

**PASTORALISTS SUSCEPTIBILITY TO HIV INFECTION:
A STUDY BASED ON SHINILE DISTRICT, SOMALI
REGION, ETHIOPIA**

Masters of Professional Thesis

By

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Executive Summary

In the hard-hit countries by HIV/AIDS, the epidemic has eroded the development gains made in past decades. The spread of HIV is heterogeneous in Sub-Saharan African countries, with different peaks which vary geographically and in terms of their distribution among social or economic groups. Thus, there is a pressing need to promote researches and policy making not only at biomedical and behavioural level but also at the underlying social, cultural and economic causes of the epidemic. Although HIV prevention policies and interventions should be based on evidences that show how the disease spreads in the community, however, very few studies have focused on the susceptibility of pastoralists, and therefore there is a great need to acknowledge and document the risk environments which contribute to the spread of HIV/AIDS in pastoral areas to curb the spread of the epidemic.

Based on the research in Shinile district of Somali region in Ethiopia, this study aims to identify the risk for the spread of HIV among Shinile pastoralists by looking at the susceptibility factors in the community. In the fieldwork in Ethiopia interviews with 20 people and 3 focus group discussions (FGDs) in the community were conducted. As a tool for identifying susceptibility factors, the study adapted the framework by Tony Barnett and Alan Whiteside and analyzes the research results in terms of identified factors.

The research shows that although there is lack of reliable data on the prevalence of the epidemic in the district, HIV/AIDS is a clear and present danger to Shinile pastoral communities. The awareness on HIV/AIDS level in the community are low, the communities have not accepted the presence and the threat associated with the epidemic. The study reveals that migration to urban centers particularly to the neighboring centers with high HIV/AIDS prevalence is likely to be one of the factors which contribute to the spread of the disease to the low risk population.

The low awareness and misconceptions on HIV/AIDS compounded by the low access to preventive health services also poses a major risk. In addition, there is a general absence of self-protection among the community, a situation perpetuated by religious and traditional norms. The study also shows that women faces a heightened risk of HIV infection as they have low awareness level due to the 'women stay home culture' among pastoralists which limited their access to HIV/AIDS information. Moreover, gender related norms which put women at risk like polygamous marriage, marriage by inheritance, early marriage and female genital mutilation (FGM) are also widely practiced.

The striking finding of the research is that being part of pastoral societies, Shinile communities have no experience of violent conflicts among their clan or the neighboring pastoral societies which is known to be common among pastoralists in general. Traditional patterns of sexual networking like wife sharing and multiple sexual partners (pre-marriage and in-marriage) which are promoted in some pastoral societies are not widely acknowledged among Shinile pastoral communities.

Finally, the study presents both short term and long term recommendations which contribute towards prevention of HIV spread among the study area. The short term include i) better understanding of the status of the epidemic ii) organise targeted awareness raising campaigns iii) community empowerment to challenge norms and culture on gender issues iv) enhance the involvement of non-governmental organisations (NGOs) and community based organisations (CBOs) in response to the epidemic and v) improve access to preventive health services. The long term recommendations are: i) Policy review on development of pastoral areas and ii) Strengthening and diversifying of pastoral livelihoods.

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Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Anti retro Viral
BSS	Behavioural Surveillance Survey
CBOs	Community Based Organisations
CSWs	Commercial Sex Workers
CRDA	Christian Relief and Development Associations
EDHS	Ethiopian Demographic Health Survey
FAO	Food and Agriculture Organisation
FBOs	Faith Based Organisations
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
GDP	Gross Domestic Product
GoE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HCS	Harargie Catholic Secretariat
HIV	Human Immuno Virus
HTPs	Harmful Traditional Practices
ITDG	Intermediary Technology Development Group
IOM	International organisation for Migration
ICE	Information, Communication and Education
MEDaC	Ministry of Economic Development and Cooperation
MoH	Ministry of Health
NGOs	Non Governmental organisations
PLWH	Peoples living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SC-UK	Save the Children – United Kingdom
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nation
UNAIDS	United Nation AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation

Chapter 1: Introduction

This chapter introduces the base of the dissertation. Section 1.1 sets up the background. Research problem and research objectives are presented in Section 1.2 and 1.3 respectively. In section 1.4 the research questions are presented. Section 1.5 describes the research methods adopted. Section 1.6 discusses research limitations that may affect the reliability of the study and the fulfilment of the objectives. The last section 1.7 deals with the organisation of the thesis.

1.1 General background

After twenty-five years, the global AIDS pandemic is still expanding. No country has remained untouched by HIV, making the pandemic an issue of global concern. UNAIDS (2005) states that “AIDS has become the most devastating disease humankind has ever faced and that it is a worldwide problem”. According to recent reports of UNAIDS, the total number of people living with human immunodeficiency virus (HIV) rose in 2006 to reach its highest level ever: an estimated 39.4 million people are living with the virus globally.

The Human Immunodeficiency Virus (HIV) epidemic is one of the primary threats to continued development in Africa. Although Sub-Saharan Africa has just over 10 percent of the world's population, it is home to almost 64 percent of all HIV infections. An estimated 21.6 million people are living with HIV-infection in this region (UNAIDS, 2005).

Unlike other regions of the world, the rate of spread of HIV is heterogeneous in Sub-Saharan African countries. Most of these countries are experiencing generalized epidemics- HIV is spreading throughout the general population, rather than being confined to populations at higher risk. Cohen and Trussel (1996) indicated that, at the same time, the difference across areas in the percentage of the population infected is staggering.

On the other hand, within a country it self, HIV/AIDS epidemic takes different forms in different societies in most Sub-Saharan African countries. In reality, a national epidemic is made up of many sub-epidemics, with different peaks which vary geographically and in terms of their distribution among socio-cultural or economic groups (Barnett and Whiteside, 2006). This is mainly due to variations in socio-cultural and economic characteristics which make an epidemic grow more or less rapidly and make a society more or less susceptible to the epidemic (ibid).

Ethiopia, located in North-eastern part of Africa is one of Sub-Saharan countries severely affected by HIV/AIDS. The epidemic in Ethiopia like other Sub-Saharan African countries is generalised and continues to impact every sector of the society. Kloss (2007) indicated that HIV/AIDS in Ethiopia is unevenly distributed across urban and rural populations, male and females, and different socioeconomic and cultural groups. HIV spread in urban areas is recently stabilising, but expanding more in the rural areas, although the extent to which different pastoralist groups are affected by HIV/AIDS and how they are affected is not well known in the country.

In epidemics in Ethiopia and elsewhere where it is generalised rather than centralised to specific groups, interventions at biomedical and behavioural level are vital. However, these are aimed at specific groups of core transmitters and are not adequate (Barnett and Whiteside, 2006). In addition, the problem in sub-Saharan Africa is even if people have the awareness of their risky behaviour; they may not have the power and incentive to change their behaviour.

Nevertheless, little attention was paid until recently in HIV/AIDS programmes and policies to the broader factors in which the HIV/AIDS epidemic can expand and develops in communities. All programmes to do with HIV/AIDS have mainly focused on the clinical-medical and behavioural levels. However, Barnett & Whiteside (2006) states that, if prevention is to move towards to an effective action, we must have to look at the underlying social, cultural and economic causes of such risky behaviour as causes of the epidemic and intervene there too.

With this background, this study attempts to identify the underlying susceptibility factors for HIV spread among Somali pastoral community of Shinile district in Ethiopia. The researcher has decided to conduct this research as a professional master thesis for three main reasons. Firstly, I am fascinated by the unique culture and pastoralist's way of life. Secondly, I am interested in HIV/AIDS research because of my previous background in public health and the current specialisation course- Rural Development and HIV/AIDS which I am taking in Larnestein University. Lastly, my research area should be in line with my organisation's mandate which is funding my study: Institute of Pastoralists and Agropastoralists Studies (IPAS), Haramaya University of Ethiopia mainly conducts researches in pastoral areas of the country.

1.2 Research problem

There has been no documented research on HIV/AIDS issues with respect to pastoralism in Ethiopia as far as could be ascertained by this study. This might be due to the fact that in areas characterized by underdevelopment, drought and political instability, HIV/AIDS in pastoral areas of Ethiopia has not yet received much attention. Coupled with lack of socio-economic information on the potential drivers of the epidemic in pastoral areas, the extent to which different pastoralist groups are affected by HIV/AIDS is not well known in the country, although it is thought that prevalence rates are relatively lower than found in urban areas.

The adult prevalence of the disease, which is mainly based on surveys of pregnant women in the largely pastoral Somali region of Ethiopia, is 1.2 percent, which is lower than that of an average for urban areas i.e. 10.5 percent (MoH, 2006). On the other hand, there is no data available on the prevalence of the disease for Shinile district of Somali region which could be due to the limited coverage of HIV/AIDS surveillance in the country. In general pastoralists are highly susceptible groups once the infection enters the community when compared to agricultural society. This is due to various factors which include their out-of-area migration, traditional patterns of sexual networking, exposure to violent conflicts etc. (Morton, 2004)).

Even though the rate of the spread of the disease is lower in Somali in general and also assumed to be the same for Shinile district, in view of the high epidemic potential in pastoral areas, there is a need to protect the community. Since HIV prevention policies and interventions should be based on evidences that show how the disease spreads in the community, and therefore, there is a pressing need to promote researches which focus on the identification of the susceptibility of various pastoral communities to HIV infection. In similar manner, there is a great need to acknowledge and document the risk environments which contribute to the spread of HIV/AIDS in Shinile district of Ethiopia to curb the spread of the epidemic.

1.3 Research Objectives

The ultimate objective of this study is to contribute towards reducing the spread of HIV infection among Shinile district pastoralists through providing better knowledge on the susceptibility factors for HIV spread in the area. Specifically the study objectives are the following:

- 1) To identify potential susceptibility factors which contribute to the spread of HIV infection among Shinile district pastoral community.
- 2) To analyze the response to the epidemic in the district by different institutions.
- 3) To generate base-line information for further similar study in the area.

1.4 Research Questions

The main focus of the research is on the risk environments (susceptibility factors) at community level for HIV spread in Shinile district pastoralist societies of Ethiopia and response to the epidemic in Shinile district. The main research questions investigated were, therefore, as follows:

- 1) What are the societal factors of pastoralists that create a risk environment for HIV infection?
- 2) To what extent do these factors present among Shinile district pastoral community and how do they contribute to the spread of HIV in the area?
- 3) What are the actions taken in response to the epidemic in the district by different actors?

1.5 The Research methodology

The initial phase of the research was an extensive review of relevant literatures to identify risk factors that contribute to the susceptibility of pastoralist societies to HIV infection. The literature review was not only limited to Ethiopian pastoralist, but also includes research conducted on pastoralist groups in neighbouring countries (Kenya, and Tanzania etc.) and elsewhere. This literature search was mainly conducted in The Netherlands for about two weeks.

Based on the factors identified during literature study, a check list was prepared which served as a guide for semi-structured interviews to be conducted during field study. The field phase of the research was conducted in Shinile district (*woreda*) of Somali region of Ethiopia. The two kebeles-Jidane and Marmarsa were chosen randomly among others since the researcher is not familiar with any of those villages and this had the advantage to avoid selection bias during field study.

A total of four weeks were used for field work in Ethiopia. During the first week statistical data was obtained from the concerned offices in the district to have a clear insight about the socio-economic environment of the district population. The two weeks were used for interview with key informants in the community and focus group discussions. Compilation of data from the field was done during the last week of field work.

The researcher was accompanied by two translators (male and female) from Shinile district Issa tribes and therefore created a rapport between the researcher and the respondents. In addition, since it was impossible to cover all the inhabitants of the two kebeles identification of key informants had to be made systematically through

discussion with district agriculture office. The following methods of collecting information were used.

Interviews in pastoral community

Data in the field was collected through a qualitative, semi- structured, and open way of gathering data to gain an insight into the potential risk factors for HIV spread among Shinile district pastoralists. A total of 20 key informants from the community were interviewed. 10 respondents from each of the two villages were interviewed individually with the help of a check list (field guide). Totally 8 women and 12 men interviewees were selected. The study differentiated between men and women and between the different age categories (young, adult and old) for both men and women. The focus of an issue for an interview varies depending on the appropriateness of the interviewee. For instance, information on the migration patterns was mainly obtained from the pastoral men as they are the main mobile pastoral groups.

No formal questionnaire was made because this study used informal methods of data collection. Qualitative methods were used so as to probe deeper into pastoral risk factor issues (migration/mobility, exposure to conflict, gender norms, access to HIV/AIDS health services, traditional practices, cultural habits (norms) of sexuality).

Separate, somewhat more structured questions were formulated to investigate the actions of various institutions (both governmental and NGOs) working in the district in response to the fight against HIV/AIDS epidemic. The main information obtained from these organisations includes their activities related to HIV/AIDS in the district, and they have also suggested on the potential risk factors for the spread of HIV infection.

The Key informants included in the interviews were: the two *kebeles*' community leaders, community elders, religious leaders, pastoralist women and men. In addition, leaders and staffs members of various government offices which include district health clinic, district health bureau, district administrative office, and district HIV/AIDS secretariat office were also interviewed on their respective organisations response on HIV/AIDS. They were also key informants on the potential risk factors for HIV spread. The representatives of three different NGOs which are involved in HIV/AIDS activities in the district were also included in the study. The NGOs are: Handicap International, Save the Children-UK, and Harargie Catholic Secretariat (HCS - a local NGO).

Focus Group Discussions (FGDs)

Three different FGDs, among adult pastoralist men, young pastoralist men and adult pastoralist women each comprises of 4 participants were conducted. The FGDs were conducted to get further information and explore views of discussant as compared to individual interview on the potential risk factors for the spread of HIV: including information related to their awareness on HIV/AIDS, mobility patterns, gender related factors, traditional practice were obtained. Before starting the discussion the preliminary results of the study were presented, as an opening for the group discussions. This meant doing a quick processing and preliminary analysis of the data collected in the individual interviews.

