

## **The Rural HIV/AIDS Epidemic in Ethiopia and Its Implications for Market-Led Agricultural Development**

---

**Clare Bishop-Sambook, Nigatu Alemayehu, Yirgalem Assegid,  
Gebremedhin Woldewahid, and Berhanu Gebremedhin**

**T**he seriousness of the HIV/AIDS epidemic in Ethiopia is widely acknowledged. Since the first HIV case was recorded in 1986, prevalence rates rose rapidly during the 1990s. By the end of 2003, it was estimated that 1.7 million people in the country (with a total population of over 70 million) 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 is estimated that 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).

The disease is taking its toll on life expectancy and is undermining the country’s efforts to reduce poverty. There have been substantial efforts recently by the government of Ethiopia to address the disease through a multisectoral approach, with increasing attention being paid to reaching the rural areas. However, addressing the epidemic is particularly challenging in such a poor country, where per capita expenditure on health is in the order of US\$6, including out-of-pocket contributions (CCM 2004). It is estimated that over 50 percent of government hospital beds are occupied by AIDS patients (GoE 2004). The problem of caring for and supporting people living with AIDS and orphans has surpassed the capacity of

traditional coping mechanisms. Since the turn of the new millennium, the government recognizes that “investing adequately in HIV/AIDS prevention is now a precondition for virtually all other development investments to succeed” (GoE 2001).

Little work has been done on the nature of the disease in rural areas, despite the fact that 85 percent of the population lives in rural areas. This essential gap in information has been noted by many (Ministry of Health 2002; Mitike et al. 2002; Garbus 2003; Bishop-Sambrook 2004a; Pankhurst 2004). The agricultural sector plays a central role in the Ethiopian economy and lies at the heart of government initiatives to accelerate nationwide economic growth. Even though rural prevalence rates are lower than urban rates (2.6 percent and 12.6 percent, respectively, Ministry of Health 2004), they are rising, and the potential scale of the rural epidemic requires an urgent response. At the household level, the impact of the disease diverts attention and resources from productive activities to caring for the sick and surviving the aftermath of the death of key household members. If left unchecked, the disease reduces the availability and quality of household labor, changes the composition of rural communities, and alters the priorities of farming households, thereby making many of the traditional production-oriented extension messages irrelevant. One significant aspect of the rural epidemic is the extent to which it may undermine efforts to improve agricultural productivity and achieve market-led development.

This chapter discusses the rural epidemic in the context of the Improving Productivity and Market Success (IPMS) of Ethiopian Farmers Project, a five-year CIDA-funded project focusing on technology transfer, improved extension, input supply, rural finance, farmer organizations, and marketing arrangements in support of a market-led integrated agricultural development strategy. The principal sources of risk of HIV infection for rural communities and impacts of the disease are identified in three project *woredas* (administrative districts), with particular attention paid to any increased risk of infection or vulnerability to impacts arising from agricultural marketing. The chapter concludes by considering measures to contain the spread of the disease in the context of the IPMS project.

### **Stages of the Epidemic**

There are three principal stages of the epidemic that a community may pass through: AIDS-initiating, with very low HIV prevalence rates and no AIDS impacts; AIDS-impending, where HIV prevalence rates are rising but the majority of infected people are still in the asymptomatic phase before becoming ill; and AIDS-impacted, when households and communities feel the impact of AIDS as infected

people succumb to AIDS-related illnesses and eventual death (Barnett and Topouzis 2003). One of the greatest challenges of working in many rural communities is that HIV/AIDS data are relatively scarce. Identification of the stage of the epidemic is more difficult when some of the classic indicators of heavily impacted communities are not relevant because of the characteristics of the local farming and livelihood systems. The picture may be further confused by the community's response to the epidemic if they do not know the symptoms of the disease or are in a state of denial about its presence.

This chapter sets out to examine three questions:

- What are the sources of risk of HIV infection for people in the project communities?
- To what extent are these communities and their livelihood systems already AIDS-impacted?
- What may a production- and market-oriented project, such as the IPMS, offer to address the epidemic?

