend around two weeks on a round trip transporting salt by camel and donkey from the Afar depression to the markets of Mekelle, Adigrat and beyond (these routes pass through Atsbi Wemberta);
- long distance truck drivers and their assistants: Ada'a Liben is bisected by the very busy Addis Ababa to Dire Dawa highway and Debre Zeit is a truck stop;
- seasonal migrants within farming communities: farmers travel from the highlands in SNNPR to work with the coffee harvest in Dale during their quiet season and stay with their host household;
- distributors of food relief: in Amhara region, for example, recipients stay in the distribution locality for one or two days whilst they collect drought relief grain. The food distributors have been informed not to exploit the beneficiaries in sex. Food for work grain in Atsbi Wemberta is distributed at two locations in the *woreda*; queues were observed late into the evening leaving many beneficiaries (including women) considerable distances to walk home in the dark;
- farmers attending the distribution of seeds and credit by the Bureau of Agriculture: they may stay several days in town if there are bottlenecks and delays in registration, screening and disbursement;
- young men seeking temporary employment: for example, working on the large commercial farms growing sesame and sorghum in western Tigray;
- adolescents attending secondary schools: moving to the *woreda* town to attend grades 9 and 10, staying with relatives or friends or renting a room;
- professionals working in rural communities: DAs and teachers living in rural areas, often unaccompanied by their families.

### (iii) Market-related risks

Activities specifically associated with agricultural marketing potentially contribute to the spread of the disease:

- trading: there is much movement of people associated with marketing both into and from rural areas (Box 3). Journeys may be completed within a day or over a period of several days.

#### **Box 3: Traders in Endasselassie, Atsbi Wemberta**

- *Salt*: men from Atsbi travel to Afar in the dry season to collect salt and sell in Endasselassie market (four days each way); some also bring back palms for weaving baskets which their wives sell;
- *Honey and butter*: women sell individually by the beaker to traders – usually young men but sometimes women as well – who then travel by bus to Wukro, Mekelle or Adigrat;
- *Flour*: women buy grain in the market, pay for it to be milled, then travel on foot with donkeys for two to three days to sell the flour, even to Afar;
- *Vegetables*: young men from Wukro grow tomatoes and potatoes and transport their produce to the market by donkey to sell wholesale.

Source: Field notes

- social gathering: weekly rural markets are a major social gathering, drawing people together, typically from a 10 – 15 km radius. Larger markets attract people from further afield and may result in overnight stays. Market days are often a source of recreation, even if there is no business to conduct (noted at Ada'a Liben). People assemble from different parts of the locality, money is available, and many drink alcohol.

- alcohol consumption (leading to unprotected sex): drinking on market days is a common and long established practice. This is most marked in Ada'a Liben<sup>5</sup> where it was observed in Dire and Hidi that between 20 – 50% of the market area is devoted to informal drinking houses. Both women and men drink *tella* (a beer made from barley) to quench their thirst (farmers noted that it is not easy to get water on market days because the *tella* producers<sup>6</sup> wish to sell their brew). Women usually return home after one or two drinks whereas men may have several drinks of *tella* before moving onto drinking *teche* (a relatively expensive local drink made from honey) or *araki* (a liquor made from wheat and maize) in houses close to the market. This may lead to unprotected sex with the young women serving the drinks<sup>7</sup>. It was noted that men do not pay for sex in the village<sup>8</sup> but rather pay in kind by establishing friendships with the young women and supporting their business (an example of the relationship between a young woman and her clients is described in Box 4). In Woge Aworambe *kebele*, Fogera and Endasselassie, Atsbi Wemberta there are a few local drinking houses situated close to the market but no houses within the market area.

**Box 4: Story of a 'kollo' seller in Addis Ababa**

A young woman gave birth to her son, as a result of rape, when she was 14 years old. She started a little business selling tea, *kollo* (roasted grains), chewing gum and other small items. The money she made was not enough to support herself and her son so she started having sex with her customers. She was not a prostitute and only slept with men after she had developed a friendship with them. She appreciated the friendship as much as the money. Some used to give her gifts and some gave money, not because she slept with them but because they wanted to help her. When she slept with men she knew well, she did not bother with condoms. Sometimes she used a condom with others although she never considered anyone to be HIV positive. She continued this lifestyle for about 10 years before becoming sick with AIDS. Now her son is selling cigarettes and *kollo* and is caring for her.

Source: Ayele (2003)

- specific marketing patterns: the marketing of *chat* requires rapid transport to the point of final sale in major towns in order to preserve quality. The selling takes place late in the evening which gives farmers the opportunity, or the excuse, to stay in town overnight. They often spend their evenings chewing *chat* and whether this is a potential HIV-risk factor depends on whether it is linked to alcohol consumption.
- seasonal flows of cash: during the peak harvesting season of red peppers in Alaba (October to January), commercial sex workers from Addis Ababa, Awassa and Adama/Nazareth move into the area. Similarly, in coffee growing areas,

<sup>5</sup> In an attempt to address the problem of excessive drinking in Ada'a Liben during the last three years, many *tella* houses (temporary structures) which once lined the route to markets, have been closed. Farmers are also urged to work in the fields themselves rather than hire labour, which was the norm during harvest time. The administrative structure, reaching down to cells of 10 households with a team leader, is seen to be an effective means of controlling anti-social behaviour.

<sup>6</sup> In Ada'a Liben *tella* tends to be brewed by poorer households whereas *araki* and *teche* tend to be made by richer households because they need some capital to purchase the ingredients.

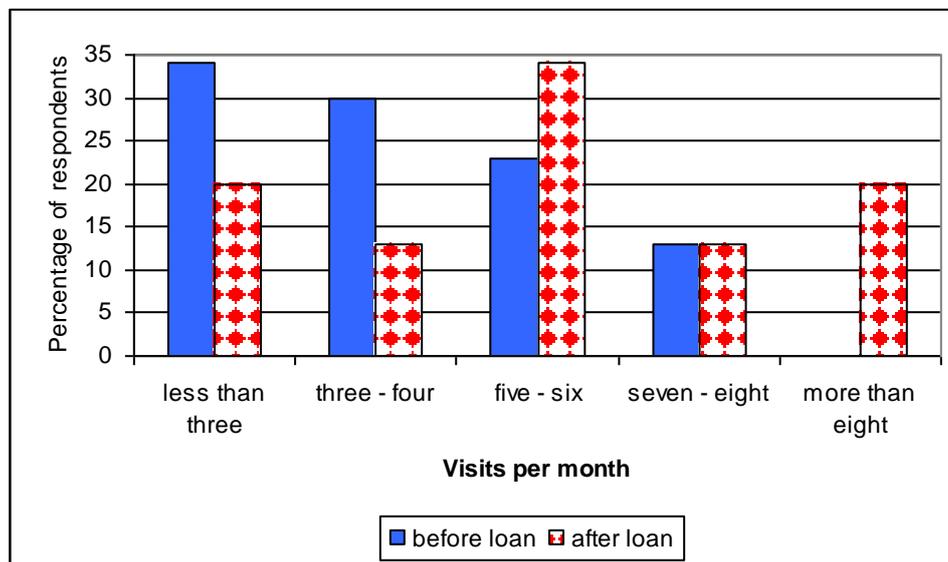
<sup>7</sup> The young women are often recent divorcees from early marriages. They are hired by the owner of the drinking house. Drinking houses often have one or two bedrooms at the rear for customers to have sex.

<sup>8</sup> In Debre Zeit it was stated that a commercial sex worker charges Birr 100 per night (plus drinks and the hire of a room).

traditionally there was much entertainment and merrymaking during the harvesting season but it is reported that this has decreased in recent years due to the poor profitability of coffee. It was reported that many male teenagers in Ada'a Liben have their sexual debut during the summer months after selling the *teff* harvest (in December) when money is readily available.