This process gave the focus group an opportunity to give their opinion adding a participatory aspect to the study. The study community was involved more in this type of collection of information as the method was informal and participatory. The same male and female translators during interview were also used as facilitators during focus group discussions. The female focus group discussion was facilitated by female facilitator and the same was true for male group focus discussions. This is to

make the discussion more comfortable, as the topics related to HIV/AIDS, sexuality and gender norms are sensitive issues in the community.

Observation

In addition to interviews and FGDS, the researcher had a general observation in the villages and it was useful to gain an understanding of the community members social and gender roles and responsibilities. It was also an opportunity for the researcher to appreciate the migration of the rural pastoralists for various reasons including in the context of current drought situation.

Data processing and Analysis

The data analysis first started with description and interpretation of the research findings. And then thematic issues were extracted from the qualitative data obtained from the research and the findings were compared and contrasted with various study findings. Similarities and differences from previous research findings were identified. The main emphasis was on the potential susceptibility factors to HIV infection among Shinile district pastoralists.

1.6 Limitation of the study

The study was mainly based on two kebeles in Shinile district and thus the findings can not be generalised for the pastoralist of Ethiopia. In addition, susceptibility factors which were investigated should be supported by further research study to establish a clear link between the factors and HIV infection for the study community, for instance, behavioural survey of migrant groups is necessary to identify to what extent the groups are exposed to risk behaviour and thus to set up a link between migration and risk of HIV infection for migrant groups.

1-7 Organization of the Thesis

The rest of this thesis is organized into four parts. The second part deals with literature review that includes global overview of HIV/AIDS condition including its social ,economic and agricultural sector impacts; HIV/AIDS situation in Ethiopia and pastoralism and HIV/AIDS in the country and elsewhere in the world. The third part presents a closer look at the study area and the study community. Part four deals with the results and discussion of key findings and finally the last section - part five presents conclusions and recommendations.

Chapter 2: Pastoralists Susceptibility to HIV in Ethiopia

Based on the literature review, this chapter presents an overview of global challenges of HIV/AIDS with main focus on the impact of the epidemic in Sub-Saharan Africa, and the situation of the epidemic and the response in Ethiopia. The chapter, however, devotes more attention to the susceptibility of pastoralist to HIV infection, although research finding on HIV/AIDS and pastoralism is scant.

2.1 Global Challenges of HIV/AIDS

The AIDS epidemic may be the most devastating health disaster in human history. The disease continues to ravage families and communities throughout the world. In addition to the 25 million people who had died of AIDS by the end of 2005, approximately 40 million people are now living with HIV. According to UNAIDS, currently nearly two-thirds of all people living with HIV are found in sub-Saharan countries and an estimated 2.1 million adults and children have died as a result of AIDS in this region during 2006 alone ((UNAIDS, 2005).

Sub-Saharan Africa is the hardest hit region in the world and HIV/AIDS is causing a widespread impact on many parts of African society. More Africans die of AIDS – related illness than any other causes (Lamptey et al, 2006). South Africa has the largest number of people living with HIV-between 4.5 and 6.2 million. Swaziland has the highest adult prevalence rate: more than 38 percent of adults are infected with HIV (WHO, 2005). While the scale and force of the epidemic have hit Africa hardest, other regions also face serious AIDS epidemics. HIV prevalence spreading fastest in Eastern Europe and former soviet republics because of increase in injecting drug uses and the break down in health care system (ibid).

Adding to an already heavy disease burden in poor countries, the epidemic is causing huge social impacts, aggravating gender inequalities, eroding the capacity of government to provide essential services, reduce labour productivity and supply and putting a brake on economic growth. These worsening conditions in turn make people susceptible to infection and undermine the ability of the individuals, households and government to respond to the epidemic. In particular the epidemic poses a huge setback on Sub-Saharan Africans' agricultural sector (Kormawa, 2005)

a) Social Impacts

The costs associated with the AIDS epidemic are lives lost, suffering of families, extreme social and emotional burdens on caregivers and orphans left behind. One of the most critical effects is that it robs the family of their only "social security" system; productive members are taken out of the equation when they become ill and die, leaving children and the elderly to fend for themselves (Munthali, 2002). The loss of productivity and food security, and the staggering costs and overwhelming demands on health systems is also huge (May, 2003)

In light of this situation, some of the strategies adopted in Malawi, for example, are: children marry earlier, drop out of school to support their family, and take on informal labour schemes (Munthali, 2003). Another research finding from Uganda showed that adding a foster child to a household (more frequent these days due to parents' having succumbed to AIDS) significantly reduces per capita consumption, income, investment in the household, and possibly also access to health services (Deininger et al. 2002). For some African societies, now HIV/AIDS means a national bankruptcy, "pushing households into poverty and starvation, people ending up in the streets (Garrett, 2000).

The loss of individuals by HIV/AIDS has also an impact on the social reproduction which goes in to reproducing the life-ways of our households, communities, institutions and even nations. In fact, the severity of this impact depends on who that individual is, where he or she fits in the community and society and how replaceable he or she is. The unmeasured consequences for the orphan generation are also of great concern, creating a lost generation in hard- hit countries. Barnett and Whiteside states that the cost of these unsocialised, uneducated and in many instances unloved children struggling to survive to adult hood are potentially enormous and are already being felt.

b) Economic impacts

HIV/AIDS has a diverse impact in the economy apart from the social chaos it creates. The epidemic is undermining the affected countries' efforts to reduce poverty and more deepening poverty and creating severe economic impacts. This is because it is different from most other diseases as it strikes people in the most productive age groups in many Sub- Saharan African countries (ECA, 2003). It kills adults in the prime of their lives, thus depriving families, communities and entire nations of their young and most productive people. The economic effects vary according to the severity of the HIV/AIDS epidemic and the structure of the national economies (Lampety et al.2006)

Already communities across large parts of the African continent are facing a day-to-day reality of declining standards of living, reduced capacities for personal and social achievement, and an increasingly uncertain future. Several findings project that there would be significant reductions in economic growth rates for African economies due to loss of capacity in the future, FAO (2003) notes that the two major economic effects of the epidemic are reduction in the labour supply and increased costs.

The loss of labour supply of young adults in their most productive years will affect overall economic output. The impact may be even much larger if AIDS is more prevalent among the economic elites. According to ECA (2003), the disease has caused not only the direct costs which include expenditures for medical care, drugs, and funeral expenses, but also indirect costs including lost time due to illness, recruitment and training costs to replace workers, and care of orphans.

Studies have found that the impacts of HIV/AIDS on macro economy are yet small in hard-hit countries, especially due to a plentiful supply of excess labour. Therefore, the effect of AIDS on the labour force will not be dramatic in the near future, as those dying will be able to be replaced by the unemployed (ECA, 2003). However, sooner or later once the prevalence rate increases there will be more highly skilled workers be affected which would cause its devastating impact on the overall economy.

For instance, a macroeconomic simulation model of the Ethiopian economy found that, although there would be a significant demographic impact from HIV/AIDS in Ethiopia, but there would be very little overall macroeconomic impact. The only macroeconomic impact on Ethiopia was found to be a negative effect on savings. This is because in Ethiopia majority of AIDS patients made less money per month (kidane, 1994). Zerfu.D (2002), however, argues that the prevalence of HIV/AIDS has a negative impact on the overall economy through lowering the active labour force.

c) Impacts on Agricultural

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. It is the single most important sector, providing livelihood for at least 53% of the economically active population in Africa. In particular, about 84% of economically active women are engaged by the agricultural sector (FAO, 2000). A significant part of the agricultural population in Africa dwells in rural communities, which are among the least privileged and bear the greatest burden of AIDS impact (Kormawe, 2005).

Studies done in Tanzania and other countries have shown that HIV/AIDS will have adverse effects on agriculture, including loss of labour supply and remittance income (Bollinger et al, 1999). The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue, any declines in household production due to mortality and morbidity related to HIV/AIDS can have serious consequences (Gillespie and Kadiyala, 2005).

Additionally, it has also been observed that as a result of AIDS, diversity of crops grown is declining. A loss of agricultural labour is likely to cause farmers to switch to less-labour-intensive crops. Guemey (2000) notes that in many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production of cash crops as well as food crops. The disruption of intergenerational transfer of agricultural knowledge as parents die due to HIV/AIDS before passing on their knowledge and expertise to their children was also identified as major impact of the epidemic (FAO, 2002). In addition, the infection rates being higher among women, who perform most of the agricultural labour in sub-Saharan Africa, agricultural knowledge is strongly affected (Kormawe, 2005).

2.2 HIV/AIDS Epidemic in Ethiopia

Available evidence suggests that HIV/AIDS epidemic in Ethiopia started in the early 1980's. The first two positive samples were retrospectively detected from samples collected in 1984 for other researches. The first two AIDS cases were officially reported from Addis Ababa in 1986 (WHO, 2003)

According to Ethiopian MoH (2006), an estimated 1.32 million Ethiopians were living with the virus at the end of 2006, with an adult prevalence rate of 3.5% from a total population of 73 million. 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 life expectancy in Ethiopia will decline to about 42 years due to AIDS by 2010; with out HIV/AIDS, life expectancy would be 55 according to the U.S. Census Bureau estimation of 2005.

The national HIV/AIDS epidemic in Ethiopia is not an evenly distributed. Like many countries in the poor world, HIV in Ethiopia spread first among commercial sex workers (CSWs), truck drivers and soldiers. These groups appeared to be among the first infected as HIV spread to towns along major roads in war zone and then continued to increase in other towns and to the general population during the 1990s (Shabbir, 2005)

Trend analysis showed a gradual increase in the national prevalence rate between 1980 and 1996(MoH, 2004). The epidemic has spread rapidly in the towns and more slowly in rural areas. Currently the epidemic seems to be stabilised in urban areas: with the number of people infected roughly equals the number of people dying from the disease, however, the epidemic appears to be intensifying in rural Ethiopia, where 85% of the population resides (Kloos, 2007).

In Ethiopia, majority (87 percent) of HIV infection results from heterosexual transmission and about 10 percent through mother to child transmission. Currently most HIV infection in Ethiopia occurs among the young population in the age of 15-34 (8.6 percent prevalence). Rates are also much higher in females than male apparently due to combination of the earlier commencement of sexual activities of the female, the older age of their partners, and gender-based biological factors (MoH, 2004).

According to Ethiopian HIV/AIDS prevention and control office (2006), the underlying factors that contribute to the spread of HIV/AIDS in Ethiopia include poverty, illiteracy, stigma and discrimination of those infected and affected by HIV/AIDS. Other relevant social phenomenon that have an effect on the spread HIV/AIDS include: high rate of unemployment, widespread commercial sex work, gender disparity, population movement including rural to urban migration and harmful culture and tradition practices.

The limited data on Ethiopia suggest that the groups engaging in high-risk behaviour or at risk in Ethiopia are the same as in many other countries. These include transport workers and other mobile men, commercial sex workers, men with disposable incomes, internally displaced people and refugees, in- and out-of-school youth, university students, police, and the military. Ethiopia has a very limited injecting drug user population, and there are no data on men who have sex with men or prisoners.

2.3 Response to the Epidemic in Ethiopia

The response to the AIDS epidemic in Ethiopia represents the collective efforts of the government, multilateral and bilateral donors, international and local NGOs, association of PLWHA, FBOs, CBOs, the private sector, civil society organizations as well as individuals.

Government Response

The Ethiopian government responded to the epidemic with various policies and interventions. Ethiopia started the policy process in 1989 almost earlier than most African countries, although it took much longer time to complete (nine years). A new national AIDS policy was issued in 1998 and the national AIDS council was established in 2001 and charged to implement the strategic plan for 2001-2005. This agency then is transformed to the HIV/AIDS prevention and control office (HAPCO) and is currently implementing the strategic plan for 2004-2008 (Shabbir et al. 2006).

The national response is currently coordinated by the HIV/AIDS Prevention and Control Office (HAPCO). The National AIDS Council, which is a multisectoral forum comprising ministries, NGOs, religious leaders and prominent individuals is chaired by the President and coordinates the response at the highest level. The management board of HAPCO chaired by the Minister of Health provides policy guidance. Similar structures are replicated at regional level.

The national AIDS policy directs all sectors to develop their own HIV/AIDS strategies and activities for the purpose of expanding the scope of the national response. However given the tremendously high cost involved, it is beyond the capability of the government to provide adequate funds for all departments to respond to the national response programme to HIV/AIDS. Therefore each sector is charged with the responsibility to raise funds and mobilize material and human resource for HIV/AIDS activities

Some Government Sectors have mainstreamed HIV/AIDS into their core policy and functions; however, HIV/AIDS is not yet mainstreamed as a priority development agenda by most sectors. The MoH is responsible for implementing, coordinating and regulating the health sector response to HIV/AIDS in Ethiopia. The National AIDS Control Program was created under the Epidemiology and AIDS Control Department after the decentralization exercise of 1993.

The Ministry of Health and Regional Health Bureaus are the major implementers of health sector HIV/AIDS interventions in Ethiopia. Activities already underway include: Promotion of safer sexual behaviour, Treatment of STIs, Voluntary counselling and testing, Blood safety, Universal precautions, Prevention of mother-to-child transmission of HIV, Management of opportunistic infections, Antiretroviral therapy, Epidemiological surveillance and Monitoring and evaluation.

The MoH and its partners are currently working towards improving availability of prevention, care and treatment services to PLWHA. Community home-based care is provided to some PLWHA mainly by NGOs and community based organizations. This effort received much needed support when Ethiopia's application to the Global Fund to Fight AIDS, Tuberculosis and Malaria was accepted. Accordingly, the country receives substantial amounts of funding for its HIV/AIDS interventions.

Local responses have been recognized as one of the major strategies for scaling up the response to HIV/AIDS in Ethiopia. The direct support for the *woredas* (districts) and Kebeles (communities) is to embark on innovative initiatives. Funds are channelled directly to NGOs, religious organisations, the private sector and local communities on a cost-sharing basis.