The findings are based on qualitative studies undertaken in three to four communities in each of three *woredas* participating in the project: Atsbi-Wemberta in the highlands in northern Tigray; Fogera adjacent to Lake Tana in western Amhara; and Ada'a Liben in the cereal-livestock systems of Oromia in the central highlands to the east of Addis Ababa. Information was gathered from interviews with key informants, such as government and NGO staff, and from group discussions with farmers, traders, and the rural youth. Groups typically comprised 10–25 people, of whom between one-third and one-half were women. The fieldwork was conducted between late 2004 and early 2005, using a range of participatory methods, including mapping, timelines, matrices, and semistructured interviews (Bishop-Sambrook 2004b). The data focused on reviewing potential sources of risk of HIV infection and examining the extent to which the *woredas* are already impacted by AIDS or their vulnerability to possible future impacts. It should be noted that the findings presented below are based on the interpretation of qualitative data, and attempts have been made to strengthen their validity by conducting the survey in a total of 10 communities.

### **Sources of Risk of HIV Infection**

In order to understand the nature of the rural epidemic, a careful analysis of who is most at risk of becoming infected and how they could become infected is required

(Pisani et al. 2003). The dominant mode of transmission is through heterosexual contact (estimated to account for 87 percent of infections) and mother-to-child transmission (MTCT) (10 percent of infections) (GoE 2004). Blood transfusion, harmful traditional practices, and unsafe injections are all recognized to be a small risk at present but require attention (GoE 1998).

Prevalence rates indicate there are significantly lower levels of HIV infection in rural communities than are found in urban areas. However, the disease may be concentrated in subpopulations within the rural community but not well established within the general population. In this case, the source of risk for the majority of rural residents is through bridging populations, people who are at higher risk and provide substantial links with other subpopulations who have lower-risk behavior. These linkages may provide a conduit for the virus to move into the general population (UNAIDS and WHO 2000). Thus, there are three steps in identifying the extent to which rural communities are at risk from HIV infection: the status of the epidemic in the urban hinterland, the presence of bridging populations, and norms and practices within a community that place people at risk. Risks specifically associated with agricultural marketing are considered separately.

#### **Urban Hinterland and *Woreda* Hotspots**

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 percent to 20 percent (Ministry of Health 2004). 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. This would appear to be borne out by the evidence from the three project *woredas*. The high urban HIV prevalence rate in Amhara is mirrored in the high rural prevalence rate of over 5 percent; whereas the more moderate urban rates of 12.4 percent in Tigray and 10.3 percent in Oromia are reflected in lower rural rates of 2.8 percent and 1.8 percent, respectively (Ministry of Health 2004). HIV-risky environments are not only urban phenomena but also exist within *woredas*, such as administrative and trading centers, military camps, and major transport routes.

#### **Bridging Populations**

There are three types of bridging population, who may link low-prevalence rural areas with higher-prevalence communities. The first are adults and the youth who link their rural communities to higher-risk urban hinterlands for employment, education, or social reasons. Because these activities take place away from home and

the confines of community norms, the lack of social cohesion and anonymity may be a contributory factor that encourages them to engage in activities outside their social norm. The group includes seasonal migrants who seek alternative employment during the quiet months in farming, for example, working as casual laborers in the construction industry in Bahir Dar, on major road construction in Amhara, in the industrial zone on the outskirts of Addis Ababa, or on large commercial sesame farms in western Tigray. In Atsbi some men have dual livelihoods, farming for part of the year and working in town as skilled carpenters or masons during the summer months. Long-term migrants include students attending further education, the youth in Atsbi migrating to Saudi Arabia (but this is less common today), and women working as housemaids. Weekly migrants include adolescents attending senior secondary schools usually located in the *woreda* town. Ad hoc movements include visits to relatives; school dropouts and military returnees moving between small towns and their rural community; administrators and government employees attending meetings or training outside the *woreda*; and farmers staying in town if there are bottlenecks in registration, screening, and disbursement of seeds and credit by the Bureau of Agriculture. People usually stay with relatives or friends, in rented accommodations, or in the home of the employer. Many men leave their wives in the villages and take on a new “wife” in their new residence. They may also stay in local drinking houses.

The second bridging population are those who may carry the virus from outside into rural communities. This includes professionals working in rural communities such as agricultural development agents, teachers, and health workers, who are often unaccompanied by their families; politicians visiting rural areas for sensitization and mobilization purposes for extended periods; the military posted to rural camps; commercial sex workers who follow the seasonal migration of people, seasonal income flows, and the military; long-distance truck drivers and their assistants on overnight stops; seasonal migrants assisting with crop harvests; long-distance salt traders stopping for one or two nights in Atsbi en route while selling salt in local markets; visiting relatives; and distributors of food relief.