- method of payment: when traders are busy, they pay farmers a nominal sum on delivery of their produce and settle the balance in the evening, requiring farmers to spend the day waiting around the market.
- unwanted sexual encounters whilst travelling to and from markets: women and girls are potentially at risk from as they travel to and from markets, and many travel in groups to improve their security. They may encounter pressure to have sex when they travel away from home whilst trading or when they sell produce and culturally they are in a weak position to refuse. In contrast to other countries in the region, sex was not reported to be part of the barter or exchange system (where it is used to secure preferential access to limited supplies).
- increased mobility: increased market orientation and production of a marketable surplus is likely to result in more frequent visits to markets or urban centres. For example, 30 women in Dale *woreda* increased the number of these visits from around three or four times a month to at least five or six times a month after borrowing money from SMFI (Diagram 1) (Kifle, 2003). Although their increased mobility was taken to be a sign of empowerment, it could also be seen as a potential risk of exposure to HIV.

**Diagram 1: Number of Visits to Market or Urban Area per Month by Women Borrowers from Sidama Micro Finance Institution**



Source: Kifle (20030

#### **(iv) Cultural norms and practices within communities**

Once the virus is present within a rural community, cultural and social practices may contribute to its spread between people. The source of HIV infection differs between household members and is strongly influenced by age and sex. Hence children under the age of five are most at risk from MTCT and possible infection through contact with infected blood and other bodily fluids; from five to the age at which they become sexually active, from infected blood and other bodily fluids<sup>9</sup>; and once, sexually active, through unprotected sex (Bishop-Sambrook, 2004). Cultural norms and practices which potentially place people at risk from HIV infection differ widely between communities and between regions. Many are now reported to be on the decline, partly as a result of efforts spurred by the epidemic.

##### **Age at sexual debut**

The median age at which young rural women (aged 15 – 24) first have sexual intercourse is 19 years and for men 22 years (CSO, 2000). Although women become sexually active at an earlier age than men this is usually in the context of marriage in contrast to men who initiate sex before marriage (Govindasamy *et al*, 2002). The Demographic and Health Survey of 2000 found that whilst it was quite common for young rural men to have premarital sex, it was rare for young rural women to do so (13% compared to 1%) (CSO, 2000). However, these incidences were much less than among the urban youth where 26% of young men and 6% of young women had premarital sex.

##### **Marriage**

Various forms of marriage exist, such as early marriage (girls may be as young as 10 to 12 years old, particularly in Amhara), marriage by abduction, polygamy and widow inheritance. Marriage by abduction is practised widely (NCTPE, 1998), particularly in rural areas (Ayele, 2003). Such marriage arrangements often place women in a vulnerable position (Box 5).

##### **Box 5: Early marriage in Atsbi Wemberta**

A mother went to Addis Ababa for a short visit and returned home to find that her husband had married off their daughter. The young girl was only 14 and had been attending school. She had her first child when she was 15 years old and subsequently has had a second. Neither she nor her husband has any regular employment and the work as casual labourers. Even after several years, the mother is still angry with her husband for spoiling her daughter's chances; her former classmates now are working as teachers. The parents have land and run a small tea room near the market.

Source: Field notes

##### **Multiple sex partners**

The practice of multiple sexual partnerships varies between regions, sex and marital status. The Behavioural Surveillance Survey of 2002, conducted amongst different occupational groups, found one third of married respondents had extramarital sex (Mitike *et al*, 2002). Discussions in the PLSs, particularly Ada'a Liben, suggest that extramarital affairs are relatively common in Oromia where both rural women and

<sup>9</sup> According to UNAIDS, 30 – 40 % of babies born to infected mothers in the developing world will be infected with HIV and there is a high degree of certainty that they will die before their fifth birthday (SNNPR Regional Health Bureau and Regional AIDS Secretariat, 2003).

men have several concurrent relationships regardless of their marital status (known as *sanyo* in Oromiffa)<sup>10</sup>. In contrast, in SNNPR, almost no married women have sexual partners other than their husbands (SNNPR Regional Health Bureau and Regional AIDS Secretariat, 2003). Although multiple sexual relationships may not be openly acknowledged by communities in Amhara and Tigray<sup>11</sup>, they are widely practiced in secret (Miz-Haseb Research Centre, 2004). In Atsbi Wemberta, it is common for husbands to have several girlfriends (divorcees or widows), possibly as a sign of status or in the quest for more children; however, it is very uncommon for married women to have extramarital affairs.

Communities do not tend to associate their customary sexual practices with the risk of HIV infection since they are conducted within community norms, including inherent elements of trust (Miz-Hasab Research Centre, 2004). The behavioural Surveillance Survey found that the vast majority of farmers perceived themselves to be at no or low risk of infection because '*they trusted their partners and had no contact with infected people*' (Mitike *et al*, 2002).

### ***Use of condoms***

The Demographic and Health Survey of 2000 found urban residents were much more likely to use a condom during potentially high risk sex than rural residents. Discussions with young farmers in Hidi, Ada'a Liben confirm this general reluctance to use condoms, partly because they are not familiar with them. However, availability would appear to be less of an issue since they are for sale in shops in rural market centres (such as Hidi) or for free in some restaurants (for example, Endasselassie).

### ***Alcohol consumption and chat chewing***

Social practices include alcohol consumption, which is often closely related to casual sex, and chewing chat (a leafy narcotic). It is generally accepted that sexual desire after chewing chat is very low. However, some species have different effects on individuals and if chewing is followed by alcohol consumption, sexual desire tends to increase (Mitike *et al*, 2002). In some parts of the country, the latter is the norm (for example, in Awassa) but the exception elsewhere (for example, Eastern Hararghe Zone and Alaba). The Behavioural Surveillance Survey found *chat* was widely used by both rural women and men, mainly to stimulate work. Chewing chat has become a major problem among the youth, exacerbated by lack of employment opportunities and general feelings of hopelessness (Govindasamy *et al*, 2002). In Tigray it was noted that people are gradually becoming more conscious about the importance of saving money and consequently are drinking less.

### ***Harmful traditional practices***

Several harmful traditional practices (HTPs) are very common in the project regions (see Box 6 for definitions). In a survey of health personnel, uvulectomy and milk tooth extraction were cited as the most common HTPs in all four regions (Table 2) (Jeppsson *et al*, 2003). Female genital cutting (FGC) is widely practised, with a

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<sup>10</sup> This concurs with the findings from a study of over 2300 respondents from 11 regions conducted in 1995 which found the Oromo to be most tolerant of extramarital affairs by married women and the Tigrays the most tolerant overall of extramarital sex (22% respondents) and among the most tolerant of extramarital sex by unmarried men (Wondimu *et al*, 2004).

<sup>11</sup> Indeed, in parts of Tigray, the attitude once held that '*to be infected with STI was seen as a sign of adventure and manhood*' although now it is seen as more of a shame.

lower incidence reported in Tigray. Other practices were regionally specific, such as incision of the eyelid in Tigray, and vein punctures in Tigray and Amhara. It is estimated that, despite being on the decline, FGC is still widespread with 80% of women aged 15 – 49 years being circumcised (CSO and ORC Macro, 2001). Most girls are circumcised before they are one year old and in 90% cases this is performed by a traditional circumciser; they may also be circumcised immediately before marriage.

**Box 6: Harmful traditional practices**

- *Uvulectomy*: the uvula is removed with a knife to treat oropharyngeal blockage, prolonged swelling of the throat, vomiting and coughing.
- *Tonsillectomy*: the tonsils are removed by the index finger of the healer to treat sore throats and difficulties in swallowing. A related practice is scraping a sore throat with a long fingernail until it bleeds.
- *Milk tooth extraction*: the teeth are extracted, sometimes involving drilling the gum, to treat diarrhoea and fever at the time of milk tooth eruption, and poorly growing older children.
- *Incision of eyelid*: eye infections are treated by cutting the eyelid with a razor blade.
- *Vein puncture on arms and blood letting on scalp*: removing blood to counter tissue swelling and deteriorating health.
- *Cauterisation*: ailments such as conjunctivitis, headache, ear infections, TB and bone fractures are treated by burning with a hot rod, burning stick or charcoals.
- *Female and male circumcision*: usually performed within a few days after birth but may also be performed at the time of marriage. Male circumcision is mandatory (for religious and social reasons). Female genital cutting (FGC) is optional but usually considered to be desirable.