AIDS Councils/committees have been established at *woreda* and *kebele* level. Each *kebele* will be provided limited money to start HIV/AIDS activities. Local NGOs, CBOs, religious organisations, youth groups etc. are encouraged to submit a HIV/AIDS proposal to the local AIDS council. The local board of the council appraises the proposals and disburses the money. A facilitator has been recruited at *woreda* level to promote responses and to facilitate the access to funds (Heilemariam, 2002).

However the level of activities and success varies considerably between the different communities. As a result of the crisis created by HIV/AIDS and the Government of Ethiopia's commitment to quickly enhance the implementation of activities, loan has been received from the World Bank and close to half of the funds are being channelled directly to the communities in a systematic and sustainable manner to stem the spread of the epidemic.

Shinn (2001), however, notes that the limited number of qualified staffs and administration problems render the coordination difficult at all level of government, down to the village level. On the other hand, the decentralisation permitted the shift of health resources from the center to regions and districts enabling some regional centers and rural communities to develop HIV/AIDS programs. However, the

decentralization initially resulted in a marked drop in implementation capacity both at the central and regional levels. It was also responsible for disruption of surveillance activities that were heavily dependent on support to regions from the center (WHO, 2003).

Role of NGOs and Community Groups

In Ethiopia NGOs and community groups play a crucial role in the response to the epidemic in the country. Because of the condition of the public health sector, NGOs are the primary providers of HIV/AIDS services and support and have been critical in breaking the silence of Ethiopia's epidemic (Mbengue, 2001). Most international and local NGOs operating in Ethiopia have been increasingly focused on HIV/AIDS. More than 48 international and 55 local NGOs have been involved in the prevention and control of HIV/AIDS in Ethiopia (Meche, 2002). Some of the international NGOs working on HIV/AIDS services delivery include Oxfam-UK, Action Aid International, save the children (SC-UK) and World Vision Ethiopia.

A recent report on mapping HIV/AIDS activities in the country revealed that out of 200 ongoing HIV/AIDS projects, 40 percent are sponsored by bilateral and UN agencies, 24 percent by international NGOs, 27.5 percent by local NGOs, and the remaining 8.5 percent by government organizations (Meche, 2002). Information, communication and education (IEC), behaviour change communication (BCC), care and support, and voluntary counselling and testing (VCT) are the most important components of HIV/AIDS services provided by NGOs. Even with their crucial involvement in HIV/AIDS, NGOs are experiencing major constraints and competition, in part as a result of decentralization. For example, when the federal government provides an NGO with funds, the amount given is subtracted from the total quota allowed to the state as a whole (Mbengue, 2001).

In addition to HIV/AIDS activities by NGOs, a significant number faith based organisations(FBOs), community based organisations (CBOs) and other professional associations and the private sector are actively involved in the multi-sectoral activities. Community/traditional organizations like *Idir*, women's and youth associations are intensively involved in the prevention and care and support activities. Professionals associations like the Public Health, Medical, Journalist and Teachers associations also play important roles in the fight against the epidemic.

In Ethiopia, in spite of the majority of the population lives in the rural areas, HIV/AIDS services in the country are mainly concentrated in urban areas. Kloos (2007) indicated that although the epidemic potential is high and the prevalence rates are rising in rural areas, they still remain less informed and little work has been done on the nature of the disease in these areas. For instance, VCT services are not well introduced to rural population of the country (MoH, 2005). In addition, few NGOs are involved in HIV/AIDS activities in the rural areas of Ethiopia (Tsfaye et al 2002). However, with prevalence rates still lower in rural areas, it is a window of opportunity for addressing the epidemic before it takes a debilitating grip on rural livelihoods.

2.4. Pastoralism and HIV/AIDS in Ethiopia

Ethiopia has oldest history of pastoralism. At present livestock husbandry in open grazing area represent 60 percent of the territory and roughly constitute 12 percent (12-15 million) of the Ethiopian population. The country ranks the third next to Sudan and Somalia in Africa in pastoral population. The main pastoralist communities in Ethiopia are the Somali -53%, Afar -29 % and Borena -10% (PFE, 2005).

The Swift's (1988) definition of pastoral production is commonly adopted in different literatures; in its essentials 'pastoral households are those in which 50% of gross household revenue (i.e. including income and consumption) comes from livestock or related activities. However, in this study for simplicity, pastoralists are livestock keepers who depend almost exclusively on livestock for their livelihood and are characterized by some degree of mobility within pastoralist ethnic groups.

The pastoral production system in Ethiopia is a contributor to the national economy. It shares 42% of the total livestock production in the country. The livestock sector contributes approximately 12 to 15% to total GDP and about 25 to 30% to the agricultural GDP (MEDaC, 1999). It is also a major source of foreign exchange, second only to coffee. Moreover, pastoralism is the main source of livelihood for millions of Ethiopians and is an efficient and effective way to utilize the virtually inaccessible remote range resources.

But, the hitherto national agricultural policies do not recognize pastoral livestock production as part of the national economy and source of livelihood. Thus, pastoralists remain socially and politically marginalised segment of the population. They live in the least developed regions of the country characterized by high illiteracy rate, inadequate infrastructure and least external support. On the other hand, pastoral areas are also the most vulnerable and chronic food insecure areas that need a long term development due to various shocks such as recurrent droughts and conflicts (PFE, 2005).

HIV/AIDS is also another threat causing an enormous impact to pastoralist community in Ethiopia. Although there is no research information on the interface of HIV/AIDS and its impact on pastoralists of Ethiopia, there is no doubt that HIV/AIDS is affecting the pastoral production system enormously. From the national statistics (MoH, 2006), the prevalence of the disease in the largely pastoral Somali region is 1.2% and in the Afar region is 1.8%, roughly lower than the national average prevalence rate.

2.4.1 Impacts of HIV/AIDS on pastoralists

Little is known empirically about the impacts of AIDS on pastoral livelihoods and communities. Studies conducted in some Eastern African pastoralists (Kenya and Uganda) indicated that; loss of labour due to HIV/AIDS especially male labour, has the potential to severely limit pastoral migration by whole households, pastoral migration by men to satellite camps, and daily patterns of herding livestock away from camps and towards key graze and browse resources. This could have very negative effects not only on livestock production and the household's welfare, but also longer-term on the management of the grazing resource itself (ITGD, 2005)

Moreover, many infected pastoralist community are now losing their indigenous skill and knowledge of livestock production and management as a result of early death from HIV/AIDS. A study from Kenya (ITDG, 2005) revealed that mortality from HIV/AIDS is denying younger generations the knowledge on range management and

other aspects critical to the survival of the pastoral community. In the long term, this has the capacity to seriously disrupt the pastoral way of life. According to FAO (2005), forced sale and unplanned slaughter of animals for medical care and funeral activity will also contribute to the erosion of sound breeding practice that preserve indigenous breeds/strains of livestock at risk of extinction in pastoral areas.

In pastoralist livelihood activities, even daily herding involves establishing and maintaining of social networks to ensure the smooth functioning of the system. The rangelands, water points and the livestock that are used by them must be collectively managed. (Morton, 2004) indicates that the loss of social network among pastoralist community attributed to stigma and discrimination related to HIV/AIDS and limited ability to engage in these processes due to morbidity and mortality among men, AIDS will have major impacts on pastoral communities, and on the environments they use.

In general, pastoralists tend to be highly susceptible group of the society and are vulnerable to impacts of AIDS once the infection enters the community when compared to agricultural society. Morton (2004) further identifies the susceptibility factors of pastoralists which is related to their mobility, a typical feature of their livelihood which not only includes migration of families and herds in search of water and pastures, but also migration by men alone for marketing and non-pastoral labour, particularly to population centers; a high degree of sexual net working (polygamy, multiple sexual partners) which is reported as traditional practice in some pastoralist groups.

Violent conflict over resource is common among pastoralists. In most cases conflicts do not only lead to livestock raiding, but also women raiding and rape. The social disruption and the direct effect of conflict can be a factor for pastoralists' susceptibility to HIV infection. At the same time, being a marginalized segment of population and living in remote areas which are sparsely populated and because of their mobility pastoralists have less access to health services including health education on HIV/AIDS which is necessary to effect changes in sexual behaviour and reduce susceptibility to HIV.

2.5 Susceptibility of pastoralists to HIV infection

It has been made clear from various literatures that not all population groups are equally susceptible to HIV infection. Some categories are more exposed to HIV risk than others. These categories include truck drivers and people living along highway routes, military personnel, commercial sex workers, the young population and also pastoralists (Barnett & Whiteside, 2002).

Susceptibility refers to any set of factors which determine the rate at which the epidemic is propagated. Susceptibility reveals aspects of situation that contribute to the increased or decreased *riskiness of an environment* which will enhance or diminish the ease with which diseases are transmitted. Susceptibility can be thought of at any level (Barnett, 2006). For example, individual may be susceptible due to unsafe sexual behaviour, household may be susceptible because of one of its members is a migrant worker or an entire society or country may be considered susceptible because its population is constantly on move-through national or international borders.

There are various factors which should be considered relevant why people become infected with HIV. These determinants are biomedical, behavioural (both at individual level), micro- level (community/society level) and macro- level determinants (national level). Figure below shows the whole story of HIV epidemic determinants adapted from Barnett & Whiteside (2006)

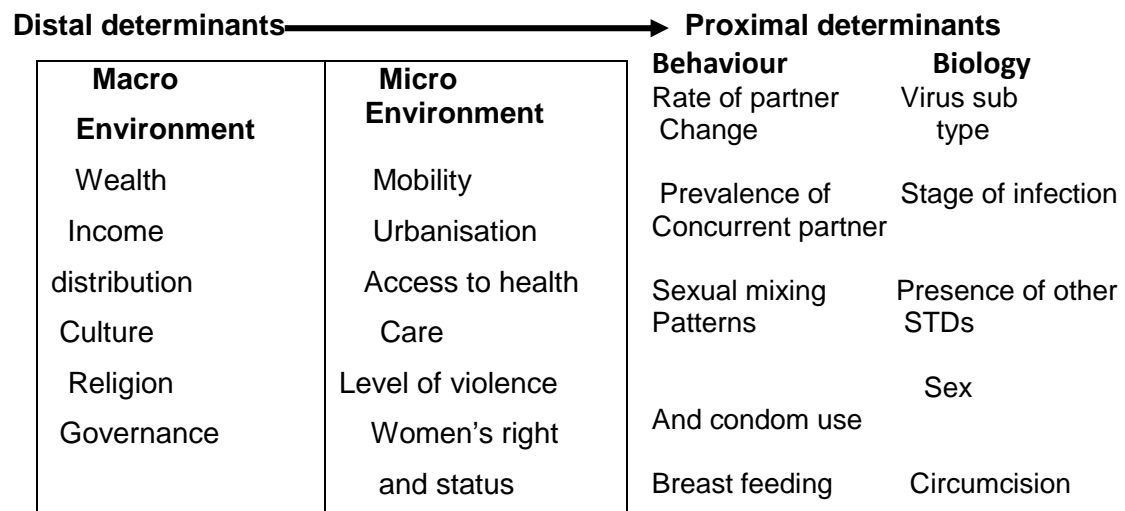


Fig 1: Determinants of HIV/AIDS, adapted from Barnett & Whiteside (2006)

In this study, the susceptibility at community level was investigated particularly specific to pastoralists. The main susceptibility factors which put pastoralists at risk of HIV infection includes their mobility, traditional sexual patterns, exclusion from health services including HIV/AIDS education and thus low awareness on HIV/AIDS among pastoralists, gender inequality which is more pronounced in some pastoral community and the violent conflict common among pastoralist groups (adapted from Morton, 2004).

2.5.1 Patterns of mobility/migration

The rapid spread of HIV across communities, counties and continents is a testimony of the linkage between population movement and the growing HIV/AIDS epidemic. According to IOM (2003), migration has been identified as one of the risk factors for the acquisition of HIV infection in wide range of setting. Previous studies have also identified that mobile group of population (e.g. truck drivers, traders, militaries. etc) were the first to be highly infected by HIV during the early epidemic.

In many countries the variation in HIV infection with in regions is also due to high seasonal and long-term mobility. Higher rates of infection can also be found along transport routes in border regions. A study conducted in Senegal by Pison (1993) shows that seasonal rural population mobility is a major contributor to the HIV/AIDS epidemic as it increases the number of sexual partnerships as well as contact with high risk sexual groups such as sex workers. In this case loneliness and insecurity, freedom from social norms provide an impetus to risky sexual behaviour.

Migration is a two-way process, different studies indicated that migration and mobility increases susceptibility to HIV infection not only for those who are mobile but also has an implication on the propagation of HIV between communities as mobile population with increased HIV risks up on return from migration may transmit to lower risk groups in areas of origin as well as destination (Boerma et al., 2002). On the other hand, partners left behind may also engage in high -risk behaviour for emotional or financial support (IOM, 1998). Rural sending communities can perceive rural –urban migrants to be disease carriers and such migrants are frequently identified as bridging populations for HIV transmission between rural and urban areas (castle, 2004).

Pastoralists' livelihood system is inherently mobile, and they account for a significant proportions of the migrant rural population in countries with severe HIV epidemic like Ethiopia. Nonetheless, there is limited information on the link between pastoralist mobility and HIV infection spread. On the other hand, different studies have mostly examined the link between mobility and HIV infection particularly for urban –rural migration, and much less attention is paid to the rural-rural migration which is the prime form of migration in search of water and pasture in the context of pastoralism.

Mobility among pastoralist itself can not be equated with risky sexual behaviour but it rather depends on the pattern of migration and other factors that determine the riskiness of migration. In this context, Morton (2004) distinguished four main types of pastoralist mobility and relates them with their degree of the riskiness to HIV infection as follows:

- a) Traditional –whole household family pastoral migration
- b) Pastoral migration carried out by men, often younger men, while the rest of the family follow a less mobile life style. This relatively increasing to traditional type for reasons which include increased cultivation and desire to access services or food aid.
- c) Journey undertaken to market livestock or live stock products or buy cereal foods and consumer goods. These trips are often long distance, as marketing centres may be far from grazing land and generally undertaken by men alone or in groups. Probably increasing as pastoralism becomes increasingly commercialised.
- d) Labour migration to non-pastoral employments, generally by men alone though occasionally by women and to a limited but increasing extent by whole households. Labour migration is largely increasing driven by shocks such as drought and often to the lower end of labour market.