The third group relates to those moving within and between neighboring rural communities. Such movement is associated with daily living (such as fetching wood, water, milling, public meetings, and community development works), attending to administrative matters (for example, rural administrators visiting the main *woreda* town or elders mediating in conflicts), and social affairs (visiting relatives, attending wedding and burial ceremonies, special church meetings or holidays). With the exception of social events and overnight stays in administrative centers, the risk of sex associated with daily aspects of rural living is considered to be very small.

### **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. Such practices that potentially place people at risk for 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.

- *Marriage*: Various forms 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. Many of these arrangements disadvantage women and place them at risk of infection through their husbands. The Demographic and Health Survey (DHS) of 2000 found that although it was quite common for young rural men to have premarital sex, it was rare for young rural women to do so (13 percent compared to 1 percent) (CSO 2000).
- *Multiple sex partners*: The practice of multiple sexual partnerships varies between regions, sex, and marital status. Fieldwork discussions suggest that extramarital affairs have been relatively common in the project *woredas*, but many are now reported to be on the decline. However, it has been found that communities tend not to associate their customary sexual practices with the risk of HIV infection because they are conducted within community norms, including inherent elements of trust (Miz-Hasab Research Centre 2004).
- *Use of condoms*: The DHS found urban residents were much more likely to use a condom during potentially high-risk sex than rural residents. This would appear mainly to be related to a general reluctance to use them (because of a lack of familiarity or cultural taboos of adultery associated with their use) rather than their availability (they are sold in shops in rural market centers or available for free in administrative offices, health centers, and some restaurants and bars).
- *Alcohol consumption*: Drinking alcohol, especially in bars and drinking houses, is often closely related to casual sex. Men do not usually pay for sex in the village but rather pay in kind by establishing friendships with young women working in drinking houses (who are often recent divorcees from early marriages) and supporting their business. Excess alcohol consumption is often more acute among the landless and unemployed young people.
- *Wedding parties, religious occasions, and holidays*: These events are celebrated by young men and women dancing and singing during the night and possibly

having a sexual relationship with a new partner. The holiday of Epiphany is traditionally taken as an opportunity to be introduced to someone and start a relationship.

- *Harmful traditional practices:* Several harmful traditional practices (HTPs) are very common in the project regions, including uvulectomy and milk tooth extraction (Jeppsson, Tesfu, and Persson 2003). Although on the decline, female genital cutting is still widespread, with 80 percent of women aged 15–49 years being circumcised (CSO and ORC Macro 2001). Almost all male Ethiopians are circumcised. Other practices are regionally specific, such as incision of the eyelid in Tigray, vein punctures in Tigray and Amhara, and tattooing of women in Tigray. Ethiopian health officials fear that the use of unsterilized instruments to perform these practices aggravate the HIV/AIDS epidemic (GoE 1998); however, the few data available have not found an association between HTP and HIV infection (Garbus 2003). There is increasing action to deter people from practicing HTPs, for example, through the work of the National Committee on Traditional Practices in Ethiopia, and there have been some successes.
- *Suckling young babies:* Sometimes women suckle another's young baby if the mother is out of the village for a day or more, possibly leading to the risk of HIV infection through breast milk.
- *Gender imbalances:* Women and girls are more vulnerable to HIV infection not only biologically but also socially because of 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 decisionmaking. They are also disadvantaged with regard to using and controlling economic resources in the household. As a result of their weak social position and the dominance of men, women are either unaware or unable to insist on condom use or to negotiate for safe sex. Gender inequalities also affects women's ability to use treatment and care services, to disclose their HIV status, to discuss issues of sexuality and safe reproductive behavior with their families, and to receive support for adherence of ARV therapy in the family and community (CCM 2004).
- *Awareness and understanding about HIV/AIDS:* The Behavioural Surveillance Survey of 2002 found farmers to be the least well informed about preventative methods, to have the highest levels of misconceptions about how it could be transmitted, and nearly all farmers had at least one stigmatizing attitude toward