Source: Jeppsson et al (2003)

**Table 2: Percentage Distribution of Occurrence of Harmful Traditional Practices by Region as Recalled by Health Personnel**

Type of traditional practice	Tigray	Amhara	Oromia	SNNPR
Uvulectomy	100	95	80	75
Tonsillectomy	25	50	55	70
Milk tooth extraction	90	85	85	75
Incision of eyelid	100	30	20	30
Vein puncture on arms	80	70	20	0
Blood letting on scalp	65	35	10	10
Cauterisation	80	40	50	60
Female genital cutting	35	85	90	75
Total	100% = 11	100% = 21	100% = 32	100% = 17

Rounded to nearest 5%

Source: Jeppsson et al (2003)

The health workers recognised that many of the traditional surgical interventions frequently resulted in serious and life-threatening complications including excessive bleeding and the possibility of HIV infection arising from of uvulectomy, vein puncturing and blood letting. Generally, Ethiopian health officials fear that the use of unsterilised instruments to perform these practices aggravate the HIV/AIDS epidemic as noted in the Government's policy on HIV/AIDS (GoE, 1998). Nevertheless, it should be recognised that the few data available have not found an association between HTP and HIV infection (Garbus, 2003). There is increasing action to deter people from practising HTPs, for example through the work of the National Committee on Traditional Practices in Ethiopia, and there have been some successes. For example, in Ada'a Liben it was reported that the incidence of HTPs

was decreasing due to the combined efforts by government, traditional practitioners and religious leaders.

### **Gender imbalances**

Not only are women and girls more vulnerable biologically to HIV infection but also socially due to discriminatory social and cultural practices (INRI, 2004). They generally have low rates of literacy, leave school earlier than boys, and have little opportunity to participate in decision making. They are also disadvantaged with regard to using and controlling economic resources in the household. Due their weak social position and the dominance of men, women are either unaware or unable to insist on condom use and negotiate for safe sex. Gender inequalities also affects their ability to utilise treatment and care services, to disclose their HIV status, and to receive support for adherence of ARV therapy in the family and community (CCM, 2004).

A study of five women living with HIV/AIDS identified socio-cultural factors and poverty, coupled with a lack of education and awareness about HIV/AIDS, as the main causes of their infection (Ayele, 2003). Their lives were disrupted by family disorganisation, abduction, rape and early marriage. They were further disadvantaged by their inability to discuss issues of sexuality and safe reproductive behaviour with their families.

### **Awareness and understanding about HIV/AIDS**

A lack of awareness hastens the spread of the disease. The Behavioural Surveillance Survey of 2002 found farmers to be the least well informed about preventative methods, had the highest levels of misconceptions about how it could be transmitted, and nearly all farmers had at least one stigmatising attitude towards people living with HIV/AIDS (PLWHA) (Mitike *et al*, 2002). Rural women were found to be the least well informed about preventative methods. Carers of people living with AIDS, who are usually wives and mothers, are at risk if they do not understand how the disease is transmitted.

Messages about HIV/AIDS are often closely intertwined with religious beliefs which can result in some confusion regarding preventative action and effective care (Box 7).

#### **Box 7: Association between religious beliefs and HIV/AIDS**

*'All diseases come from Allah. This one, however, is serious and has no medicine, [and so] we are frightened. It [AIDS] kills you by causing a lot of suffering.'* (Rural Muslim religious leader, Ethiopia)

*'The disease is the result of our sin and our distance from religion. If we didn't commit sin, this thing would never have come. Thus God will be merciful for us if we get closer to our religion.'* (Urban woman, Ethiopia)

*'My mother was upset. She tried to comfort me by saying that "God will know and you will be cured by the holy water." Then, I took holy water and I had hope on it. While I was taking holy water in the church, I listened to God's word.'* (Urban woman, Ethiopia)

Source: ICRW (2003)

Factors found to increase awareness and understanding of HIV and AIDS among the youth included urban residence, education – particularly secondary education, listening to the radio regularly and, only for women, ever-being married or in work (cited in Govindasamy *et al*, 2002). Their main sources of information were community meetings, radio, schools and teachers, friends and relatives.

It was noted both in Ada'a Liben and Atsbi Wemberta that there has been a change in the level of intensity of awareness raising activities during the last five years. Whenever people gather together, at weddings, funerals and community meetings, government officials, religious leaders and village leaders, must spend some time talking about HIV/AIDS. It is recognised that a continual process of education is required in order to effect behavioural change and first hand experiences are proving very effective (Box 8).

**Box 8: PLWHA contributing to process of behaviour change**

In Ada'a Liben *woreda* one HIV positive woman was taken back to her community where she had slept with many men. This proved to be very effective at bringing the realities of HIV/AIDS home to the community since people knew how she had lived her life and were able to work out how she had become infected.

*Source: Field notes*

Radio listening groups have been formed in Amhara and Oromia to listen and discuss serial dramas developed using the research-based Sabido methodology: Yeken Kignit '*Looking over one's daily life*' in Amharic and Dhimbibba '*Getting the best out of life*' in Oromiffa (Population Media Centre, 2004).

**Infrastructure**

Access to VCT centres is very limited in rural areas. In Ada'a Liben, for example, the population of over 300,000 is served by one centre at Debre Zeit hospital. There are no mobile services so if people living deep in the countryside want to find out their status and change their behaviour, it is difficult for them to do so. Sometimes, even when services are available, the fear of stigma and the potential breach of confidentiality encourages people to travel to major the towns for HIV tests rather than use the local VCT centre (as noted in Amhara).

**5. Vulnerability to the impacts of AIDS in the PLSs**

This section considers the impacts of AIDS to date in the PLSs, prior to discussing the implications of the disease for the IPMS project in the final section.

**Denial and stigma**

It is difficult to identify and assess impacts of AIDS in the PLSs because most rural communities still in a stage of denial regarding the disease. In Ada'a Liben it was noted that if someone is sick they hide away at home and neighbours will reflect on how they have lived their life to work out if it might be AIDS. Whilst levels of awareness about the disease are high, there is a reluctance to admit that people from the community are infected or dying from AIDS. It is still something which is affecting their neighbours rather than themselves (Box 9).

**Box 9: Importing the source of infection**

A resident of Hidi brought a woman from nearby Nazareth to live with him. She died of AIDS although it was attributed to TB. The man subsequently became sick and his neighbours looked after him.

*Source: Field notes*

Levels of stigmatisation have traditionally been high in rural areas. For example, in Amhara it was noted that in the early stages of the epidemic when the incidence of

the disease was relatively low, PLWHA were only accepted by their family and alienated by the community. However, as many communities are now being confronted with the reality of the disease, stigma appears to be reducing (as noted in SNNPR).

### **Impacts on rural livelihoods**

The livelihoods of whole households are compromised by the impact of AIDS. Time and cash are diverted from productive activities into medical treatment, caring for the sick and burying the dead. Studies conducted in the mid-1990s found that: rural women spent 100 hours per week nursing the sick, time which was found by spending 75% less time caring for their children and 50% less time working on their farms (Baryoh, 1994); and that the average cost of treatment, funeral and mourning expenses amounted to several times the average annual household income (Demeke, 1993).

The impact of AIDS on rural livelihoods differs between occupational groups. Those who depend on their physical well-being or appearances for their livelihood are particularly vulnerable. Farmers and transporters of produce may lack the physical energy to do their work. Customers may shy away from buying from retailers or sellers who look sick due to stigma and misunderstanding regarding the transmission of the disease (Box 10). Once the signs of the disease become evident, infected individuals often withdraw from public space, including visits to the market.

