



RENEWAL Ethiopia Background Paper: HIV/AIDS, Food and Nutrition Security

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“The seriousness of the HIV/AIDS epidemic in Ethiopia is widely acknowledged... Ethiopia is classified 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.

Little work has been done on the nature of the disease in rural areas, despite the fact that 85% of the population lives in rural areas and that the agricultural sector plays a central role in the Ethiopian economy. With rural prevalence rates estimated to be 2.6% (in 2004) it suggests that the disease is at a much earlier stage of its trajectory in rural communities in comparison with urban areas where prevalence rates are estimated to be 12.6% (in 2004). This presents a window of opportunity for addressing the epidemic in rural areas before it takes a debilitating grip on rural livelihood”. (Bishop Sambrook, 2004).

“There is a desperate need for food in all of the (urban) households visited by the home and community-based care volunteers. Severe financial constraints on households (lack of access to finances was compounded since a large proportion of the clients in Home and Community-Based Care are the family bread winner) mean many are starving and most malnourished”. (Coughlin, 2005).

1. Introduction and Overview

The Regional Network on HIV/AIDS, Rural Livelihoods and Food Security (RENEWAL) was launched in 2001. Facilitated by the International Food Policy Research Institute (IFPRI) and with support from several donors, RENEWAL is a growing regional network-of-networks. Currently active in Malawi, Uganda, Zambia, South Africa and Kenya, RENEWAL comprises national networks of food and nutrition-relevant organizations (public, private and non-governmental) together with partners in AIDS and public health. RENEWAL aims to enhance understanding of the worsening interactions between HIV/AIDS and food and nutrition security, and to facilitate a comprehensive response to these interactions. The core pillars are locally prioritized action research, capacity strengthening and policy communications. RENEWAL believes that the process of developing networks is both a means and an end. Impact may be enhanced and sustained when locally prioritised research is linked with capacity strengthening and policy communications.

IFPRI is currently active in Ethiopia through its Ethiopia Strategy Support Program (ESSP), and considerable scope exists to compliment the rural development thrust of the ESSP through the introduction of RENEWAL activities in Ethiopia. **The purpose of this paper is therefore to map the context of HIV/AIDS and food and nutrition security in Ethiopia, and to identify the knowledge gaps that RENEWAL could help address through its activities in Ethiopia over the coming five years.** In order to achieve this purpose, the Background Paper was undertaken to achieve the following broad objectives:

1. Description and analysis of the context of HIV/AIDS and food and nutrition security in Ethiopia.
2. Identification of existing policies and programmes in place in Ethiopia that address the interaction between HIV/AIDS and food and nutrition security, and a description of the current knowledge gaps.
3. Identification of the role RENEWAL can play to facilitate action research and policy development in a coordinated manner between the health, food and nutrition-relevant sectors at the national level in Ethiopia. This is based on the knowledge gaps identified above as well as the outcomes of the recent International Conference on HIV/AIDS and Food and Nutrition Security in Durban, 14-16 April.

The Background Paper was based primarily on a wide-ranging desk-top study, key informant interviews with diverse stakeholders across sectors in Ethiopia, and a number of meetings with government and donor groups to elicit comments on the findings and recommendations.

The paper has been structured as follows. Section One introduces food and nutrition security in Ethiopia and the emerging crisis around HIV/AIDS, discussing why it is unique compared to other health and development issues, and provides an overview of some key research documents on the issue of HIV/AIDS, food and nutrition security in Ethiopia. Section Two provides an overview of livelihoods in Ethiopia, drawing out key vulnerabilities to food insecurity. Section Three discusses issues around food security, poverty and famine in Ethiopia. Section Four provides a detailed analysis of vulnerability in peasant agriculture, the pastoralist economy and urban communities. This section is complemented by a short discussion on nutritional status in Ethiopia, which emphasises the importance of the relationship between HIV infection and nutritional status.

Section Five provides a detailed analysis of HIV/AIDS in Ethiopia at present looking at both prevalence rates and projected figures. Section Six begins to assess the interactions between HIV/AIDS, food and nutrition security. In particular the section provides a critical evaluation of the bidirectional relationship between HIV/AIDS and food insecurity and how a mainstreaming approach can be built upon this understanding. Section Seven provides an HIV/AIDS audit of all food security, poverty and development strategies and policies in order to identify the policy gaps that exist in relation to HIV/AIDS and food and nutrition security. Section Eight identifies key knowledge gaps in Ethiopia, building on discussions from the IFPRI conference on HIV/AIDS, food and nutrition security held in Durban, South Africa.