Migration by men alone, particularly to population centres for marketing and non-pastoral labour (type c and d) can definitely be regarded as a factor of susceptibility to HIV infection. This may be so even when sexual morals within the pastoralist community are strict. A study by May (2003) among Maasai pastoralist present evidence on the extent to which Maasai pastoralist interact sexually with non-Maasai women and concludes urban migration as a risk factor increasing susceptibility to HIV among Maasai pastoralists.

More over, there are also other factors /conditions which determine the riskiness of such group sexual behaviour, for instance, the use or non-use of condom during sexual contact and the also tendency of alcohol consumption which is often related to casual sex (Bishop et al., 2005). Sexual morals in that particular community have also an influence on how the group should interact. In general the link between mobility and HIV infection is related to the conditions and structures of the migration process including separation from families and partners and separation from the socio-cultural norms that guide behaviours in stable communities.

2.5.2 Traditional Sexual networking patterns

There are also cultural aspects of susceptibility. Because of the importance of human behaviour in HIV transmission, it requires examination of the social and cultural context of sexual risk behaviour (Gupta, 2001). Sexually is understood here as the social construction of biological drive.

Social norms have implications for patterns of sexual relations as well as individual's attitude towards and practice of sexuality. The construction and reconstruction of what and whom we desire and how, has many variations of meaning and significance

(Barnett, 2006). Sex is deeply a private activity in almost all societies. But it is learned, coded and interpreted in many different ways and carefully controlled, disciplined in all societies and is culturally embedded.

Sexual intercourse is not intrinsically a risky behaviour, beyond the obvious risk of conception in case of heterosexual. However, when the deadly disease appears and the social and economic environment in such as to facilitate rapid and /or frequent partner change ,then the environment may be described as a risk environment and the act of sexual intercourse becomes a risky behaviour (Barnett,2006). 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, 2004).

The practice of multiple sexual partnerships was identified as one of the factors that are significantly associated with HIV infection indifferent literatures. For instance, Helleringer (2007) in his study identified that sexual networks observed in Likoma Island (Malawi) are compatible with widespread sexual transmission of infectious diseases including HIV into low risk groups. This transmission occurs not only through having large numbers of sexual partners but also through the interconnectivity of the partnerships. A network that includes a large proportion of persons with higher HIV prevalence from factors other than the network will contribute to the dynamics of HIV transmission.

In some pastoralist groups there are social institutions within traditional pastoralist societies which promote multiple sexual contacts have been reported in different literatures. For instance, Coast (2002) summarises for the Maasai: polygamous marriage as a norm; early sexual debut for females, with strong social sanctions for non participation; high level of sexual networking within and outside of marriage (by unmarried warriors with unmarried girls and wives of elders, by widows); non-consensual sex as “commonplace”.

However, this doesn't mean that all pastoralist societies share this orientation. For example the numerous Muslim pastoralist societies of the world allow polygamy, but generally take much more negative attitude to adultery and pre-marital sex-at least with in pastoralist groups (Morton 2004).

2.5.3 Gender related factors

Gender has been identified as the key cross-cutting issue in addressing the epidemic which is visible in the growing body of literature on gender and HIV/AIDS. Simply by fulfilling their expected gender roles, women and men are likely to increase their personal risk of HIV infection (WHO, 2003). Thus, understanding of susceptibility to HIV infection in specific society also necessitates understanding the gender norms and sexuality as constructed by complex social, cultural forces that determine the distribution of power (Gupta, 2002:2)

Gender roles for women and men vary considerably from one culture to another, as well as between social groups in the same culture. Being a woman or a man generally includes complying with strictly defined expectations and norms; in addition, it is fairly consistent across culture that one finds a distinct difference not only between women's and men's roles, but equally in access to resources and decision-making authority. Gupta (2000) further explains that these gender norms have implication for 'patterns of sexual relation' as well as individuals' attitude towards and practice of sexuality.

Firstly, in many African societies, it is a norm that women should marry at younger age which could be due to traditional norms of virginity since sexual activity may occur at early age for female and thus it is common for adolescent women to marry considerably older men. In such relationships men are likely to have many sexual partners before marriage, making them more likely to carry the HIV virus (Bankole et al., 2004). Moreover, the paying of bride wealth also increase women's susceptibility particularly where the rates are high for bride wealth, men might have to wait long before being able to afford (Muller, 2005).

The other gender related norm which demands innocence from women about sexual matters; leading to culture of silence which means it is inappropriate for women to discuss sexual issues. Thus, women are less informed about sexuality including HIV/AIDS related information and are less able to prevent HIV infection (Muller, 2005). Yet again, the notion of masculinity in most societies emphasis men to be self-reliant and prevents men from seeking knowledge on issues such as HIV/AIDS. There is also a proclaimed need to prove one's manhood by having multiple partners in some societies (Muller, 2005).

In some cases due to fewer means to earn income and as a result of famine and destitution many women may rely on sexual networks and transactional sex as means of survival strategy to sustain themselves and/or their families in the face of economic uncertainty (Smith, 2000). And hence, the women's survival strategies, in particular multiple partner strategies have turned in to death strategies.

Unfortunately, most researches fail to appreciate gender norms specific to pastoralist women which contributes to their susceptibility to HIV infection. However, study conducted by ITDG (2005) among Kenyan pastoralists shades light on the condition of women living in pastoralist areas. Rights to security, freedom from inhuman or degrading treatment, to information, education, expression, association, privacy and confidentiality are hard to come by for pastoral women of Kenya. And where these rights are compromised, individuals are at risk of HIV infection.

In Ethiopian, Somali society is extremely patriarchal, and Somali women and girls face gender-specific risks and vulnerabilities, and experience the effects of generic risks and vulnerabilities more acutely than do Somali men and boys. Indicators of the marginalization of females are apparent at all levels, from intra-household male bias to discriminatory traditional norms to under-representation in local and regional government. The Somali compensation culture, for instance, values women very precisely, as "half of men": "If a man is killed, his family has to be compensated with 100 camels. If a woman is killed, she is compensated with only 50 camels. So we are only treated as the half of men" (quoted in Devereux 2006: 123).

Even though it is difficult to generalise, such low status of pastoralist women and their lack of decision making power exposes them to infection through culturally imposed obligation; women are expected to accede to sexual advances of their spouses. They have no say on their accordance to practices such as wife sharing, wife inheritance and female genital mutilation (FGM), which put them directly in the line of infection (ITDG, 2005).

2.5.4 Access to health services

Health services play an important role in the control and prevention of HIV spread. Firstly, through comprehensive evaluation, diagnosis and treatment of more common sexual transmitted diseases (STDs), susceptibility and infectiousness to HIV would decrease. When someone develops an STD infection, they are also at high risk of acquiring HIV. Conversely, when an HIV-infected person is also infected with another STD, they are much more likely to transmit HIV than someone who is only HIV-infected. STD treatment reduces the ability of an HIV positive individual to transmit HIV. By targeting the identification and treatment of STDs, Adult Health Services works to reduce the transmission of HIV.

HIV/AIDS preventive activities also include HIV prevention from mother to child during pregnancy and child birth, HIV counselling and testing, prevention with HIV positive individuals through care and treatment, and behavioural interventions. These HIV prevention packages have substantial contributions to further prevention and control of the spread of the epidemic in communities as indicated in various literatures.

In addition, health services are also responsible to provide education on HIV/AIDS through various mechanisms including individual education and community out reach health education which plays a major role in combating the denial, silence and misconceptions on HIV/AIDS. Educating people on how to stop the transmission of HIV, encourages people to respond in informed ways to people who have HIV/AIDS, and helps people apply the facts about HIV to their own behaviour. These goals are accomplished through easy educational programs designed to reach a variety of audiences in the community.

Accordingly, less access to HIV/AIDS education facilities is related to low awareness levels and misconceptions on HIV/AIDS infection. In Ethiopia there is a substantial difference in access to health services between rural and urban areas. As result knowledge on HIV/AIDS is lower for rural areas: EDHS (2005) indicated that women and men living in the rural areas of the country are less likely to have knowledge on HIV/AIDS with difference much more among women than men.

Different studies have also indicated that the likelihood of protecting one self from HIV infection is related to the awareness on means of transmission and prevention about HIV. Thus, low education and awareness on HIV/AIDS could be regarded as one of the susceptibility factors to HIV infection. However, inadequate knowledge about modes of transmission and methods of prevention doesn't necessarily mean that high risk behaviours are practised.

Pastoralists being a marginalized segment of population and living in remote areas which are sparsely populated areas, and because of their mobility they have less access to health service including health education on HIV/AIDS (Morton 2004). For instance, in the largely pastoralist Somali region of Ethiopia, respondents expressed least knowledge with only half women and two-third of men having heard of HIV/AIDS during 2005 Ethiopian demographic health survey.

2.5.5 Exposure to violent conflict

Pastoralism as a mode of production requires movement across boundaries and within boundaries for search of water and pasture. This movement when restricted often leads to disputes between them and other neighbouring groups. Hence, violent conflicts over resource are common among pastoralists because of the shortage of pasture and water. Especially in North-East Africa pastoralist may find them selves caught up in conflict even crossing borders (Kenya, Ethiopia, Sudan, and Uganda), leading not only to livestock raiding but also women raiding and rape.

Conflict situations aggravate a number of factors which fuel HIV/AIDS crisis. These include the break down of families and communities, forced displacement, poverty, the collapse of health service and physical and sexual violence. Women more than men are at risk of rape and sexual assault in conflict situations, and consequently of HIV infection. Morton (2004) describes that the social and economic disruption caused by conflict as well as the direct effects of sexual violence and rape in pastoralist conflict context must be regarded as an environment of susceptibility and vulnerability to HIV/AIDS.

In Ethiopia pastoral areas are the most conflict prone areas. For instance, numerous armed conflicts occurred among Borena and other neighbouring pastoral groups, and for some Somali region is synonymous with inter-clan conflict, which is indeed frequent and has claimed thousand of lives over many years. The causes of conflict are largely multi-dimensional in pastoral areas the major ones, however, are associated with restricted movement, and range and water resource limitation resulted from the growing expansion of crop encroachment and 'privatization' of prior communally owned water and rangeland resources (Hags Richard,1997). Hence, conflict in pastoral areas of Ethiopia for majority of the pastoralists has been remained the cause for poverty aggravation.

Pastoralists have their own traditional means of conflict resolution. They are very effective and widely accepted in the community. However, most traditional peace forums that were strong enough in gaining acceptance in earlier times have weakened today. This comes about as traditional customary institutions (sets of rules) for commons management become compromised due to the presence of outside influences and actors which significantly change both resource availability, and conceptions about who is subject to traditional rules (Unruh,2005).

Chapter 3: The Shinile community

This chapter deals with the study area, the social organisation of Shinile community and the livelihood system in the district.

3.1 The study area -Shinile district

Shinile communities are inhabitants of Shinile district which is one of the six districts in Shinile zone. The district is part of Somali region located at about 15km from Dire Dawa administrative zone. It is located at the northwest point of Somali region bordered on the south by Dire Dawa administrative region, on the west by the Erer district, on the north by Djibouti, and on the east by Dembel district.

The altitude of the area ranges between 950-1300 meters above sea level. There are two rainy seasons in the area- *Gu* and *karan*, both of which are equally important. The *Gu* falls between late March and late May while the *karan* season is between late July to late September. Annual average rain fall is 400mm and the average temperature of the area is 27.5⁰c.

The pastoral land mainly belongs to the arid and semi-arid environment which is characterized by extreme variability and unreliability of rain fall both between different years and between different places in the same year. Consequently these areas are characterized by the scarcity and seasonal variation of vegetation and high vulnerability to drought (Ahmed,etal, 2003)

Topographically, the district consists of undulating hilly parts interspersed with expansive plains. More specifically, it encompasses a rugged undulating area covered by bushes. This area is dissected by gullies and dry riverbeds due to runoff rainwater from the neighbouring mountains. A lowland hill area neighbouring these foothills is used for irrigated farming and other agro-pastoralism activities. The low-lying flat semi-arid area to the north-central area is characterized by loose soils and by bush and woody grasses cover. These vast flat areas provide grazing areas for cattle and sheep. The rivers found in the area are seasonal - flowing only during rainy seasons. Shallow wells, dug in the proximity of these riverbeds provide most of the water for the pastoralists in Shinile.

Somali region is one of the regions in the country where social services are poor throughout the region. In terms of access to infrastructures-health, education, water and roads, the region is the most marginalised when compared to other regions (Deveruex, 2005). According to available district administrative data (1995) regarding basic infrastructures in Shinile district, the education coverage is 26%, human health service coverage 31%, animal health coverage is 10% and safe water supply is 21%.