people living with HIV/AIDS (PLWHA) (Mitike et al. 2002). Rural women were found to be the least well informed about preventative methods, which places them at risk both during sex and as caregivers of PLWHA. There has been a change in the level of intensity of awareness-raising activities during the last five years in rural communities. Whenever people gather together, government officials, religious leaders, and village leaders spend some time talking about HIV/AIDS. Development agents, health workers, teachers, peer educators, and serial radio dramas are also important sources of information. Village HIV/AIDS clubs and students perform drama on market days and at school events. Some *woredas* have found that the first-hand experiences by local PLWHA are proving very effective in stimulating behavior change. In contrast, when messages about HIV/AIDS are closely intertwined with religious beliefs, it can sometimes result in confusion regarding appropriate preventative action and effective care.

- *Infrastructure:* Although the number of voluntary counseling and testing centers based in rural areas has increased significantly in the last year, services are still relatively limited. Even when they are available, the fear of stigma and the potential breach of confidentiality encourage some people to travel to major towns for HIV tests rather than use the local center.

### **Marketing-Related Risks**

Certain aspects of agricultural marketing may play a major role in driving the rural epidemic. Marketing involves much movement of sellers and buyers both into and from rural areas, on journeys that may be completed within a day or over several days. Weekly rural markets in the *woreda* are a major social gathering, drawing people together, typically from a 10- to 15-kilometer radius. Market days are often a source of recreation, even if there is no business to conduct, and are acknowledged as an opportunity to meet secret lovers. Drinking on market days is a common and long-established practice and may lead to casual unprotected sex. Activities are heightened during the harvesting season, when money is available and commercial sex workers move into market centers. Indeed, in Ada'a it was reported that many male teenagers have their sexual debut during the months after selling the *teff* harvest, when money is readily available. Larger markets attract people from further afield and may result in overnight stays. Livestock traders from Ada'a are reported to have women in some towns they visit who are known *kimite* ("a woman waiting for a particular man") and share their household expenses. Occasionally, if buyers

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 whole day waiting around the market.

Engagement with the market, and hence market-related risk of infection, is strongly influenced by gender roles because women and men usually occupy distinct niches in the marketing chain. Women sell small volumes (of the main cash crops, vegetables from their home gardens, small livestock and their products, and honey) according to household needs, usually in the local market on a regular basis. Men tend to sell the majority of the cash crops, fattened cattle, and other livestock; when selling in bulk, they often travel further afield to major markets to get better prices. Women and girls are potentially at risk from unwanted sexual advances while they travel to and from markets, and many travel in groups to improve their security. They may also encounter pressure to have sex when they stay away from home while trading, and, culturally, they are in a weak position to refuse.

### **Summary of Risks by Person**

From the above analysis of bridging populations and cultural norms, it is evident that the source of HIV infection differs between household members and is strongly influenced by age and sex. Those at highest risk are married men and the youth, at moderate risk married women and women heading households, and at relatively low risk, the elderly, children, and babies.

- *Babies and children* under the age of 5 are most at risk of infection from their mothers during pregnancy, birth, and breastfeeding (occasionally other women) and possible infection through contact with infected blood and other body fluids (through circumcision or HTPs such as tonsillectomy).
- *Children* from 5 to the age at which they become sexually active are at risk from infected blood and other body fluids (for example, through HTPs including milk tooth extraction).
- *Adolescents*, once sexually active, are at risk through unprotected sex (at dances, weddings, casual laboring, urban migration, and secondary school) and from infected blood and other body fluids (through HTPs). Young men are particularly at risk from visiting town for work, trade, recreation, and drink. Young women face additional risks through abduction, rape, early marriage, and female genital cutting.

- *Married men* are the highest-risk group: they have more opportunities for casual sexual relationships because of their greater mobility, propensity to migrate seasonally, and access to cash; and if they have extramarital affairs they are likely to have several different partners.
- *Married women* are generally a much lower-risk group than men in terms of their behavior, although they are at risk of infection through their husbands: they migrate less, tend not to travel unaccompanied, and tend not to stay away from home overnight; however, in some cultures it has been common for them to have extramarital affairs within the community; they may also be at risk through caring for PLWHA.
- *Female heads of household* are at moderate risk of infection: they may form relationships with men in order to gain assistance with farm work; and if they migrate to town, they may end up working in bars and having sex with customers.
- *Elderly men* are a low-risk group: they do not usually stay away from home overnight, but if they do have extramarital affairs when they go to town to market or attend court cases, they are most likely to have a stable relationship. In Fogera, there has been a tradition for elderly men to form relationships with widows, but this is on the decline.
- *Elderly women* are at minimal risk of HIV from sexual encounters, but as caregivers of people living with AIDS, they are at risk if they do not understand how the disease is transmitted.