#### **Box 10: Impact of stigma on livelihood**

*'Some people might have been buying milk ... from that family. They stop that if it is discovered a relative or a member of that family who lives in the same house died of HIV. Besides, people will stop buying anything from the suspected person's family if the family has a shop, or they stop borrowing materials and the family will be isolated and left alone. Whether the HIV-contracted person is alive or dead, people are frightened to share things with such kind of a family.'* (Rural man, Ethiopia)

Source: ICRW (2003)

The ability of households to mobilise additional labour or to call on others to assist with their work, may assist their survival in the short term. However, experience from southern and eastern Africa demonstrates that if the disease progresses unchecked, extended families become saturated with caring for orphans and asset bases are steadily depleted, and the long term viability of rural communities is completely undermined. Some of these characteristics are already emerging in parts of rural Ethiopia, as found in a recent study of HIV/AIDS affected households in Ambassel and Alaba (Laketch, 2004).

Potential impacts which may be observed during the next few years as communities move from a status of AIDS-initiating or AIDS-impending to AIDS-impacted<sup>12</sup> include: reduced ability to participate in communal work (such as constructing rural roads, additional classrooms, water conservation and afforestation), changes in cropping and livestock practices, reductions in the area cultivated and the use of irrigated land, changes in the use of shared labour and share-cropping, changes in the allocation of tasks between household members, changes in household asset base and expenditure patterns, and changes in the composition of rural households.

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<sup>12</sup> The epidemic in different communities may vary from (Barnett and Topouzis, 2003): *AIDS-initiating*: very low HIV prevalence rates and no AIDS impacts; *AIDS-impending*: HIV prevalence rates are rising but the majority of infected people are still in the asymptomatic phase before becoming sick from AIDS-related illnesses (this may take up to eight years); and *AIDS impacted*: households and communities feel the impact of AIDS as infected people succumb to AIDS-related illnesses and eventual death. Due to the time lag between infection, illness and death, communities will remain heavily AIDS-impacted for several years even after HIV prevalence rates begin to decline.

## 6. Implications of HIV/AIDS for Project Design and Implementation

Activities associated with marketing agricultural produce (such as the movement of people, cash payments with seasonal peaks, night trading and alcohol consumption) potentially play a role in hastening the spread of the disease in rural communities. Hence initiatives to strengthen the orientation of agricultural production towards market-led development presents both an opportunity and threat to the rural epidemic. Whilst any contributions towards reducing poverty will contribute to reducing susceptibility to HIV/AIDS, there are very real risks that the additional cash and the stimulus to travel further afield to market produce could result in increasing the risk of exposure to HIV. However, if the marketing chain is brought closer to the producer, it could result in reducing the need to travel.

These relationships have implications for the IPMS project and some of the key points for consideration are discussed below:

- What is the stage of the AIDS epidemic in each of the PLS (AIDS-initiating, impending or impacted)? What activities are currently taking place to assist the community to prepare and respond to the disease effectively?
- To what extent does the vulnerability to the impact of AIDS vary between farming systems? How may IPMS activities strengthen resilience?
- Will market-related agricultural development pose any additional risks of HIV infection to rural communities and, if so, to whom?
- What opportunities are there to train farmers on how to manage their market earnings through savings and investment, and broaden their horizons in order to improve the well being of their whole family?
- How can IPMS activities empower women economically in order to reduce their risk of HIV infection and strengthen their resilience to the impacts of AIDS?
- How can IPMS activities ensure the rural youth participate fully in the opportunities of market-led agricultural development?
- What steps will be necessary to ensure HIV/AIDS infected and affected households will be able to participate in, and benefit from, IPMS activities? What particular challenges do they face with regard to market engagement and how may these be overcome?
- Are there any groups within the rural community associated with agricultural production and marketing initiatives who are traditionally overlooked by HIV/AIDS awareness and outreach activities because they do not usually belong to formal associations (such as petty traders and retailers, ambulant traders, transporters, owners of hotels and drinking houses)?
- Are there occasions when people are gathered together (for example, market days, daily labourers working at coffee washing stations, seasonal migrants working on farms, commercial sex workers moving into an area during harvesting season) which could be used to educate them about HIV/AIDS?
- Are there opportunities for farmers' groups, associations and cooperatives which are registered as legal entities (for example, at the *woreda* level) to apply to EMSAP emergency fund through HAPCO to undertake HIV/AIDS activities?
- To what extent are traditional cultural norms and social practices fuelling the spread of HIV in the community and could these be effectively addressed through community conversations and radio listening groups?

The HIV/AIDS strategy for IPMS, aiming to reduce the rural population's risk of HIV infection and vulnerability to the impacts of AIDS, is described in a separate paper.

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## **Appendix 1: POLICY AND INSTITUTIONAL FRAMEWORK FOR ADDRESSING HIV/AIDS**

**National AIDS Policy 1998:** The policy provides a framework for implementing programmes to prevent the spread of the disease, decrease vulnerability of individuals and communities to HIV/AIDS, care and support for people living with HIV/AIDS, and to reduce vulnerability, stigma and discrimination, and the adverse socio-economic consequences of the epidemic (CCM, 2002).

**Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2001 – 2005:** The framework focuses on reducing the transmission of HIV and associated morbidity and mortality; and reducing its impact on individuals, families and society at large. The strategy is built on four issues: multi-sectoralism, participation, leadership and efficient management (including adequate monitoring and evaluation).

The strategy highlights (i) prevention: strengthening services for sexually transmitted infections (STI) and tuberculosis (TB); condom promotion and accessibility; information, education and communication campaigns; alleviating poverty and increasing employment opportunities particularly for women and youth; gender-specific interventions to empower women and girls to reduce their risk of HIV infection; safe blood supply and preventing occupation exposure; and (ii) care and support: clinical and home- and community-based care for people living with HIV/AIDS (PLWHA); social support for PLWHA and their families; ethical, legal and human rights framework for PLWHA; sector-specific interventions to mitigate impact; HIV/AIDS research and surveillance (Garbus, 2003).

Within the Strategic Framework, pastoralists and farmers were listed among the priority target groups for information, education and communication (IEC) and behaviour change communication (BCC). Opportunities in the farming sector include developing IEC materials specifically for farmers, training communicators from churches, mosques and farmers' associations, promoting IEC at market places, and training agricultural extension workers.

**Strategic Plan to Combat HIV/AIDS Epidemic in Ethiopia (2004 – 2007):** This builds on, and updates, the activities of the strategic framework. Five major intervention areas are identified: creating an enabling environment; making preventative activities more effective; scaling up care and support services; governance; and financing. In order to make preventative activities more effective it is recognised that it is necessary to move away from just passing on information about modes of HIV transmission and precautions to avoid contracting the virus, to adopting a holistic approach with more open interactions and dialogue between the youth and parents, friends, religious leaders, teachers and others.

**Ethiopia Multi-Sectoral AIDS Programme (EMSAP):** The major source of funding for addressing HIV/AIDS in Ethiopia is through a USD 63.4 million loan from World Bank Multi-country HIV/AIDS Program (MAP) funds. It was launched in 2001 to help implement a three year programme within the HIV/AIDS Strategic Framework (2001 – 2005) and was subsequently extended by 18 months until December 2005 due to slow disbursement. The objectives of EMSAP are to reduce the spread of HIV/AIDS epidemic, alleviate its impact, and increase access to treatment, care and support for those infected and affected by HIV/AIDS. The key actors are government agencies at federal and regional levels, NGOs, community based organisations (CBOs), faith based organisations (FBOs), and the private sector.

The programme places much emphasis on developing and expanding local responses to the epidemic, and this is reflected in the budget allocation. Just under half of the programme's budget is allocated to an emergency HIV/AIDS fund (USD 28.1 million) for channelling grants through the *woredas* directly to community organisations at the *kebele* level and NGOs. One third of the budget (USD 19.7 million) is used to support multi-sectoral activities to scale up and mainstream HIV/AIDS. Other elements include USD 8.8 million for capacity building for NGOs, CBOs, and sectoral ministries, and USD 6.8 million for programme co-ordination and management (for the federal and regional HAPCOs and *woreda* facilities). *Woredas* covered by EMSAP are selected on the basis of agreed selection criteria including the HIV prevalence rate. It is estimated that the coverage of the fund is reaching more than 60% of the country, covering over 260 *woredas* (out of 560 in total) (CCM, 2004).