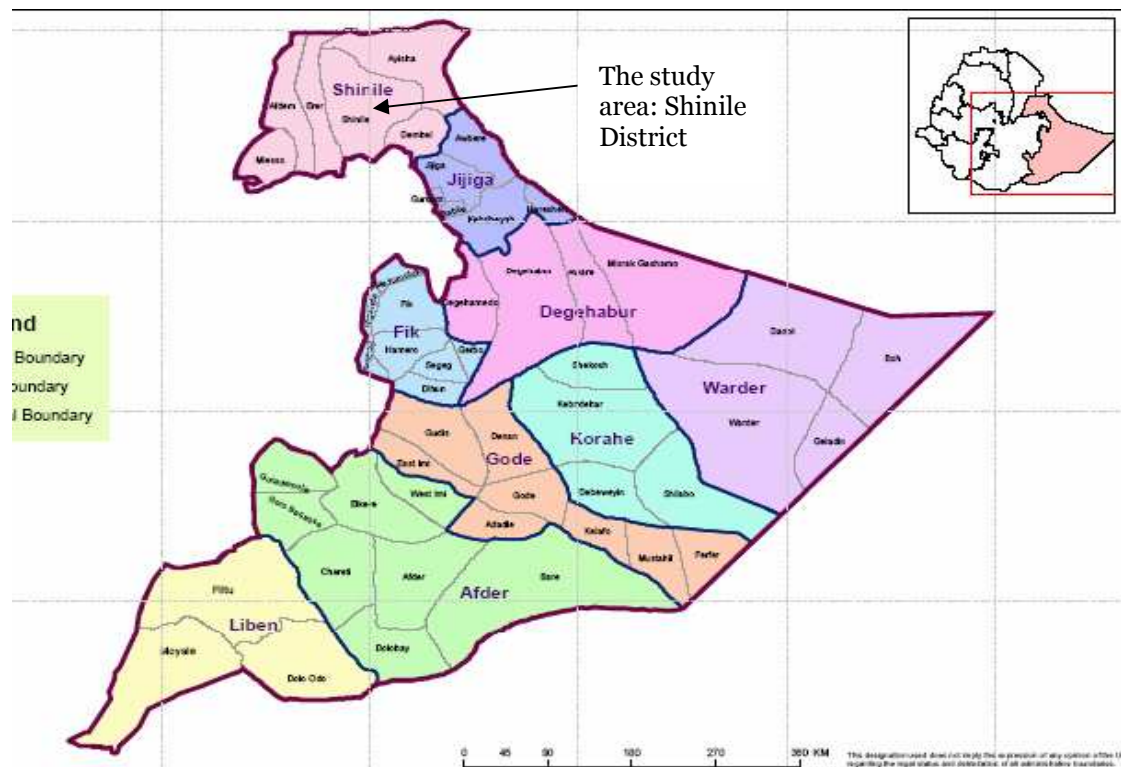


Fig 1: Map of Somali Region
Source: SC-UK (2001) Livelihood zones in Shinile

3.2 The Shinile community

The people of shinile belong to the sub-clans of Issa which inhabits the territory stretching from Dire Dawa to the Republic of Djibuti (Devereux, 2006: 35). Shinile district population is estimated to be 113, 630, of which 47% are male and 53% are female and are 100 percent Muslim by religion. The Issa are united under constitutional order, the *Heer Issa*, which promotes peace and stability through out Issa territory, and hence there are few territorial disputes or conflicts over natural resources in the area.

Most of shinile's external linkage is with Dire Dawa, Djibouti and Somaliland (Somalia). These areas also provide labour opportunity for Shinile inhabitants. The people of shinile have relatively little contact with other parts Ethiopian highlands and Somali region too. This restricts their mobility and magnifies the effects of droughts, as they have few places to move to with their animals to find water and pasture.

The family system, like in all Somali areas is the 'extended family' system the different generation of family live together or in neighbouring homes (satellite camps). This family system means that resources are freely shared among the extended family. Indeed an Issa saying *'iisuhu sahay loomaqaato* (you don't need to carry your own food when journeying through Issa land), under scores Issa generosity and spirit of sharing. Families, especially the Issa pastoralists, are largely polygamous (with two wives being more common), except for young and poor families who are not in a position to support extra families. The father is the head of the family and clan/sub-clan authority is vested on clan elders (*Odayaasha*), who handle all disputes and other clan/sub-clan decisions.

Like all other pastoral communities, the social organization of the Shinile Issa pastoralist is based on age and gender. In Shinile, roles and responsibilities among the community members are assigned according to the age group. And hence, there is a clear division of labour for members of the family, depending on gender and age to perform specific tasks.

In general, men of all age groups are largely responsible for long-distance herding of large livestock (cattle and camels), building and repairing of livestock enclosures, digging of wells during dry seasons. Performance of minor surgical operations on animals such as castration, amputation of limbs or horns, in case of accidents slaughtering of animals, meat processing and animal treatment ,sale of livestock participation in clan meetings, conflict resolution are also responsibility of men. Young men are only allowed to take the animals to distant grazing areas when they are above the age of 15 years on average.

Women too have specific tasks assigned to them. Married pastoral women are managers of household. Women carry on the day to day management of livestock production and retain primary responsibility for dairy related activities. They are responsible for milking, milk processing and sale, supervising suckling calves and small stock (goats and sheep), and treating of young stock. Women are solely responsible for most household and domestic chores including food preparation, looking after children, fetching water and firewood .Women are also responsible for building and/or repairing the temporary shelters.



Picture 1: Women building a shelter in Shinile

Women's role in livestock management is essential. Because milking and calf management is done on a daily basis, they are often the first ones to see that an animal is sick. They use certain indicators and will alert their husband when something is wrong with an animal. Women also have good knowledge of the character and the production potential of animals, and their advice is appreciated for decisions on breeding and selection. They can also suggest measures to be taken depending on observation on grazing resource and animal performance.

3.3 Livelihood System in Shinile district

The overwhelming majority of the Somali region population remain pastoral, sedentary agriculture has increased in importance, particularly since the last three decades. Agropastoralism is practiced in higher rain fall areas, where families cultivate privately owned land in rainy season and at the same time keep livestock. Collection and marketing of firewood and charcoal has increased sharply in recent years and now present major economic activities. In the extended family and clan structure of Somali people, remittance undoubtedly also play a prominent economic social role, however, migration does not generate significant flows of income and remittances back in to shinile district (Devereux,2006).

Shinile district is one of the pastoralist districts of the region and rearing live stock particularly sheep and goats is the dominant livelihood activity. Pastoralists make up 85% of the district population and the others are agropastoralists and traders. The study *kebeles*: Jidene and Marmarsa have approximately 600 households with an average household family size of six people (Watins and Fleisher,2002))

The Issa community keeps a full range of livestock sheep, cattle, goats and camels. The total livestock of Shinile district is estimated to be 400,000 (TLU) of which goats and sheep are more predominant (see table-1 for the detail). Every household keeps at least one pack camel, even if they don't have a camel herd; the camels are considered as *gaadiid* (vehicles), rather than productive animals. The main crops cultivated among the agro-pastoralists, however, includes sorghum and maize (SC-UK, 2001)



Picture 2: A young shinile man with his camel herd

Table 1: Livestock population in Shinile district

Animals by type	Number of Animals (TLU)
Cattle	65,000
Camel	75,000
Sheep	120,00
Goat	140,00
Total	400,000

Source: District Agricultural Bureau report, 2003/4.

In the dry season, the herd is divided in to smaller groups ,with sheep and milking animals staying with core family (xaas) near villages, while hardier animals (camels, cattle ,goats) are driven to further areas for water and pasture. In the rainy season all livestock remain around homes.

Milk selling is a rare practice among Shinile pastoralists. This is mainly because the pastoralists are far from trading centres. Only those pastoralists living in the 'cactus belt' near the southern foothills and those living around villages and along the Ethio - Djibouti railway may sell some milk in some of the seasons. The proportion of milk sold increases during the dry season, when livestock move closer to the south foothills (to escape the cold and to find better pasture). However, these sales are still too little to contribute significantly to household income.

Among pastoralist/agropastoralists wealth is determined mainly by livestock holdings and is followed by land holdings particularly for agropastoralists. Based on these criteria, three major groups have been identified- poor, middle and better off households.

Table 2: Wealth characteristics of Shinile Agro pastoralists

Livestock	Poor (25-35%)	Middle (45-55%)	Better off (15-35%)
Owned goats	4-10	10-20	20-30
Owned cattle	2-5	5-10	8-15
Owned camel	0-2	2-5	5-10
Pack animals	0-2	1-2	2
Income per year In birr (1 birr = 15 euros)	500-1500	1500-3000	3000-4000

Source: SC-UK (2001) Shinile agropastoralists livelihood Zone.

In times of crisis, pastoralist communities have traditionally come together to support their weakest and most vulnerable members. A well-established culture of wealth redistribution has ensured that the needy are helped, and the community survives. However, societies impoverished by successive droughts are now finding it harder and harder to provide for their poorest members. Many pastoralists who have lost all their livestock have been forced to abandon their traditional way of life - the only existence they have known. Some have been lucky enough to join kinsmen already settled in the wetter, more fertile areas, and have turned to agro-pastoralism to reduce their dependence on cattle. Others, out of desperation, have migrated to the towns where they survive through relief hand-outs and the like.

Chapter 4: Result and Discussion

This chapter presents the result from the field study on the susceptibilities factors of Shinile pastoralists to HIV infection and discusses the key findings. The research results corresponded to the findings in other studies; similarities and differences between the research results and findings in other studies were identified. The chapter is classified in different sections as follows: section 4.1 presents prevalence of HIV/AIDS in the study area, section 4.2 discuss the potential susceptibility factors and section 4.3 deals with the response to HIV/AIDS in Shinile district.

4.1 Prevalence of HIV/AIDS in the Study Area

The HIV national adult prevalence rate in Ethiopia is estimated to be 3.5 percent while the urban and rural is 10.5 percent and 2.0 percent respectively. The disease prevalence in Somali region is 1.2 percent with an approximately 28,500 people living with virus in the region in 2005 (MoH, 2006). In general the age group 15-24 years is the most affected by HIV/AIDS for both sexes and there are more female cases than males in this group.

The prevalence of HIV/AIDS in Shinile district is not well known. Data from both HIV/AIDS secretariat office and district health bureau indicates that three voluntary testing mass campaigns were conducted in the town of Shinile although the total number population undergone testing was not mentioned; only one HIV-positive case was found. The district clinic health worker also indicated that no case of HIV-positive was diagnosed and died of confirmed AIDS due to lack of HIV testing facilities. It was also identified that no any other further attempt was made to investigate the condition of the epidemic in rural areas among the pastoral /agro-pastoral areas of the district.

In short, information obtained from various respondents and available data do not clearly indicate the HIV/AIDS situation of the study area. But according to the district health worker and 17/20 respondents of the two villages, Tuberculosis (TB) and Malaria are the big health problems and there are increased illness and deaths due to TB in the villages in recent times. On the other hand, all of the interviewees mentioned that HIV/AIDS is not their problem/ does not present in their community and again only two pastoral men have heard or/and seen people living with HIV/AIDS (PLWH). All respondents also commented that drought is the main problem which is killing their livestock and consequently malnutrition which is affecting their community but not HIV/AIDS.

Table 3: The presence of HIV/AIDS in the study villages from interview

Responses	Men (N=12)	Women (N=8)	Remarks
TB and Malaria are main causes of ill health	10	7	Others mentioned diarrhoea, Malnutrition but non mentioned HIV/AIDS
HIV/AIDS is not our problem/ does not present in our community	12	8	AIDS can't be among us because we are faithful , some said it is a problem of Christians
Heard or/and seen PLWH in the community	2	0	The two men heard a person with HIV in other village and seen in the town.
Drought is the main problem	12	8	When asked for what is the main problem they all rash to say drought

TB is less “shameful” than AIDS. Therefore, TB as a cause of illness and death can be attributed to the fact that people talk more easily about TB, but in actual fact it might be HIV/ AIDS. Ironically, the diseases mentioned as causes of ill health are among the diseases whose symptoms overlap with HIV/AIDS and some are opportunistic infections of HIV/AIDS (ITDG, 2005). A similar situation is reported from a study in Kenya that pastoralists correlate AIDS deaths and opportunistic illnesses with non-stigmatizing diseases such as TB and malaria (ITDG, 2005).

In addition, even if there is a suspicion of HIV/AIDS in their community, it is not admitted for fear it would be seen as a declaration that the disease was present in the community. This social denial in the community was confirmed by the fact that none of the respondents mentioned as HIV/AIDS can present in their community (see table-1). This is in contrast with the finding from BSS (2002) where majority of Oromia pastoralists included in the study knew someone who was infected with HIV and/or had died of AIDS.

Box 1: Responses on the existence of HIV/AIDS in the study community

“I was born and lived in this village for such long time and I heard about this disease recently while people are talking about it. I am sure that there is no one with HIV infection in our village, and I haven’t also seen anyone with AIDS”. (Married men, 55 years old , Marmarsa)

“There would be no one with AIDS in our village because we (the wives) trust our husbands and they also trust us (their wives) because we are Muslims”. (Married women, 50 years old, a mother of three children, inhabitant of Jidane village)

“There are many deaths due to various illnesses these days than before, but since the health facilities are far from us and we don’t have money to afford modern health services, in most cases we don’t simply know the cause of deaths in our village ”(one of the elder men FGD in Marmarsa).

“We do not know whether those TB cases are just TB’s or that some are actually HIV/AIDS, because we don’t have facilities to test for HIV/AIDS, but AIDS may be a killer here” (Shinile district Health worker).

During focus group discussion with elders, it was indicated that the inhabitants have already felt the increase in the burden of deaths and illness even though they are unable to attribute it to HIV/AIDS. In addition, due to the lack of testing facilities in the health service, a lot of AIDS cases might remain undiagnosed, and thus stay out of the statistics. This means HIV/AIDS might be a more serious threat to the community than it is perceived by officials as well as the community.

Findings from the fieldwork suggest that, at present, HIV infection rates might appear to be relatively low in the study area and AIDS-related impacts to date negligible. This might be due to the study community is in a social denial phase of response to HIV/AIDS. During this phase, the incidence of the disease is still relatively limited. Due to the stigma attached to open admission of extra marital sexual relations, the disease is generally not named; there is no open discussion of the disease (FAO, 2004). Sadly, this hinders prevention and control of the spread HIV/ AIDS epidemic in this community.

On the other hand, TB may present in the area for a long time due to consuming unpasteurized milk which is a source of Tuberculosis infection. In addition, as result of recurrent droughts there is chronic malnutrition in the area thus weakening individuals' resistance to diseases and further exposes to TB infection. Hence, it could be among one of the causes of ill health and deaths in the area. It would therefore be a mistake to assume that all TB cases are actually AIDS cases in disguise. However, be it TB or another disease, all diseases which weaken or decrease human resource through illness or death, may impact seriously on pastoral production systems.