### **Impacts of AIDS on Communities and Livelihood Systems**

The section above clearly demonstrates that all rural communities are at risk from HIV infection because of both their close linkage with the external world and practices within the community. However, it is often difficult to identify the stage of the disease in the community, largely because of denial and stigma. Although levels of awareness about the disease are high, there is a reluctance to admit that people from their community are infected or dying from AIDS, although it may be something that is affecting neighboring *woredas*. In addition, as a result of high levels of stigmatization and misconceptions about the modes of transmission, PLWHA who are displaying symptoms of AIDS are often not seen in the community because of self-exclusion or marginalization by others.

Despite the propensity to deny the presence of HIV/AIDS, recent changes in behavior suggest that many people recognize the threat the disease poses. The most common change has been toward multiple sex partners by reducing the number of extramarital affairs, the use of prostitutes, and polygamous marriages. However, it was noted that this change is also taking place for economic reasons and not just as a result of HIV/AIDS awareness. People are also taking steps to reduce their risk of exposure by decreasing the remarriage of divorcees, widows, and spouses and avoiding unnecessary overnight stays away from home. The youth would appear to be among the more committed to change, expressing an interest in establishing one-to-one partnerships, taking premarriage HIV/AIDS tests, and having less extramarital sex. Nevertheless, the use of condoms continues to be extremely low despite their availability.

Another indication of the reality of the rural epidemic is reflected in the changing composition of communities. In all three *woredas*, it was noted that during the last 5 to 10 years there have been fewer polygamous marriages (now accounting for 5–15 percent of total households in the study communities), a growth in monogamous households (40–60 percent), and fewer remarriages among widows and widowers. Female-headed households (15–25 percent) have experienced the highest rate of growth, and households headed by single men, orphans, and grandparents have also increased (each typically accounts for 5–10 percent). Not all these changes can be attributed to the impact of AIDS because there are other reasons that account for the growth in single-adult-headed households, such as the migration of husbands in search of work, an increase in divorce, war (in Atsbi), and a land shortage (Fogera).

Changes in livelihood systems may also indicate the impacts of AIDS. Livelihoods appear to be reasonably buoyant in Ada'a, which may mask, possibly only temporarily, the impact of AIDS. Ada'a benefits from proximity to centers of economic activity, including the industrial zone of Addis Ababa, offering nonfarm employment opportunities and access to major agricultural markets. Poorer households with very small holdings or no land are increasing their nonfarm activities (brewing, distilling, pottery, weaving, silversmithing, and grain trading) or migrating to town. More children are attending school, and, as a result, parents are taking over their farming and household activities. However, it is likely that Ada'a is AIDS-impending because the community is potentially at high risk as a result of its location (with the major urban center of Debre Zeit and the Addis Ababa–Djibouti highway) coupled with a strong tradition of extramarital affairs and high alcohol consumption. An indication of possible times to come is reflected in one busy market center where it was noted that less time is now spent on funerals because of the high number of deaths.

During the last five years in Atsbi, the agricultural sector has been characterized by leading farmers increasing their land under small-scale irrigation, growing an increased range of crops (including vegetables, fruits, spices, and pulses) and adopting improved crop and livestock breeds (such as poultry and dairy cows). The area under fallow has been reduced because of population pressure, and there has been a shift from cattle to smaller livestock because of pressure on grazing land. The practices of reciprocal labor and sharecropping are decreasing because farmers find it more productive to work their own land. All households are increasing their nonfarm activities (such as trading, brewing, selling food, and construction works) except those headed by women and grandparents. The highest level of denial about AIDS was expressed by men and youth in Atsbi. The *woreda* is likely to be at the stage of AIDS-initiating or AIDS-impending.