**Global Fund to fight AIDS, Tuberculosis and Malaria:** Ethiopia has submitted two applications to the Global Fund (GF) for financing HIV/AIDS related activities. Under the second round of GF financing, the country secured USD 55.3 million for a two year project running from October 2003, and a further USD 45 million has recently been approved under the fourth round. The main focus of the first project was to scale up and expand activities under the national HIV/AIDS policy, in particular focusing on *woredas* which were not covered by EMSAP. The second funding application focused on increasing access to ARV therapy, including VCT and PMTCT services, and support for orphans and vulnerable children.

The Country Co-ordinating Mechanism (CCM) which oversees the use of funds comprises representatives drawn from government ministries, NGOs, PLWHA, academic institutions, multilateral and bilateral development partners, the private sector and the Chamber of Commerce. The CCM is chaired by the Minister of Health and has three sub-committees that are responsible for HIV/AIDS, TB and malaria. The CMM works closely with the Ministry of Health regarding malaria and TB, and with the HAPCO for HIV/AIDS.

**National AIDS Prevention and Control Council:** The Council was established in 2000 to oversee the implementation of the strategic framework, examine and approve annual plans and budgets, and monitor performance and implementation. It is chaired by the President and the members are drawn from government, NGOs, religious bodies and civil society.

**AIDS councils in the regions:** AIDS councils have been established at regional, *woreda* and *kebele* levels. The membership of regional AIDS councils is drawn from regional government, regional bureaux, religious organisations, NGOs, the private sector and PLHWA. The *woreda* AIDS council has a similar composition with 40 - 60 members and 11 member executive committee. *Kebele* AIDS councils typically consist of a leader (chairman of the *kebele*), secretary (for example, the director of local elementary school) and 15 – 25 members (drawn from religious bodies, associations of youth, women, elders, health post officials, and DAs).

**National HIV/AIDS Prevention and Control Office (HAPCO):** This was formerly the National AIDS Council Secretariat, and was re-established in July 2002 as the executive arm of National AIDS Prevention and Control Council. The office manages the EMSAP and Global Fund (HIV/AIDS component). Applications for funding are received from regional administrations, government organisations, CBOs, PLWHA associations, NGOs, FBOs, private organisations and individuals. All requests are reviewed by a panel of eminent persons.

There have been problems of coordination between HAPCO and the Ministry of Health (MOH) both at federal and regional levels (GoE, 2004). There has been a lack of clarity between their respective roles and mandates, and the strained relationship between the two has negatively impacted on the development of effective national response. In an attempt to increase coordination, HAPCO was relocated into the MOH in late 2004.

**Regional HAPCO activities:** HAPCO offices established at regional and *woreda* levels act as conduits for financing of *woreda* and *kebele* based activities. The regional HAPCO co-ordinates the regional response and provides technical support and financing to the regional bureaux, including agriculture and co-operatives, in the areas of awareness raising and mainstreaming HIV/AIDS activities into work programmes.

EMSAP *woreda* offices usually have two staff (a coordinator or facilitator and accountant/finance officer); those benefiting from GF monies also have a Monitoring and Evaluation (M and E) officer. The *woreda* facilitator supports the work of the executive committee of the *woreda* AIDS council. Activities include capacity building among different target groups, project proposal development, M and E for senior persons in the community, developing leadership qualities for political and significant leaders, behavioural change communication for anti-AIDS clubs, peer education, campaigns to reduce stigma and discrimination, and promotion of the use of VCT services. Despite *woredas* having a critical strategic role to play in the success of community-based responses, due to limited human and material resources and weak support from the regional bodies, they have been unable to develop their capacity to play their role effectively (HAPCO, 2003).

Money from EMSAP emergency grant fund is paid directly through the *woreda* to the *kebele*. The activities are driven by *kebele* plans which are submitted to the *woreda* executive committee and consolidated into a *woreda* action plan which forms part of the regional plan. Up to USD 1000 is available to each *kebele*, payable in two parts based on performance, to undertake awareness raising activities, and to provide care and support to orphans and PLWHA.

## Part 2 HIV/AIDS STRATEGY FOR IPMS

### 1. Rationale

The agricultural sector has a unique role to contribute to addressing the HIV/AIDS epidemic in rural communities. The impact of the disease can undermine development initiatives, diverting attention from productive activities to caring for the sick and surviving the aftermath of death. The death of key adult household members is usually accompanied by a loss of labour, skills, knowledge and assets. Indeed, if left unchecked, the disease changes the composition of rural communities and the priorities of farming households. In heavily AIDS-impacted areas in parts of eastern and southern Africa, many farmers are now principally concerned about basic food security and the survival of their families, thereby making many of the traditional production-oriented extension messages irrelevant.

Agriculture has the potential to contribute to HIV/AIDS prevention, care and mitigation activities but to date, the agricultural sector and institutional responses in Ethiopia have been weak. Yet there exists a great opportunity to avert a deepening of the rural crisis in communities where HIV prevalence rates are, at present, relatively low. For example, the rural prevalence rates for the regions covered by IPMS range from less than 2% to over 5%. Consequently, by understanding of the dynamics of HIV/AIDS in the PLS and the stage of the disease in the community, it will be possible to identify opportunities where the project may contribute to addressing HIV/AIDS in the agricultural sector. Moreover, it is essential to ensure that the project does no harm with respect to hastening the spread of the disease or increasing vulnerability to the impacts of AIDS.

The overall thrust of the HIV/AIDS strategy for IPMS falls within the domain of integrating HIV/AIDS considerations into the broad framework of the existing project design (CIDA, 2003). However, in the process, several of the principles for HIV/AIDS mainstreaming have been observed, such as relying on existing institutional structures, building capacity and understanding about HIV/AIDS, and establishing partnerships with other organisations based on comparative advantage. Further details are presented in a separate paper.

### 2. Purpose and Objectives of Strategy

**The overall purpose of the HIV/AIDS strategy in the IPMS is to reduce the rural population's risk of HIV infection and vulnerability to the impacts of AIDS. The specific objectives are fivefold:**

- to understand the HIV/AIDS context of the PLS;
- to develop the skills of agriculture TVET staff, *woreda* staff and DAs to identify and address HIV/AIDS issues in the agricultural sector;
- to empower communities to understand and address factors contributing to the spread of HIV/AIDS in their communities;
- to identify opportunities to minimise the risk of HIV infection and mitigate the impacts of AIDS in rural communities through project activities and linking with HIV/AIDS specialist organisations; and
- to contribute to the knowledge base about HIV/AIDS in the agricultural sector.

### **I. 3. Strategy Outputs and Activities**

This section sets out the activities and work plans associated with the six strategy outputs.

#### **II. Output 1: HIV/AIDS risk and vulnerability baseline data established by PLS and performance indicators identified through data collection**

##### **Activities**

- (i) Develop methodology for analysing risk of HIV infection and vulnerability to impact of AIDS in each PLS (the Guide on Conducting HIV Risk and AIDS Vulnerability Impact Assessment Study in the PLSs is presented in Annex I) (responsibility of HIV/AIDS advisor).
- (ii) Introduce RDOs to data collection methods (by HIV/AIDS advisor).
- (iii) Collect and synthesise secondary data on HIV/AIDS and the agricultural sector in Ethiopia (IPMS staff).
- (iv) Conduct HIV/AIDS risk and vulnerability assessment in two *kebeles* in each of the main farming systems found in each PLS (ideally the same PLS as the gender and socio economic analysis) (RDOs with *woreda* staff and DAs) (see Appendix III).
- (v) Interpret the findings from primary and secondary data collection with respect to their implications for project design and delivery (IPMS team with RDOs, HIV/AIDS advisor, *woreda* staff and DAs).
- (vi) Identify key indicators to monitor change with respect to HIV/AIDS risk and vulnerability during the life of the project (IPMS team with RDOs, HIV/AIDS advisor, *woreda* staff and DAs).