4.2. Potential Susceptibility factors

This section deals with the potential susceptibility factors and discuss the main key findings mainly migration, gender related factors and low level of awareness and misconceptions in the community and low access to health services. It also presents the two other susceptibility factors for pastoralists but found to be less important for the spread of HIV in the study area –traditional sexual networking and exposure to violent to conflicts.

4.2.1 Migration/Mobility

Migration is part of the livelihood of the majority of Shinile district community. The study villages' inhabitants depend mainly on livestock keeping for their survival. Apart from livestock migration, Shinile communities have to make trips for cereal purchase, livestock sale, cross border trade and labour migration to urban centers. The intensity of the mobility varies depending on the seasons (See fig -2 for mobility of Shinile community seasonal calendar).

The migration pattern varies depending on the reasons for mobility. The rural-rural migration to distant areas in search of water and pasture for livestock is mainly during dry season (*Jilaal*) of the year for an average of 6 months (from October to March). During this period, livestock (except sheep and some cattle and milk animals) move from the interior plains to the southern foothills. In general when the rainy season is normal, all movements of livestock are restricted to within the Zone-but cross over neighbouring/adjacent districts.

During the *jilaal* season, when livestock split and part go to distant areas for pasture and water, families' also split-women and children stay in the settlements with sheep and milking cattle. The strong members of the family (mainly men) take the other livestock to pastures and water sources further from home areas. In most cases men of age groups 18 to 45 are the ones to trek the animals to distant grazing areas. However, during the rainy period, livestock come back to their original places especially to the plain areas of the interior district. All other livestock would normally stay in their home areas and most households get back together.

When rains fail, it is considered as a bad year. During these years, all pastoralists will split the herds in a similar way as in the *jilaal* season. However, longer distances will be travelled depending on the availability of pastures and water. In such times, elders usually seek the assistance of government authorities to enable their communities to graze in the pastures of the neighbouring zones in order to prevent possible conflict over resources.

However, as evidenced from pastoralists, currently they have to move long distances and stay for longer period mainly due to the inadequate rainfall even during the rainy seasons. During field study, it was also observed that the failure of the rain this year has aggravated the situation and there were death of livestock and has lead to the displacement of pastoralists/agropastoralists community.

Activity	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Season												
Livestock migration				Livestock around home(may move to foot hills during bad season)								
Cereal purchase												
Livestock sale												
Cross-border trade												
Seeking labour												

Fig 2: Mobility among Shinile community

Source: SC-UK (2002) Shinile pastoral livelihood zone, seasonal calendar

Shinile district pastoralists have also to travel to market centers to sell their livestock and milk and its products. The main market places for the study villages are Shinile town market, *Dire Dawa* and *Meisso*. Livestock may be even traded to Djibouti and Addis Ababa markets mostly by traders. Men are responsible for the sell of livestock and women sell milk and its products. However, women may sell livestock only with permission from the husband and if he is away, they can only sell goats just to raise enough money to keep the family going. They can not sell larger stock as indicated by the respondents.

The study found that trip to market is made by household head (father) or elder son to the market to sell livestock and purchase cereals and other items with the proceeds. Most of these trips take place in the dry seasons (refer to fig -2 for more information). During marketing of livestock, groups of pastoral neighbourhoods would combine their animals (mainly goats) and drive them to the markets.

On the other hand, due to proximity to urban centers and access to Ethio-Djibouti railway transportation compounded by the effect of recurrent droughts in the area, there is high labour migration to urban centers both by men and women. It was indicated that increasing number of young people are leaving the village especially females for labour work to urban centers as survival is becoming very difficult in rural areas. Young men may also go to Djibouti, Dire Dawa or other trading centers to seek casual labour work.

'It is common for young women to go to Djibouti to work as housemaids and send back some remittances', (Comment from one of the women interviewees)' An elder man commented to the discussants during FGD with young men saying, what are you doing here? I advise you not to waste your time; you better go to Dire Dawa town so that you can earn money'.

According to the villagers', there are also a significant number of Shinile origin traders moving between Shinile, Dire Dawa and Djibouti for trading *chat*, livestock, cereals and other goods using the rail way transport which cross all the three areas. There are also a significant number of people who are involved in informal cross-border trade mainly between Ethiopia and Somaliland (Somalia) and Djibouti, although the government has already abandoned such activities.

During the field study, it was also observed that pastoralist women have migrated to Shinile town walking very long distance due to the current drought. They pointed out that their animals have died and their husbands have left home for labour work to towns.



Picture 2: Pastoral women migrating to urban areas due to drought

Over all, the study found that migration to urban centers for marketing and labour is very common among the study *kebeles* community. In the spread of HIV epidemic, however, mobility has been identified as one of the factors to fuel HIV spread among different communities. The rural –urban migration has important out comes for both sending and receiving communities and it has always facilitated the spread of infectious disease including HIV/AIDS (Coast, 2004).

Nevertheless, mobility alone can not be a risk for HIV infection; it depends on the extent to which the migratory group engages in unprotected sex with infected people. Concerning the migratory groups' of the study village's sexual relations in the destination areas, however, the opinions found during FGDs and individuals' interviewees were different. In this regard, this study found that there is deep-seated belief among the community that there is less sexual contact among the Muslim Somali population in general.

Individual men who have experience of migration to urban centers were interviewed on the migratory group experience in the centers. And when they are probed in-depth in private settings (i.e. in most case when some one is interviewed other will join thus the interviewee lack privacy), 8/12 of the interview commented that although the norm in the community is very strict on extramarital relation, every one is not the same and thus there can be such sexual affairs at destination area for migratory groups of men.

But on the other hand, during focus group discussion both in male and female groups the participants insisted that there is no such relationship at all in their community be it in their village or at migration places. This may be largely due to community pressure as revealing the existence of extra-marital affairs could be considered as declaring that there is promiscuity in their community and consequently there is also a fear of intimidation by others, though there is a doubt on the extent of the non-existence of such affairs as expressed indirectly (see the response below from focus group discussion among adult men).

Although we have to separate for longer period from our partners due to migration, we are faithful to our partners. For instant, I stayed for eight years alone without my partner when I migrated to work in different areas (One of the participants of FGD in Marmarsa, married adult men). But another discussant mentioned, for instance, we miss some of our group members during trekking of livestock to urban areas for sale in a group, although we think they went back to their wives, we don't exactly know where they go (FGD with married men of Marmarsa).

This indicates that although the norm in the community plays its own role in shaping the individuals sexual orientation, the study community migration to urban centers could possibly expose them to behaviours and norms that tend to be different from those of their place of origin, thus exposure to risk of HIV infection. Since migration is identified to be a primary cause of change in behaviour (Coast, 2004). A study by Zaid et al (1997) showed that migrant Pakistan workers had unprotected sexual encounters as they are apart from their wives for long periods of time and are at risk of HIV infection.

Migration by men alone in study villages, particularly to population centres for marketing and non-pastoral labour can be a factor of susceptibility to HIV infection. This may be so even when sexual morals within the pastoralist community are strict. A study by May (2003) among Maasai pastoralist present evidence on the extent to which Maasai pastoralist interact sexually with non-Maasai women and concludes urban migration as a risk factor increasing susceptibility to HIV among Maasai pastoralists

Again, it was indicated that migrant women work as housemaids and involve in small business in areas of destination, but none of the respondents pointed out the engagement of migrant women in transactional sex. This might be because it is considered as immoral and thus less likely to be mentioned. However, the distressed migration due to drought especially by Shinile young pastoral women to urban centers for labour work may expose them to risky condition as they may engage in risky livelihood options for survival. In some cases pastoralists women in other regions have migrate to town and ended up as prostitutes or heavily involved in transactional sex. For instance, Getachew (2001) suggests that some Ethiopian Afar women become prostitutes in Djibouti, and there are some prostitutes by Beja women of Ethiopia in Port Sudan.

It was identified that although there is consumption of *chat* (a plant generally chewed in the early afternoon when the heat is greatest, that acts as a mild stimulant) among the migratory men as the case in the community, the tendency of alcohol consumption is less likely due to the strict norm against it. Engaging in risky causal sexual behaviour also depends on factors which determine the riskiness of such group sexual behaviour, for instance, the tendency of alcohol consumption which is often related to causal sex (Bishop et al., 2005). Thus, the tendency to engage in risk causal sexual contact as a result of alcohol consumption at destination areas by migratory groups could be insignificant.

In short, migration and mobility can possibly create patterns of sexual behaviour and mixing which are perfect for the spread of HIV/AIDS for Shinile community. The separation from social norms, family and partner and community supervision may enforce engagement in causal sex during migration. The riskiness may be even further aggravated by the misconceptions about HIV/AIDS including condom use among the Shinile community (discussed more in section 4.2.2.1). Barnett and Whiteside (2006) presents evidence from South Africa, the condition in which labour comes in to an area of high seroprevalence, and where working and living conditions encourage sexual mixing and transmit infection to low risk group of population.

In similar manner, migration can be risky not only to the migrant groups but to the sending study kebeles community depending on the extent of HIV spread in the area of destination. There is a strong link between the study community and Dire Dawa. The fact that Dire Dawa is one of the towns in Ethiopia which are highly affected by HIV/AIDS (Adult prevalence rate is 12 percent -MoH, 2006) could be a risk for Shinile communities. Lydal (2000) supports this idea and indicated that there is increased spread of HIV in South Ethiopia, among Omo pastoralists, as a result of an increased exposure to urban centres where there is increased commercial sex and HIV spread in the centres.

4.2.2 Access to Health Services

The study villages have less access to health services. Shinile clinic is the only health service facility to serve the whole district population as can be identified from district health personnel. The clinic is approximately about 15 km far from the study villages and it provides basic health care services. There is no HIV/AIDS community outreach education service which is run by the clinic (mentioned the head of the clinic).

Again, the main problem in the existing health service is lack of facilities: services including HIV testing (VCT), treatment of HIV/AIDS (ARVs), care and support for PLWH, prevention of HIV transmission from mother to child (PMTCT) and unit for treatment of sexually transmitted disease are not available. Although provision of condom is free of charge but the number of users is very low (only five registered clients).

‘The local community needs evidence to believe that HIV/AIDS presents in their community but we have no way of testing HIV, however, it is very important to see if the disease is here, and then if it is to have a campaign on HIV/AIDS’. ‘Although condoms are readily available free of charge, the actual users of condoms are significantly very low’, said Shinile district clinic health worker

4.2.2.1 Awareness levels on HIV/AIDS

In the villages where the study was conducted, men generally had basic knowledge on HIV transmission and prevention methods with all most of all of them able to mention some means of transmission methods. The most frequently mentioned modes of transmission were: use of contaminated sharps and sexual intercourse. None of male and female respondents mentioned transmission from mother to child and through contaminated blood transfusion and from mother to child. The sources of information mentioned by male respondents were from market centres, community meetings and media mainly through radio broadcast.

On the other hand, women interviewed were less informed about HIV/AIDS, and were unable and/or unwilling to mention means of transmission and prevention. This might be due to the culture of 'a woman stays home' among pastoralists, thus, have limited their access to information including education on HIV/AIDS. It could be also due to the taboo against open discussion on HIV/AIDS and sexuality which has limited information sharing among the community as it may be considered immoral to discuss. This implies that pastoralists particularly women are more at risk of HIV infection due to their low awareness on self protection and means of transmission. (Below one of the women's comment is presented).

'I have heard about the disease from media. I don't know the means of transmission and prevention, I don't want to know about HIV/AIDS because, I don't understand it and also I have no risk of getting HIV infection- it is Christians' infection' (married women in Marmarsa)

Table 4: Interviewees Responses on HIV/AIDS awareness

Responses	Men (n=12)	Women (n=8)	Remarks
Mentioned means transmission			6/8 women were unable /unwilling to mention means of transmissions. None mentioned transmission from mother to child and through contaminated blood.
Sharing of sharp materials	12	2	
Sexual contact	12	2	
From mother to child	0	0	
Through contaminated blood	0	0	
Means of prevention			The respondents are strictly against the use of condom
Avoid sharing of sharp materials	12	2	
Be faithful and abstinence	12	2	
Condom use	0	0	
I am not at risk of HIV infection	10	8	
Source of information			Media and peer groups are the main sources of information for women.
Community meetings &Market places Media (radio) &Peer groups	10	2	
Mentioned three sources	2	6	
Need for HIV testing	0	0	They are even nervous when asked the such question

Source: Own primary data from field interview, Aug 2008

Concerning condom use as method of HIV prevention, both discussants and interviewees said that, '*our religion teaches us to avoid extramarital affair and we don't use condom at all*'. They are strictly against the use of condom as they believe that it encourages promiscuity and its use also contradicts their religious norm which doesn't allow the use of contraceptives including barriers like condom as identified during this study. Muslim population in other parts of the world also share this orientation, for example in Pakistan, the use of barrier methods in sexual intercourse, including condoms, is unfamiliar to the vast majority of the population (Zaid *et al*, 1997).

In addition, the misconception that condoms carry the virus and transmit HIV infection was common amongst the study communities. Though it is not clear how such misconception is propagated throughout the community, suspicious of condoms is one of the reasons refrained them from using condoms for fear of getting the virus. This is in line with the BSS (2002) study findings in different areas of Ethiopia where the same myth about condom was persistent among the community.

Most of the pastoralists, on the other hand, gave great emphasis to protecting themselves from sharp objects rather than protecting themselves during sexual contact. This might be due to the fact the community depends much on culture, and the belief that less extra marital sexual contact among the community (findings of this study in the previous section). Sadly, misconceptions related to condom use are masking the main mode of transmission - heterosexual transmission, and the community rather fear condom it self as a source of the virus and other sharp materials.

The study findings indicated that there is a general absence of awareness on self-protection measures, a situation perpetuated by religious and traditional beliefs. This is reflected in the respondents' preferences for HIV/AIDS protection; while the high preference for abstinence and faithfulness are commendable, however, it is doubtful the extent to which they are practised. This implies that that religion contributes significantly to safer and appropriate behaviours as long as the religion is followed strictly.