In contrast, Fogera is already AIDS-impacted with the disease taking its toll on rural livelihoods. Poor and female-headed households are struggling to survive the loss of key adults and asset depletion (particularly the sale of livestock) during illness. They are resorting to sharecropping, hiring out their children for farm work, brewing local drinks, collecting and selling fuelwood, or migrating to town and receiving alms. In some communities, relatives, close friends, and neighbors assist with farming activities; they may also lend money or contribute to supplement food shortages. Some widows weed other people's land in exchange for assistance with plowing, but reciprocal labor groups are becoming less popular because of the labor shortage. Today, there are indications that only relatives and close friends attend funeral ceremonies.

Within communities the impact of AIDS differs between occupational and wealth groups. Those who depend on their physical well-being or appearances for their livelihood are particularly vulnerable. Farmers and transporters of produce lack the physical energy to do their work. Customers shy away from buying from retailers or sellers who look ill because of stigma and misunderstanding regarding the transmission of the disease. Once the signs of the disease become evident, infected individuals often withdraw from public space, including visits to the market. The disease makes many poor livelihoods untenable, whereas the opportunities for recovery are much stronger in resource-rich households with the options of remarrying, hiring home help, and hiring labor to work on the farm.

### **Opportunities for Addressing HIV/AIDS through Market-Led Growth Strategies**

The recommendations below specifically focus on opportunities available to address HIV/AIDS through improving agricultural productivity and marketing. They are

relevant to the IPMS project and may be implemented with the support of local resources such as the *woreda* HIV/AIDS prevention and control offices. The review in the preceding section highlights the need to tune interventions first to the needs of different communities, depending on the stage of the epidemic, and second to different groups within the community, depending on their specific sources of risk.

### **Raising Awareness and Understanding about HIV/AIDS**

The focus varies between AIDS-initiating and AIDS-impending communities (modes of transmission, local sources of risk, and methods of prevention) and AIDS-impacted communities (safe care and nutrition needs of PLWHA).

- Train agricultural staff; members of farmer organizations, cooperatives, and marketing groups; and members of trade associations about HIV/AIDS and its implications for agriculture.
- Work with groups 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, and owners of hotels and drinking houses.
- Use occasions when people are gathered together (for example, market days, seasonal migrants working on farms, or commercial sex workers moving into an area during harvesting season) to educate them about HIV/AIDS and its prevention.
- Hold intensive awareness campaigns during seasons of high risk, such as harvesting and holidays.
- Distribute HIV/AIDS leaflets to members of cooperatives and farmer groups.

### **Reducing Risk of Exposure to HIV Infection**

This is relevant for all communities regardless of the stage of the epidemic; the main emphasis is to reduce the risk of activities leading to unprotected sex with infected people.

- Reduce the need to migrate through improving food and nutrition security by increasing output, improving the quality of produce, widening the range of products, and making more efficient use of inputs (including labor).

- Reduce the wish to migrate by increasing livelihood options in and around the community and extending the growing season through developing small-scale irrigation, product diversification, agroprocessing, strengthening existing and creating new market linkages, and developing the farm input supply chain.
- Reduce the need to travel to markets by bringing the marketing chain closer to the producer (market information readily available in rural community and new modes of market engagement such as forward contracts).
- Reduce the behaviors of high alcohol consumption and extramarital affairs by training farmers how to manage their market earnings through savings and investment, and broaden their horizons to improve the well-being of their whole family.
- Reduce women's weak bargaining position regarding unwanted sexual encounters by empowering them economically through income-generating activities and gender training. Make the marketing chain more women-friendly and secure.
- Encourage rural youth to participate fully in the opportunities of market-led agricultural development.
- Introduce methods of payment for products that reduce the time spent at market.

#### **Reducing Vulnerability to AIDS Impacts**

This is relevant for AIDS-impacted communities.

- Overcome barriers to participating in agricultural production and marketing by infected and affected households, such as their depleted resource base, the need to be close to home to tend to the sick, loss of key skills, and their inability to undertake risk.
- Develop market opportunities for crops and livestock that are suited to the resource base of infected and affected households.
- Provide assistance to infected and affected households to overcome constraints imposed by HIV/AIDS on their market-related activities (for example, transporting produce to market, processing, and forming retailing groups among petty retailers in the market).

- Promote crops and livestock that contribute to balanced diets for PLWHA and prolong their lives through the provision of antiretrovirals.
- Use cooperatives and farmer organizations as an entry point for mitigation, care, and support activities in communities, for example, by developing income-generating activities, savings, health insurance, or establishing a social fund to provide care for orphans.