#### **Output 2: Skills to integrate HIV/AIDS considerations into activities by RDOs, *woreda* staff and Development Agents strengthened through training**

##### **Activities**

- (i) Prepare outline of training objectives (see Appendix II) (HIV/AIDS advisor).
- (ii) Develop course and training materials to be delivered at each PLS drawing on findings from baseline study (HIV/AIDS advisor).
- (iii) Hold briefing with regional and *woreda* resource persons.
- (iv) HIV/AIDS advisor and resource persons to train RDOs, *woreda* staff and DAs at one FTC in one PLS per region (three days per course).
- (v) Training at subsequent PLSs within a region will be conducted by resource persons.

#### **Output 3: Skills to integrate HIV/AIDS considerations into training activities by agriculture TVET staff strengthened through participatory curriculum development**

##### **Activities**

- (i) Prepare TOR for service provider to work with agriculture TVET staff using participatory curriculum development methods to develop course on 'HIV/AIDS and the agricultural sector' (two credit hours = 30 hours).

- (ii) Select service provider to run course (for example, HAPCO, NGO, or consultancy) (IPMS team).
- (iii) Develop course content and assemble materials (service provider and IPMS team).
- (iv) Service provider to run one course for five to six staff from agriculture TVET colleges for five days during summer (July - September) and provide technical support during subsequent curriculum development (additional 10 days).

**Output 4: Opportunities for reducing risk of HIV infection and vulnerability to AIDS impacts strengthened through adapting project activities**

**Activities**

- (i) Organise stakeholder workshop in each PLS to discuss findings from HIV/AIDS assessment in each PLS (see output 1) and their implications for project activities (IPMS team, RDOs, *woreda* staff and PLS stakeholders and HIV/AIDS advisor).
- (ii) Adjust existing project activities to minimise risk of HIV infection and reduce vulnerability to AIDS impacts (IPMS team, RDOs and HIV/AIDS advisor).
- (iii) Identify opportunities to link with specialist HIV/AIDS organisations in order to improve their outreach into rural communities (IPMS team, RDOs and HIV/AIDS advisor).

**Output 5: Knowledge about HIV/AIDS and agriculture and innovative prevention and mitigation interventions increased through case studies and impact assessments**

**Activities**

- (i) Submit results from secondary and primary data analysis (under output 1) into IPMS knowledge management system (IPMS team).
- (ii) Explore options for GIS applications (IPMS team).
- (iii) Conduct in-depth case studies on aspects of interactions between HIV/AIDS and agriculture in the PLSs following baseline study and stakeholder workshop (the case studies may be conducted in year 2 onwards) (IPMS team and results-based management advisor).
- (iv) Conduct studies on innovative approaches to addressing HIV/AIDS in the agricultural sector following strengthening of project activities (under output 4) (IPMS team and HIV/AIDS advisor).

**Output 6: Community understanding and ability to address factors contributing to the spread of HIV/AIDS increased through community conversations**

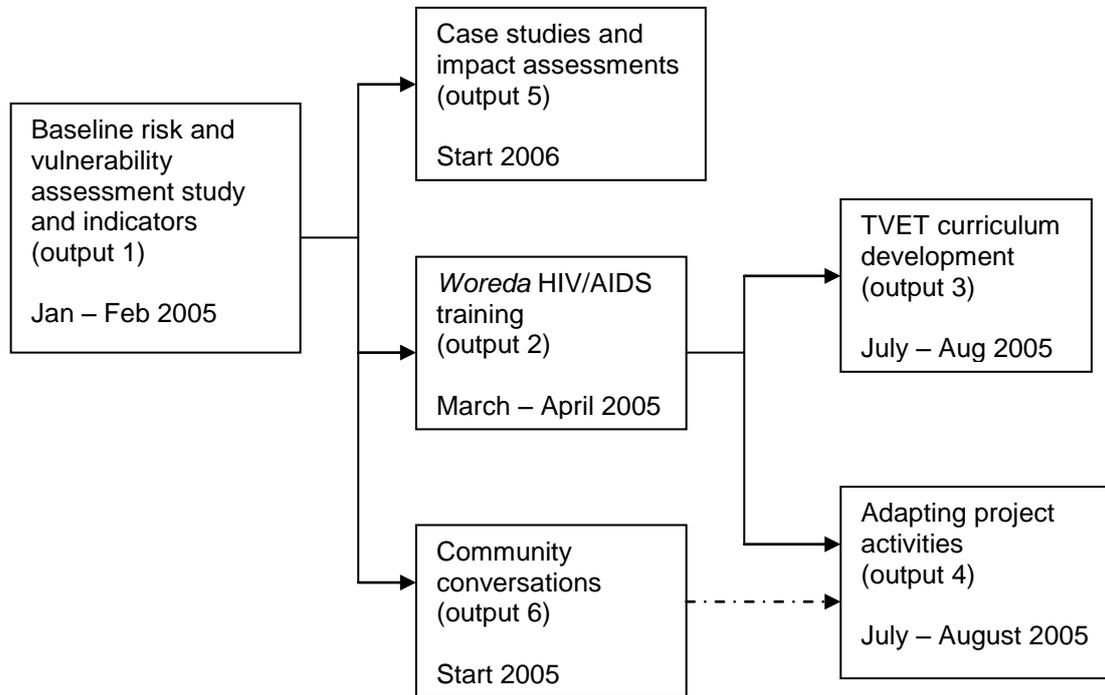
**Activities**

*Following UNDP Community Conversation methodology:*

- (i) Identify community partners, such as NGOs and CBOs, to facilitate community decision-making process (IPMS team);
- (ii) Train trainers to run skills building workshops to train facilitators in community capacity enhancement methodology (UNDP service provider);

- (iii) Train facilitators who will conduct community conversations in project *kebeles* (trainers);
- (iv) Conduct facilitated at least two community conversations per month in project *kebele* over period of 18 months (facilitator);
- (v) Arrange exchange visits between *kebeles* participating in this activity (IPMS team); and
- (vi) Follow-up and site support visits (UNDP service provider).

**4. Work Plan**



## **Appendix II: OUTLINE FOR TRAINING COURSE ON INTEGRATING HIV/AIDS CONSIDERATIONS INTO AGRICULTURAL ACTIVITIES**

**The HIV/AIDS advisor will develop the course content and materials in order to deliver the training as detailed below:**

### **Training objectives**

- To increase the understanding of the context of HIV/AIDS in the *woreda* environment;
- To identify opportunities for agricultural-based initiatives to contribute to HIV prevention, AIDS care and mitigation activities; and
- To develop the skills of *woreda* staff and DAs to integrate HIV/AIDS considerations in their work in the agricultural sector.

### **Participants per PLS**

- *Woreda* administration including Administrator, Head of OoARD, Head of Agriculture, OoA Gender Focal Point, OoA HIV/AIDS Focal Point, OoA Extension, Head of Women's Affairs, Cooperative Officer, HAPCO facilitator (9 persons);
- Development agents and home agents working in *kebeles* participating in the project (16 persons);
- Staff from local Agriculture TVET (1 or 2 persons);
- Representatives from project *kebeles* such as AIDS committee, women's association, youth association, farmers' association (20 persons);
- Maximum 50 people.

### **Resource persons**

In addition to the IPMS HIV/AIDS advisor, other resource persons may include:

- Regional administration including HAPCO secretariat, BoARD HIV/AIDS Focal Point, BoARD Gender Focal Point, Women's Affairs Bureau Head, Women's Affairs HIV/AIDS Focal Point, Cooperatives HIV/AIDS Focal Point;
- IPMS RDO.

### **Venue**

- FTC in one of the project *kebeles*.

### **Duration**

- Three days.