All of the interviewees also perceived them selves to be at no risk of infection because 'they trust their partners and had no contact with infected people' and there is even nervousness about the need for HIV testing in the community as none of the respondents mentioned the need for HIV testing (see table 4). Thus, such negative attitudes towards testing due to the perception of being at no risk of infection can potentially aggravate HIV infection spread in the community.

Finally, this study suggests that areas with high misconceptions and low awareness such as Shinile pastoral are at higher risk from the onslaught of HIV/AIDS. In order to increase the awareness on HIV/AIDS and change the persisting misconceptions among the community, education plays a crucial role. However, as identified during field study, Shinile pastoralists have limited access to health service including HIV/AIDS education and others which may be due to the community are mobile, live in remote areas and most importantly due to the low attention from government and external supporters.

4.2.3 Gender related norms

In this study various genders related factors which directly or indirectly contribute to the spread of HIV infection were investigated and are discussed as follows;

Early marriage

The tradition of marrying daughters at an early stage is common in pastoral areas of Ethiopia. Early marriage in this case is a marriage that takes place when the girl is below 18. Child marriage is regularly made through agreement by parents and happens by making a child girl grow with family of in-lows home to be looked by her mother-in lows, in order to prepare her for future life. In the study area, young girls were given at very early age even before they are ten years old. However, the age of marriage is a bit higher than it was before; now most girls get married on average when they are aged 15 -18 years (see the comment given below from one of the respondents)

It was like parents start to seek out who is wealthy man in the village who can offer large number of livestock for dowry, to whom they can give their daughter for marriage when the girl is still very young', Said a married woman in Marmarsa village recalling back to her age during her first marriage.(Married women in Jidane kebele)

The increase in the age of first marriage for girls might be due to the effect of various campaigns on the early marriage in the country. Although married women in the study might be less likely to have multiple partners, the fact that their partners' age can be higher (might had multiple sexual partners) and the limited access to information, schooling, and community participation as a result of marriage will heighten their risk. Clarks (2004) showed that married adolescent girls in rural Uganda tend to have higher rates of HIV infection than their sexually active, unmarried peers.

Arranged marriage is not that much common in the community. It was identified that currently in most cases the girls are allowed to marry a man of her own choice but if a girl is forced to marry through arrangement, there are cases sometimes where the girl escaped to other urban centers. This may be due to when the age for marriage improves the likelihood of arranged marriage also decreases. Thus, also reduces the marriage of a girl to an older partner and contributes to reduced susceptibility of women to HIV infection since older men have more likely to have multiple sexual partners before marriage (Muiller, 2005).

These days there is no arranged marriage for girls and she can refuse to marry some one whom she doesn't want. But before, once the man has brought the necessary dowry, the parents of the girl used to force her to marry the man. (Age 45, married man, Jidane)

Bride wealth payment

Bride wealth paying is one of the preconditions during marriage in Shinile. In the study villages, specific number of livestock has to be given to girl's family and it is based on the laws and rules in their traditional constitution (Xeer). The study found that recently due to the general increase in poverty and the loss of livestock due to recurrent droughts, the bride wealth rate is determined through negotiations between the two parties. This finding is unlike some communities where the man has to wait longer for the same reason and thus may have multiple sexual partners before marriage which is identified as a susceptibility factor for women (Muller, (2005).

Access to information

Another susceptibility factor for women in study *kebeles* is women usually don't participate in community meetings; and are not responsible to make trips to market places which are believed to be the main source of information for pastoralists. This indicates that study *kebeles*' women have less access to information including HIV/AIDS related, but information plays an important role for prevention of HIV infection. In addition, there is negative attitude towards learning about it, since HIV/AIDS is a taboo subject in the community. Similarly, Mueller (2005) suggests that women are less informed due to social norms and are less able to prevent HIV infection.

Marriage by inheritance

At the same time marriage by inheritance is also very common in Shinile. The widow is inherited to husband's relative mainly to his brother but also to his cousin if he doesn't have any brother. Marriage by inheritance in Shinile also occurs through a man marrying his sister in-law when his wife dies. In spite of the government effort to inhibit this practice, there is a high resistance since it is supported for social and religious reasons, and women are forced to be inherited as identified during field work (See profile of a widow presented in Box 2).

Box 2: A widow's story

My husband has died of illness about fifteen years ago. We had 4 children when he died. His family and my neighbours told me that I have to marry his younger brother otherwise I will lose all my children and property to my husband's relatives. Then I decided to marry him since I can't live without my children and I had no option though I was not willing to do so (Inherited widow, 50 years old)

Polygamy

Regarding polygamous marriage, the practice is widely accepted among Issa pastoralists. They are largely polygamous (with two wives being more common), except for young and poor families who are not in a position to support extra families. The reasons mostly given are: religious, as a means to ease the burden of work by single woman, sign of wealth or symbol of status, to increase the number of children etc.

And thus, it is more common among relatively the wealthier households. Currently, however, it is decreasing because men can not afford more than one wife due to general poverty. In this case, a man marrying more than wife also leads to insecurity of women and facilitates the spread of HIV/AIDS

The different types of relationships, such as polygamy or widow inheritance which are common among the study villages, do not alone drive the HIV/AIDS epidemic. However, they are a potential source of infection if one of the partners is infected or engages in sex with high risk groups outside that relationship. Findings by Kloos (2007), indicates the same traditional practices which are common among rural communities of Eastern Ethiopia and concludes as potentially risk practices.

Female genital mutilation (FGM)

According to this study, all study respondents and discussants agree on the wide practice of FGM in the community and all females participated in study had undergone FGM. They agree that this practice should continue for both religious and social reasons. The most common type of FGM that is practiced in Somali including Issa clan is infibulation¹. The purpose of infibulation is to protect women from rape and impregnation by invaders, but recently there is a shift to *Sunna*² which is a less severe form of FGM.

Traditional practitioners usually undertake these activities and they are widely respected. They perform these operations in return for cash and gifts. The community indicated that these days they don't use sharp materials in general including for the purpose of such as FGM. In addition, there is increasing action to deter people from practising FGM (for example, through the work of the National Committee on Traditional Practices in Ethiopia) and there have been some successes.

In a nationwide survey conducted among health personnel, Female Genital Mutilation was cited as the most common harmful traditional practices in Somali (Jeppsson et al, 2003). According to the NCTPE (National committee on Traditional Practices of Ethiopia) survey 1997/98, pastoralists inhabiting in Somali are among those ethnic groups referred to as strong hold, due to much higher prevalence level of FGM practice. Approximately 80% of females in Somali had undergone FGM. The health workers recognised many of these traditional surgical interventions frequently resulted in serious and life-threatening complications (including HIV as possible complication).

Generally, Ethiopian health officials fear that the use of unsterilised instruments to perform these practices aggravate the HIV/AIDS epidemic (as noted in the GoE's policy on HIV/AIDS (GoE, 1998)). Nevertheless, it should be recognized that the few data available have not found an association between such practices and HIV infection (Garbus, 2003). Thus, although the risks of HIV infection through FGM at present is small, but require attention.

4.2.4 Patterns of sexual networking

The study notes that the Muslim faith allows men to have more than one wife but it is strictly against extramarital relationships. In accordance with Somali Muslim culture, the occurrence of relationships outside marriage is not widely acknowledged and thus, there is a deep seated belief among the respondents that there is less extramarital sexual contact among Issa pastoralists. Although polygamous marriage, and marriage by inheritance is widely practiced, patterns of sexual networking like wife sharing, multiple sexual partner pre-marriage by warriors and in-marriage which are traditional among some pastoral societies do not exist among Shinile community, for instance, Coast (2002) indicates high level of sexual net working within and outside marriage for Maasai pastoral community.

This finding is in line with the suggestion given by Morton (2004) which states that most of the Muslim pastoral societies are strict towards extramarital relationships. However, when asked on the existence of extramarital relationship, 8/20 believes the existence of such practices in their community. In spite of the strict norm, there might

¹ Infibulation is removal of the clitoral hood, the clitoris, the labia minora and majora and stitching together the two sides of vulva leaving very small hole for passage of urine and menstrual flow

² Sunna is excision of prepuce, with or without excision of part or the entire clitoris

be also a tendency to practice pre-marital sex among the adolescence. But of course, there is a need to confirm such findings through further behavioural studies in these groups. Yet, several previous studies done in various parts of Ethiopia indicate that the level of sexual activities among youth is increasing despite the strict social norm on premarital sex (BSS, 2002).

Box 3: Existence of extramarital relationships in the community

'I had a girl friend before I get married, she mostly lives in Djibouti but also comes to the village sometimes. We did not disclose our relation even to any of our close friends' (Mentioned by one of the young men interviewees).

One of elder men interviewees said. 'These days we hear young boys having relationships with young girls before marriage but the boy has to marry the girl immediately once this is made known before the parents of the girl and the elders'.

'I don't think that all people are faithful to their marriage since all people are not the same. Again there is a tendency for adolescents to have pre-marital sex now days, for instance, there was a child born out of marriage in our village just before few weeks'. (Elder man in Marmarsa)

In conclusion, unlike some communities in Ethiopia and else where, where out of marriage sexual relations are existent, in the study community the strict social norm which disapproves extramarital relationships contributes to reduction of such practices and hence will contribute its own in the struggle to curb the epidemic. But still the wide prevalence of other risk customary relationships like marriage by inheritance and the relative increase in practice of unsafe pre-marital sex pose further risk for HIV spread.

4.2.5 Exposure to violent conflicts

For some Somali region is synonymous with inter-clan conflict, which is indeed frequent and has claimed thousand of lives over many years. There is a significant number of Somali people internally displaced due to conflict as well as drought in the region. Conflict and displacement is associated with increased risk of HIV transmission among affected population because of behavioural change due to interruption of social networks and economic vulnerability (particularly among women and adolescent) as well as sexual violence and disruption of preventive health service.

Nonetheless, in the study area, none of the respondents have mentioned any experience of exposure to violent conflicts. Unlike other pastoralists of Somali region and other pastoral areas in the country, the pastoralist of Shinile have no experience of disputes on pasture and water within their clans or sub-clans and neighbouring pastoral groups. This might be due to the fact that the Issa clan is the only clan which is inhabitant of the district. In addition, it is due their traditional constitution the Xeer /Issa which promotes peace and disputes to be resolved early. Thus, the two villagers have never displaced from their area due to conflict nor had no any kind of conflict associated problems.

Yet, the people of Shinile are rather more getting displaced due the drought and are likely to face its consequences. During the field study, it was observed that some households have displaced from neighbouring kebeles and have temporally settled in the study villages with their animals. In addition groups of women were seen in the town of Shinile and explained that they have left their village due to drought. This

might be due to the fact that pastoralists move to villages near to the aid centers during such crisis. In his study Deveruxe (2005) indicated that currently out of the total internally displaced people in Somali region, drought accounts for 80%. Whether it is due to conflict or other reasons like drought, any condition which leads to the disruption of society favours a risk condition for HIV infection as it affects the social networks in the community, leads to livelihood insecurity and break of families.

4.3 Response to the epidemic in the district

The government is responding to the epidemic through establishing district HIV/AIDS secretariat which is staffed with four professionals. The main actions taken by the department in response to the epidemic by the department until recently is sensitising the community on the means of HIV transmission and prevention methods. Various workshops and trainings are organised for kebeles HIV/AIDS agents (three persons in each kebeles) and community leaders.

According to the HIV/AIDS secretariat officer, it's expected that these people once they are trained, they would be responsible to mobilise the community and create awareness on HIV/AIDS through out the community. There are also three anti-HIV/AIDS youth clubs in Shinile town which are organised by the secretariat office. These clubs are based in town, but they are involved in teaching the rural community as pointed out by the secretariat officer. Less attention is usually paid to education on avoiding unsafe sexual practices than contact with contaminated sharp materials (see the comment given below).

The main focus of our education is that we try to make the community understand that HIV/AIDS does not only spread by sexual contact but also through contaminated sharp materials. This is because from religious teachings they believe that the disease spreads through extramarital relationship (promiscuity) and such relations do not exist among Muslim community. So if we teach that it can also spread through contaminated sharp materials, they will accept that there would be a possibility to get the infection. Commented by staff from HIV/AIDS secretariat

On the other hand, according to the district health worker there are no any HIV/AIDS related services including VCT, PMCT, ARV provision and treatment and prevention of STDs in the district which are made available to the community by the government and other institutions. Moreover, although the national HIV/AIDS policy directs all sectors to develop their own strategies for the purpose of expanding the national response, this not case which can be evidenced from the district health sector and agricultural sector where their respective organisations have not yet mainstreamed HIV/AIDS issues in to their programmes and activities.

In view of high epidemic potential in the poorer and less informed rural population, there is a need to scale up the capacity and resources necessary for an effective response to the epidemic. This provides a great opportunity to respond to the epidemic in its early stage in rural areas of the country (Kloos, 2007). But, it is observed that little work has been done in study area in response to the epidemic from the government side. In addition, the inhabitants are denied access to different HIV/AIDS related services, which is basically provided by the government and other NGOs. Over all, even though pastoralists play a role in development of the county, and accounts for significant proportion of the country's population, however, little attention was paid in response to the epidemic in Shinile in times of such deadly epidemic.

Concerning civil society organisations responses, there is an NGO called Handicap International which has HIV/AIDS related project in the district. The organisation has engaged in these activities since one year. The main focus of the project is awareness rising on HIV/AIDS throughout the community. People living with HIV/AIDS (PLWH) basically Somali tribes from other areas are trained to teach the community through house to house education. This is because there is no one in Shinile district who has tested positive and declared him/her self to teach the community. Although the involvement of people living with HIV/AIDS in educating the community is among the known effective strategies, but due to the prevalent stigma and discrimination attached to PLWH in the community there is a great challenge. When asked about the stigma and discrimination in the community towards PLWH, one of the HIV/AIDS secretariat staff members told a history as follows;

Box 4: Stigma and discrimination towards people living with HIV/AIDS

I was with one of the trained individuals who are HIV positive and we entered to a household in a village to teach about HIV/AIDS. After getting in to the house we both greeted and shook hands with the members of the household and then after a while we started discussing about HIV/AIDS. And my friend told them that he is living with the virus then the problem came, the father yelled 'I will kill you! Looking for something to beat us and said go out of my house! How would you dare to touch us with your disease?'