## Conclusion

Initiatives to strengthen the market orientation of agricultural production present both an opportunity and a threat to the rural HIV/AIDS epidemic. Although any contributions toward reducing poverty and the need to migrate may reduce 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. Hence, activities associated with promoting the marketing of agricultural products need to be designed with care to ensure they play a role in arresting, rather than hastening, the spread of the disease in rural communities.

## References

- Barnett, T., and D. Topouzis. 2003. *FAO and HIV/AIDS, towards a food and livelihoods security based strategic response*. Rome: FAO.
- Bishop-Sambrook, C. 2004a. *The challenge of the HIV/AIDS epidemic in rural Ethiopia: Averting the crisis in low AIDS-impacted communities, findings from fieldwork in Kersa woreda, Eastern Hararghe Zone, Oromiya Region*. Rome: FAO.
- . 2004b. *Addressing HIV/AIDS through agriculture and natural resource sectors: a guide for extension workers*. Rome: FAO Socio-economic and Gender Analysis Programme (SEAGA).
- CCM. 2004. *Application for global fund, fourth call for proposals*. Addis Ababa: Country Coordinating Mechanism.
- CSO. 2000. *Ethiopia demographic and health survey*. Addis Ababa: Central Statistical Office.
- CSO and ORC Macro. 2001. *Ethiopia and demographic health survey 2000*. Addis Ababa: Central Statistical Office and U.S.A.: ORC.
- Garbus, L. 2003. *HIV/AIDS in Ethiopia*. Country AIDS Policy Analysis Project. San Francisco: AIDS Policy Research Center, University of California.
- GoE (Government of Ethiopia). 1998. *Policy on HIV/AIDS*. Addis Ababa: GoE.
- . 2001. *National strategic framework 2001–2005*. Addis Ababa: GoE.

- . 2004. *A comprehensive strategic plan to combat HIV/AIDS epidemic in Ethiopia (2004–2007)*, Final Report. Addis Ababa: GoE.
- INRI. 2004. Ethiopia: Efforts underway to achieve gender parity, in *INRInews*, UN Office for the Coordination of Humanitarian Affairs.
- Jeppsson, A., M. Tesfu, and L. A. Persson. 2003. Health care providers' perceptions on harmful traditional health practices in Ethiopia. *Ethiopian Journal of Health Development* 17 (1): 35–44.
- Ministry of Health. 2002. *AIDS in Ethiopia*, 4th ed. Addis Ababa: Disease Prevention and Control Department, MOH.
- . 2004. *AIDS in Ethiopia*, 5th ed. Addis Ababa: Disease Prevention and Control Department, MOH.
- Mitike, G., W. Lemma, F. Berhane, R. Ayele, T. Assefa, T. Michael, F. Enqusellase, A. Alem, Y. Abebe, and D. Kebede. 2002. *HIV/AIDS behavioural surveillance survey*, Ethiopia Round One. Ethiopia: Department of Community Health, Addis Ababa University, and Ethiopian Public Health Administration.
- Miz-Hasab Research Centre. 2004. *HIV/AIDS and gender in Ethiopia: The case of 10 wereda in Oromia and SNNPR*. Addis Ababa: Miz-Hasab Research Centre.
- NIC (National Intelligence Council). 2002. *The next wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China*. Washington, D.C.: NIC.
- Pankhurst, A. 2004. *Conceptions of and responses to HIV/AIDS: Views from twenty Ethiopian rural villages*, Paper presented at Second International Conference on the Ethiopian Economy organised by Ethiopian Economic Association at United Nations Conference Centre, June 3–5, 2004, Addis Ababa.
- Pisani, E., G. P. Garnett, N. C. Grassly, T. Brown, C. Hankins, N. Walker, and P. D. Ghys. 2003. Back to basics in HIV prevention: Focus on exposure. *British Medical Journal* 326: 1384–1387.
- UNAIDS, UNICEF, and WHO. 2004. *Ethiopia, epidemiological fact sheets on HIV/AIDS and sexually transmitted infections*. Geneva: WHO.
- UNAIDS and WHO. 2000. *Guidelines for second generation HIV surveillance, second generation surveillance for HIV: The next decade*. Geneva: UNAIDS.