### **Content**

- HIV risks in the external environment;
- Bridging populations linking rural communities with the external environment;
- HIV risks within rural communities;
- Impacts and responses to AIDS-related illnesses and deaths;
- Sources of vulnerability to AIDS;
- Potential implications of HIV/AIDS for IPMS project, and project for spread of HIV/AIDS; and
- Opportunities to reduce risk of HIV infection and vulnerability to AIDS impacts through agriculture, and implications for IPMS project design.

## **Appendix III GUIDE ON CONDUCTING HIV RISK AND AIDS VULNERABILITY IMPACT ASSESSMENT STUDY IN THE PILOT LEARNING SITES**

### **1. Purpose**

There are four main reasons for conducting a HIV risk and AIDS vulnerability assessment study at each PLS:

- To increase the understanding of the sources of risk of HIV infection in the PLS;
- To increase the understanding of the impacts of AIDS to date and potential future sources of vulnerability;
- To identify possible inter-relationships between HIV/AIDS and the project; and
- To identify opportunities within the project for promoting prevention, care and mitigation activities, as appropriate.

### **2. Study Methodology**

Nine tools are described below which can be used to gather data about the dynamics of HIV/AIDS in each PLS. They are presented in four steps: to assess the HIV risk environment of the PLS; to assess the impacts of AIDS to date in the PLS; to assess future vulnerability to the impact of AIDS; and to draw out the implications for project design and implementation.

The first tool is used with key informants who know the *woreda* well, such as the HAPCO facilitator, staff from the Rural Development Department and health workers. Tools 2 through 7 are used with the community. It may be appropriate to meet with women and men separately in order to discuss some of the issues associated with HIV/AIDS. Tools 8 and 9 are used by the project staff to reflect on the findings and their implications for project activities.

<b>HIV/AIDS assessment data collection methods</b>
<b>Step 1: Assessing the HIV Risk Environment of PLS</b> Tool 1: Understanding the external environment Tool 2: Identifying Bridging Populations Tool 3: Understanding the internal environment
<b>Step 2: Assessing the Impact of AIDS to Date in PLS</b> III. Tool 4: Changes in household composition and size Tool 5: Changes in livelihood activities and outcomes Tool 6: Community response to HIV/AIDS
<b>Step 3: Assessing the Future Vulnerability of the PLS to the Impacts of AIDS</b> Tool 7: Indicators of community's possible vulnerability to impacts of AIDS
<b>Step 4: Project Perspective</b> Tool 8: Summary of risks and vulnerabilities Tool 9: Project perspective

The fieldwork should be conducted in a participatory manner. Open-ended questions should be asked when appropriate and the answers recorded as fully as possible. The tools may be used suggested as checklists and they may be adapted as necessary. Meeting the women, men and youth separately enables a range of views and opinions to be heard. The Research and

Development Officer should include one or two women in the study team, if possible (such as the Home Agents), in order to enable women farmers talk more easily.

### 3. Study Sites

It is suggested that the assessment is conducted at *woreda* level (Tool 1) and in two *kebeles* in each of the main farming systems identified in the PLS (Tools 2 to 7). The gender and socio-economic analysis will be conducted in the same *kebeles*.

### 4. Discussing HIV/AIDS in the Community

Although many people are familiar with mobilising communities and their representatives to participate in meetings, the topic of HIV/AIDS is very sensitive and may require different approaches, depending on the stage of the disease in the community and how the community has responded to date. Stigma and discrimination often surrounds HIV/AIDS due to misunderstandings and misconceptions about sources of infection. It is easier to discuss HIV/AIDS in communities which already acknowledge the full reality of AIDS and are actively trying to cope with its impacts, than in communities which are in denial and discriminate against PLWHA and their families. Stigma also makes it difficult to reach the more vulnerable groups since targeting may draw more attention to their plight. Infected people often try and hide their status for fear of discrimination and, once the symptoms become apparent, many isolate themselves and withdraw from public space.

#### Tips on dealing with stigma and discrimination during community mobilisation

- Be tactful and sensitive to PLWHA and their families
- Avoid language or behaviour which will offend or hurt them
- Avoid stigmatising or discriminating actions or language with others
- Include PLWHA and their families in community discussions
- Ask local HIV/AIDS specialists to assist with the community dialogue
- Increase community understanding about the basic facts of the disease

## STEP 1: ASSESSING THE HIV RISK ENVIRONMENT OF PLS

### Tool 1: Understanding the external environment

*With key informants answer the following questions:*

1. On a sketch map identify the major towns, market places, health centres, hospitals, schools, trading centres, administration, places of work, colleges etc (to a radius of around 50 – 100 km).
2. Identify areas which are considered be hotspots for exposure to risk of HIV infection.
3. Examine the reasons why these areas are particularly HIV-risky environments: is it due to data on HIV prevalence rates from VCT centres etc; observed behaviour which is potentially risky; high rates of illness and death among adults showing AIDS-related symptoms?

### Tool 1: Understanding the external environment

HIV-risky hotspots in <i>woreda</i>	Reasons for assessment as HIV-risky environment

## Tool 2: Identifying bridging populations

Meeting with **groups from community** discuss the following questions:

1. Movement from community to external environment: **identify interactions between members of community and external environment (indicate on the map):**
  - who travels outside the community? (women, men, youth, elderly, children)
  - where do they go?
  - when to they go? (daily, weekly, dry/wet season, harvest, hungry season etc)
  - why do they go? (to buy or sell, recreation, education, health, collect water/wood, earn money etc)
  - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
  - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
  - what do they do that might result in unprotected sex?
2. **Movement from external environment into the community:** identify any movement of people from the external environment into the community (indicate on the map):
  - who comes to the community? (women, men, youth, elderly, children)
  - when do they come? (daily, weekly, dry/wet season, harvest, hungry season etc)
  - why do they come? (to buy or sell, recreation, education, health, administration, collect water/wood etc)
  - where do they come from?
  - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
  - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
  - what do they do that might result in unprotected sex?

## Tool 2: Identifying bridging populations

<b>Potential bridging populations</b>	<b>Reasons</b> (where do they go? when to they go? why do they go? how long do they stay? where do they stay? what do they do that might result in unprotected sex?)
<b><i>FROM COMMUNITY TO EXTERNAL ENVIRONMENT</i></b>	
<b><i>FROM EXTERNAL ENVIRONMENT TO COMMUNITY</i></b>	

### Tool 3: Understanding the internal environment

Meeting with **groups from community** discuss the following questions:

1. On a sketch map of the community identify the main places in the community where people meet (market place, bars, hotels, fishing beach, homes, school, water points, woods, neighbours etc).
2. **Movement within the community:** identify interactions between members of community (indicate on the map):
  - who visits these different locations? (women, men, youth, elderly, children)
  - when to they go? (daily, weekly, dry/wet season, harvest, hungry season etc)
  - why do they go? (buy, sell, recreation, education, health, collect water/wood etc)
  - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
  - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
  - what do they do that might result in unprotected sex?
3. Other HIV-risky behaviour: **Is there anything that the community does which increases the likelihood of HIV infection?**
  - what is the event? (for example, dances, weddings, rape, abduction, circumcision, widow inheritance, seasonal practices)
  - who is at risk?
  - why does this practice occur?
4. Infrastructure: **where are the following services available (nearest):**
  - **access to information on HIV/AIDS and sexually transmitted diseases (STIs)?**
  - **access to condoms and cost**
  - **voluntary counselling testing (VCT) centre**
  - **treatment for STIs**
5. **What vision do the youth have for their future?**

### Tool 3: Understanding the internal environment

Groups at risk within community	Reasons
<b>MOVEMENT WITHIN THE COMMUNITY</b> (where do they go? when to they go? why do they go? how long do they stay? where do they stay? what do they do that might result in unprotected sex?)	
<b>EVENTS, CULTURAL AND TRADITIONAL NORMS</b> (what is the event? who is at risk? why does this practice occur?)	
<b>INFRASTRUCTURE</b> (nearest service available?)	
Access to information on HIV/AIDS and STIs	
Access to condoms	
VCT centre	
Treatment for STIs	
Youths' vision for the future	

## STEP 2: ASSESSING THE IMPACT OF AIDS IN PLS TO DATE

### Tool 4: Changes in household composition and size

*Meeting with groups from community discuss the following questions:*

Identify the different types of household that are present in the community.