The same organisation's community organiser department indicted that mass event every three months together with mobile VCT service has already planned to be implemented as part of the project component. In addition, the project has an advisory committee to oversee the implementation of the project; it has ten members composed of religious and community leaders. Simultaneously the organisation is also working with the district clinic to establish VCT service in the coming few months as stated by the head of the health clinic.

Handicap International has also a plan at the same time to launch education program on HIV/AIDS through radio in Somali language; it is on the pre-testing stage as the project officer mentioned. Religious and community leaders are also trained through the project to sensitise the community on HIV/AIDS in religious institutions. This is mainly to avert the social denial: the belief that HIV/AIDS doesn't transmit to Somali community and HIV/AIDS does not exist in the community. This is an encouraging initiative which should further expand in the community and implemented in a sustainable manner since there is a deep rooted misconceptions in the community.

Some other two NGOs- Save the children-UK and Harargie Catholic Secretariat (CHS) have HIV/AIDS related activities as a component of HIV/AIDS mainstreaming in their projects. Their main activities are also awareness rising through training programs for different stakeholders in their project area in the district.

The involvement of few NGOs on HIV/AIDS in study district; most of their activities to date which is mainly focused on information, education and communication (IEC) amongst the community is an indication that until recently the pastoral sector was overlooked not only by the state government but also by NGOs. This is in agreement with the findings of Tesfaye *et al*, 2002 which indicates that although there are over

175 NGOs conducting HIV/AIDS-related programmes in Ethiopia, very few directly address the needs of the agricultural sector and smallholder producers.

No other CBOs and FBOS working on HIV/AIDS were able to be identified in the district. However, there are religious committees which are informally working with the district HIV/AIDS secretariat such that they will incorporate HIV/AIDS with religious teachings. Moreover, it is also to engage the young boys in religious activities so as to make them busy and divert their attention from being involved in risk behaviours. Although it is commendable to involve religious institutions in the response to HIV/AIDS as they play a crucial role in averting the misconceptions held in the community, the exclusion of girls from such teachings has its own implication in creating knowledge gap on HIV/AIDS between male and women adolescents in the community.

There is lack of collaboration between various institutions (NGOs and Governmental sectors) and coordination of activities in relation to HIV/AIDS response in the district as identified through this study. It was evidenced that there is no any link between those NGOs and governmental organizations including HIV/AIDS secretariat office and there is a gap in experience and information sharing among these institutions.

Chapter Five: Conclusions and Recommendations

This chapter presents the summary of the main findings of the research and the recommendations to various concerned bodies. Under section 5.1 conclusions are presented while section 5.2 highlights the recommendations that have to be implemented in order to reduce the susceptibility of Shinile district pastoralist to HIV infection.

5.1 Conclusions

In view of the foregoing findings, the study arrived at the following main conclusions;

HIV/AIDS is a clear and present danger to Shinile pastoral communities: HIV/AIDS awareness levels in the community are low and the community have not fully accepted the presence and threat associated with the pandemic. The prevalent perception that HIV/AIDS is a disease of 'other' people is widespread and commonly held. Although the community is experiencing an increase in morbidity and mortality, some of which are attributed to HIV/AIDS opportunistic infections like TB, there is absence of reliable and consistent data on HIV/AIDS prevalence for pastoral communities of Shinile district.

The susceptibility of Shinile pastoralist is mainly related to migration particularly to urban centers, gender related factors and the low levels and misconceptions on HIV/AIDS: Increased migration of labour to urban center due drought and destitution compounded by high proximity and link with urban centers is accelerating exposure to high-risk conditions. The gender norms in pastoral areas as well as the misconceptions which are enforced by the social and religious norms are also identified to be the risk factors. Strikingly, exposure to violent conflict and traditional sexual net workings which are among the main factors to contribute to the spread of HIV among pastoralist don't significantly present in Shinile district.

Women face heightened risk of HIV/AIDS infection in Shinile district: Women are socially and culturally subjugated to men. Women are represented in inferior position than men. They have lower awareness rates, and where they are aware of preventive measures, they do not seem to want to use them for fear of being seen as immoral. The women stay home culture among the community also limits their access to HIV/AIDS information. More over, traditional practices like polygamous marriage and marriage by inheritance poses a major risk for HIV infection among women.

Pastoral communities lack the facilities to understand and respond to HIV/AIDS: It was identified that pastoralists in Ethiopia in general and Shinile district in particular live in areas of underdeveloped infrastructures. They lack access to health services which play a crucial role in prevention and control of the epidemic through education on HIV/AIDS, HIV testing and counselling etc. The low awareness level, misconceptions and denial among the community is a reflection of the inadequate HIV/AIDS related services and education in the district which are necessary to bring behavioural change among the community.

Social and religious norms contribute both to safe practices and at the same time perpetuate risk attitudes among communities: The strict disapproval of extramarital relation due to religious and social norm among the Shinile pastoralists is contributing to safe practices, though there is a doubt on the extent of non-practice of such affairs. On the other hand, it is perpetuating a low risk perception and denial among the community, thus hindering taking protective measures in case of exposure to risk conditions.

The actions taken by different actors in response to epidemic in the districts are inadequate and are not well coordinated: In the face of almost overwhelming risk among pastoral communities, the support of civil society and government agencies is grossly inadequate in their action to the epidemic. As well, there is paucity of numbers and resources in civil society organizations.

5.2 Recommendations

Based on the findings and conclusions of this study, both short-term and long-term recommendations have been advanced. But it should be noted that although the recommendations are made specific as much as possible, since various stockholders are involved in HIV/AIDS response at various levels and due to the answer to “who has to do what” in particular in response to the epidemic is beyond the scope of this study, thus some recommendation might look very general.

Short-term Recommendations:

A) There is a need to conduct base line HIV/AIDS surveillance in order to have better understanding of the status of pastoral area epidemic: It is impossible to respond effectively to the epidemic in Shinile district in the absence of reliable prevalence data. Thus, it is strongly recommended that the district health bureau and district HIV/AIDS secretariat office should assess the status of HIV/AIDS epidemic and identify appropriate interventions in collaboration with the regional government and other NGOs.

B) Targeted HIV/AIDS awareness campaigns should be organised so as to reduce aversion to discussion of HIV/AIDS related issues especially in public and raise HIV/AIDS awareness: Efforts and actions both by government organisations and NGOS to raise HIV/AIDS awareness should be stepped up. Cultural norms still hinder the discussion of sexuality and HIV/AIDS in public especially across the gender divide, therefore awareness campaigns need to be targeted at different gender and age categories. Because of the conservative nature of the pastoralist communities, culturally and religiously sensitive approaches should be adopted in addressing the HIV/AIDS epidemic.

C) It is recommended that the community has to be empowered so as to challenge the cultural norms which contribute to increased women risk to HIV infection: Many aspects of the HIV/AIDS epidemic in the area are closely related to gender inequalities and cultural norms. Organising discussion forums on gender issues would enable different members of the community to identify, explore and address cultural and gender issues, and would provide the basis for behaviour change (at individual, household and community level) in order to minimise the risk of infection. The women affairs department in the district should take the initiatives in mobilising the community and other concerned bodies to support in implementing the same.

D) Traditional social and indigenous administrative and religious institutions should be integrated in the fight against gender inequalities and HIV/AIDS: These institutions play a major role in Shinile communities' day to day life. Moreover, culture, tradition and religion have their own contributions to curb the spread of the epidemic. To ensure the influence these institutions hold in the community to fight gender inequalities and HIV/AIDS and to enhance coordinated action in the fight against the epidemic, other organisations working on HIV/AIDS in the area should acknowledge the contribution of traditional institutions, and should involve them.

E) There is a need to improve access to preventive health service in the community: Health services including HIV testing and others are lacking in Shinile district. The district health department in collaboration with other NGOs working in the district on HIV/AIDS should work on advocacy and lobby to make the pastoralist voice heard such that they get access to services including HIV/AIDS related.

F) Involvement of NGOS and other CBOS in response to epidemic in the district should be enhanced: The limited number of civil society organisations working on HIV/AIDS and their inadequate response to epidemic is an indication for a need to scale up supporting and creating enabling environments by the district government bodies in which the public, civil society and international partners can jointly generate the capacity and resources necessary for an effective response to the epidemic in pastoral areas.

G) There is a need to coordinate HIV/AIDS activities among various institutions in order to make efficient use of resources: The study notes that there is a fragmentation of efforts among different government actors in implementing HIV/AIDS interventions at the community level. Moreover, experience and information sharing among various institutions working on HIV/AIDS is also lacking. The different actors involved in HIV/AIDS activities have to establish formal networks and partnerships among them through organising experience sharing forum, various training and workshops on 'partnership in responding to epidemic'.

Long- Term Recommendations:

A) Policy review by the state government: Key development policy documents (such as Poverty Reduction Strategy Paper) should be reviewed to ensure that the potential role of pastoral production system is fully utilised to secure sustainable livelihoods in pastoral areas in country in the long run.

B) Strengthening and diversifying of pastoral livelihoods are strongly recommended to concerned bodies working in development of pastoral areas: Pastoral livelihoods are becoming more insecure due to recurrent droughts, as result increasing labour migrations to urban centers. Women and the youth are particularly vulnerable to insecure and poor livelihoods which may drive them to labour migration thus into HIV risk environments. Through strengthening and diversifying their livelihood options in pastoral areas (for example, poultry, animal fattening, trading, small scale irrigation and horticultural production) it is possible to change their outlook towards the future and stem the rural-urban drift and other potentially risky behaviours.

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Annexes

Annexe-1 : Semi- structured Interview Guide

The study used a list of broad topics and developed sub question for interview during field study, and therefore the following questions were included in semi- structured interview guide.

Topic 1: Migration /mobility

- 1.1 For what reasons do the inhabitants migrate?
- 1.2 During which seasons do men/women migrate for different reasons?
- 1.3 For what reasons do women and men make trips respectively?
- 1.4 How is the pattern of migration in your village? (Migration by Male/Female alone, the whole family).
- 1.5 Why do the community members migrate to urban centers in particular and which places are the main destinations?
- 1.7 How long do they stay in urban areas during migration and what do the migrant groups do there?
- 1.8 How is the proximity of your village to transport networks?
- 1.9 How is exposure to causal sexual contact in the area of migration for male migrants?
- 1.10 To what extent do the migrant women engage in transactional sex at the area of distinction?
- 1.11 How is alcohol consumption in the community and at destination for migratory groups?

Topic 2: Traditional patterns of sexual networking

- 2.1 What are the common customary sexual behaviours in the community?

- 2.2 To what extent polygamous marriage, wife sharing, multiple sexual partners (pre-marriage, in- marriage)
- 2.3 Does marriage by inheritances prevalent in the community?
- 2.4 Does the community perceive these behaviours as risky?
- 2.4 How the communities do perceives extramarital relationships?

Topic 3: Access to Health services

- 3.1 What is the main health problem in your community?
- 3.2 What type of HIV/AIDS related health services are available to your community?
(Like HIV testing, ARVs and prevention of transmission from mother to child etc.)
- 3.3 Where does some one get health services when one gets health problem?
- 3.4 To what extent do you think the community is getting preventive health services?

HIV/AIDS awareness levels

- 3.5 Heard about HIV/AIDS before? If yes, what are the sources of your information?
- 3.6 Seen/heard some one who is leaving with HIV/AIDS in the village?
- 3.7 Can you mention means of HIV transmission and prevention?
- 3.8 Do you perceive that you can be at risk of HIV infection?
If not, can you mention the reasons?
- 3.8 Do you have access to HIV/AIDS related information and services?
- 3.9 How do the community perceive some one living with HIV/AIDS (Positive attitude, willingness to live, share and have contact with PLWH?)
- 3.9 Do you think that there is a need for HIV testing services?
- 3.10 Does the community accept condom use during sexual contact? If not, why?

Topic 4: Exposure to violent conflict

- 4.1 How is exposure to conflict (traditional /military) in the community?
- 4.2 What are the causes of conflict in your area?
- 4.3 How do you resolve such conflicts?
- 4.4 Are there any migration, displacement and sexual violence as consequences of conflict in the community?
- 4.6 What other factors have caused displacement to the community other than conflict, if any?

Topic 5: Gender related factors

- 5.1 At what age for male and female marriage occurs in the community?

5.1 How bride wealth paying takes place among Issa community? How is the rate determined?

5.3 To what extent women sexual violence prevalent in the area?

5.4 Can women able to negotiate safe sexual relationship (able to say no to sex, insist on the use of condom)?

5.5 Do women in the community make decision such as whom they will marry and when they marry and decision on access to HIV related information and uses of service related to HIV/AIDS (like PMTC, VCT and etc.)

5.6 Do women inherit property including livestock?

5.7 To what extent traditional practices like FGM are practiced in the community?

5.7 What are the roles and responsibilities of women in the community?

Annexe-2: Study sample profile

Interviewees	No.	Remarks
Informants in the community	20	12 men and 8 women totally
Pastoral women and men	14	Interviewed on the potential risk factors using the semi-structured interview guide
Keble leaders	2	
Religious leaders	2	
community elders	2	
Informants of various institutions	7	2 were women and 5 men
District HIV/AIDS secretariat	1	The staff members/ leaders were interviewed on their respective organisation's response to HIV/AIDS and suggested on the potential risk factors for the spread of HIV in the area.
Health clinic health worker	1	
District health bureau	1	
District administration office	1	
NGOs working in the district	3	
Focus Group Discussions	3	4 participants in each, the male FGDs are divided by age category: young age (20-35) and adult age above 35. The female FGD was among adult
Male focus group	2	
Female focus group	1	