Note the total number of households in the community (approximately). Define a household to be the unit in which people eat together in the evening.

Use proportional piling to determine the distribution of total households across the household types. Take a large number of seeds or stones (100 or 200) and explain that this represents the total number of households in the community. Ask for a volunteer to distribute the seeds between the different household types. Give other people a chance to adjust the distribution until all are happy. Add up the number of seeds in each group and divide by the total number of seeds in order to calculate the present percentage distribution.

Repeat the exercise in order to determine the distribution five years ago and ten years ago.

#### **Movement between groups:**

- Have there been any movements between the household types?
- Which household types are expanding in number?
- Which household types are contracting in number?
- What are the reasons underlying these changes?

#### **6. Changes in household size:**

- Have there been any changes in the number of people living in a household by household type during the last five years?
- Which household types are expanding in size?
- Which household types are contracting in size?
- What are the reasons underlying these changes?

Tool 4: Changes in household composition and size

	<i>Household type *</i>					
	Married - monogamous	Married - polygamous	Female-headed HHs	Single male-headed MHHs	Orphan-headed HHs	Grandparent-headed HHs
<b>HOUSEHOLD DISTRIBUTION</b>						
Distribution at present (total = 100%)						
Distribution 5 years ago (total = 100%)						
Distribution 10 years ago (total = 100%)						
Reasons for growth/ decline in number of households						
<b>CHANGES IN HOUSEHOLD SIZE</b>						
Average number of people per household today						
Average number of people per household two years ago						
Average number of people per household five years ago						
Reasons for change in household size						

\* The households listed here are for illustrative purposes

#### **IV. Tool 5: Changes in livelihood activities and outcomes**

*Meeting with **groups from community** discuss the following questions:*

1. During the last five years, have any changes taken place in farming activities and, if so, what?
  - Area cultivated per household
  - Use of irrigated land
  - Fallow land per household
  - Crop enterprises
  - Livestock enterprises
  - Division of labour between household members
  - Use of reciprocal labour groups/labour sharing
  - Use of share cropping
  - Use of labour saving technologies and practices
2. During the last five years, have any changes taken place in non-farming activities and, if so, what (for example, fishing practices, forestry, soil and water conservation, income generating activities)?

During the last five years, what other changes have taken place in rural livelihoods:

- Division of labour between household members
  - Household asset base
  - Household savings
  - Expenditure patterns
  - Use of labour saving technologies and practices
  - Composition of diet
  - Health of household members
  - Attendance at school
  - Contribution to communal labour activities in community
  - Burial traditions
4. Why have these changes occurred?
  5. Have they occurred among specific types of households?

### Tool 5: Changes in livelihood activities and outcomes during last five years

	Nature of change	Reasons for change	Household types affected
<b>FARMING ACTIVITIES AT THE HOUSEHOLD LEVEL</b>			
Area cultivated			
Use of irrigated land			
Fallow land			
Crops/trees grown			
Livestock reared			
Division of tasks between HH members			
Reciprocal labour groups/labour sharing			
Use of share cropping			
Use of labour saving technologies and practices			
<b>NON-FARM ACTIVITIES AT THE HOUSEHOLD LEVEL</b> (eg fishing, forestry, trading, brewing, selling food)			
<b>OTHER CHANGES AT THE HOUSEHOLD LEVEL</b>			
Division of labour between HH members in HH tasks			
Household asset base			
Household savings			
Expenditure patterns			
Use of labour saving technologies and practices			
Composition of diet			
Health of household members			
Attendance at school			
Contribution to communal labour activities in community			

Changes in burial traditions			
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## Tool 6: Community response to HIV/AIDS

*Meeting with **groups from community** discuss the following questions:*

1. Are there any activities taking place in the community to raise awareness about HIV/AIDS. If so, what activities, who is undertaking them and who is supporting them (by providing trainers, materials etc)?
2. Are there any activities taking place in the community to reduce the risk of HIV infection? If so, what activities, who is undertaking them and who is supporting them (by providing trainers, materials etc)?
3. Has the community noted any changes in high risk behaviour among certain groups in the community?
4. How does the community help people living with HIV/AIDS?
5. What are the traditional practices for treatment of people living with HIV/AIDS, if any?
6. Are there any activities taking place in the community to help households cope with the impacts of AIDS during sickness and following death? If so, what activities, who is undertaking them and who is supporting them?
7. Are there any activities taking place in the community to help households cope with the impacts of AIDS following death? If so, what activities, who is undertaking them and who is supporting them?
8. What happens to AIDS orphans living in the community?

## Tool 6: Community response to HIV/AIDS

Indicators	Description of community response
HIV/AIDS awareness raising activities? (what activities, by whom, target group, support?)	
Activities to reduce risk of HIV infection? (what activities, by whom, target group, support?)	
Any changes in high risk behaviour observed?	
Activities to assist people living with HIV/AIDS? (what activities, by whom, support?)	
Traditional practices for treatment of people living with HIV/AIDS	
Activities to assist households cope with the impact of AIDS during sickness? (what activities, by whom, target group, support?)	
Activities to assist households cope with the impact of AIDS following death? (what activities, by whom, target group, support?)	
AIDS orphans in community?	

### **STEP 3: ASSESSING THE FUTURE VULNERABILITY OF THE PLS TO THE IMPACT OF AIDS**

#### **Tool 7: Indicators of community's possible vulnerability to impacts of AIDS**

*Meeting with groups from community (where the impact of AIDS to date has been low) discuss the following questions for different types of household:*

1. How do households cope when an adult member (husband or wife) is ill for a long time or dies? How do these responses vary depending on whether it is a man or a woman who is ill or dies?
2. If an adult member of a household is ill for a long time or dies, how do households raise cash, if required?
3. What happens to the household assets (including access to land) when a man dies?
4. What happens to the household assets (including access to land) when both parents die?
5. What happens to the surviving household members after the death of a key adult?
6. How do households generally cope with shortages of labour and farm power?
7. How do households generally cope with food shortages?
8. How do neighbours or the community help households cope with any long term sickness, death and post death?

## Tool 7: Indicators of community's possible vulnerability to impacts of AIDS

Indicators	Response according to wealth of household		
	Rich	Middle wealth	Poor
How do households cope with long term illness or death of wife?			
How do households cope with long term illness or death of husband?			
How raise cash during long term illness or death?			
Transfer of assets when man dies			
Transfer of assets when both parents die			
What happens to surviving household members?	Widow:  Widower:  Orphans:	Widow:  Widower:  Orphans:	Widow:  Widower:  Orphans:
How respond to labour or farm power shortages?			
How respond to food shortages?			
How do neighbours or community assist with any long term sickness or death?			

## STEP 4: PROJECT PERSPECTIVE

### Tool 8: Summary of risks and vulnerabilities

*Project staff to consider the following questions:*

1. Summarise sources of risk of HIV infection by the group at risk.
2. Identify what the individual, household and community can do to reduce the risk of infection.
3. Summarise the sources of vulnerability to the impact of AIDS by the vulnerable group.
4. Identify what the individual, household and community can do to reduce the vulnerability to impacts.

### Tool 8: Summary of risks and vulnerabilities

	Reduce risk of infection	
	Sources of risk or vulnerability by group	Opportunities to reduce risk or vulnerability
<b>HIV infection</b>		
<b>AIDS impacts</b>		

## Tool 9: Project perspective

*Project staff to consider the following questions:*

### Tool 9: Project perspective

What are the potential impacts of AIDS on the project?
Will HIV/AIDS infected and affected households be able to participate in IPMS activities?
<b>What are the potential impacts of the project on the risk of HIV infection?</b>
What may the project do in prevention, care and mitigation activities?
Who may partner the project in these activities?