These gaps feed into Annexure One, which details how RENEWAL can respond by facilitating action research, capacity strengthening and policy communications in Ethiopia.

This is complemented by Annexure Two, which provides an analysis of key stakeholders in Ethiopia and their respective HIV/AIDS policies and programmes. This stakeholder mapping enables an assessment and coordination of activities between HIV/AIDS and food security.

2. Food and Nutrition Security in Ethiopia

“The agricultural sector remains our Achilles heel and source of vulnerability...Nonetheless, we remain convinced that agricultural based development remains the only source of hope for Ethiopia”. (Prime Minister Meles Zenawi 2000)¹.

The Ethiopian economy is among the most vulnerable in sub-Saharan Africa (Devereux *et al*, 2005; Pankhurst & Gebre, 2002). It is heavily dependent on the agricultural sector, which has suffered from recurrent droughts and extreme fluctuations of output. Agricultural production, for instance, grew by about 2.3% during 1980-2000 while population was growing on average at a rate of 2.9% per year, leading to a decline in per capita agricultural production by about 0.6% per year (Demeke *et al*, 2004). The number of food insecure households in Ethiopia has been increasing since the 1960s, as domestic food production has failed to meet the food requirements of the country. The annual food deficit increased from about 0.75 million ton in 1979/80 to 1.4 million tons in 2000 (Mulugeta & Etalem, 2003). As a result the most important basic deprivation that plagues Ethiopian society is a lack of access to adequate food and nutrition. The country has been receiving on average 700 thousand tons of food aid per annum in the last fifteen years, which is a serious concern among experts and policy makers.

As Prime Minister Zenawi argues above, despite this current food insecurity, Ethiopia has great potential for increasing agricultural production and productivity and thereby ensuring food security (IFPRI, 2004). Ethiopia is well endowed with potentially cultivable land resources, has an immense untapped irrigation and hydroelectric potential, has diverse climatic features to grow a large variety of crops and sustain pastoral activities, and has the largest livestock population in Africa (Demeke *et al*, 2004). In order to build on these “natural endowments”, the varied nature and causes of food insecurity and general destitution across Ethiopian society have to be understood. In policy discourse, the imperative to move away from repeated “emergency” food aid distributions and to find ways of tackling the longer-term causes of food insecurity have been long and widely acknowledged (Sharp *et al*, 2003). Key widely known factors behind worsening vulnerability to food insecurity are population pressure, size of landholdings and land degradation, deforestation, soil erosion and erratic and inadequate rainfall pattern in addition to the less articulated issues around the adequacy of policy and institutional frameworks and design of intervention programmes. The existing suite of interventions in Ethiopia is essentially oriented towards addressing these factors.

A major factor that has to date not received concerted attention in the agricultural sector is that of HIV/AIDS. Although HIV prevalence is still relatively low when compared to countries in southern and east Africa, Ethiopia is one of the most seriously affected countries in the world (MoH, 2004). As a consequence, the epidemic is recognised as one of the major causes of vulnerability in both urban and rural areas (Demeke *et al*, 2004; HAPCO, 2004). The magnitude of the Ethiopian AIDS epidemic has recently become apparent: in 2004 an estimated 1.5 million people were living with HIV/AIDS and the national prevalence rate stood at 4.4 percent; 12.6 percent urban and 2.6 rural (MoH, 2004). AIDS is the leading cause of death for those aged 15 to 49, and the number of AIDS orphans is palpably growing by the day (Demeke *et al*, 2004). Deaths due to AIDS has brought down life expectancy gains and on average is expected to reduce it by 4.6 years in 2003 (MoH, 2004).

2.1 Understanding Why HIV/AIDS is Unique

HIV/AIDS is clearly more than a health issue as the socio-economic consequences of the epidemic can seriously undermine the development achievements of existing policies and programmes. In many countries around the world, development is being seen against the backdrop of four long-wave events

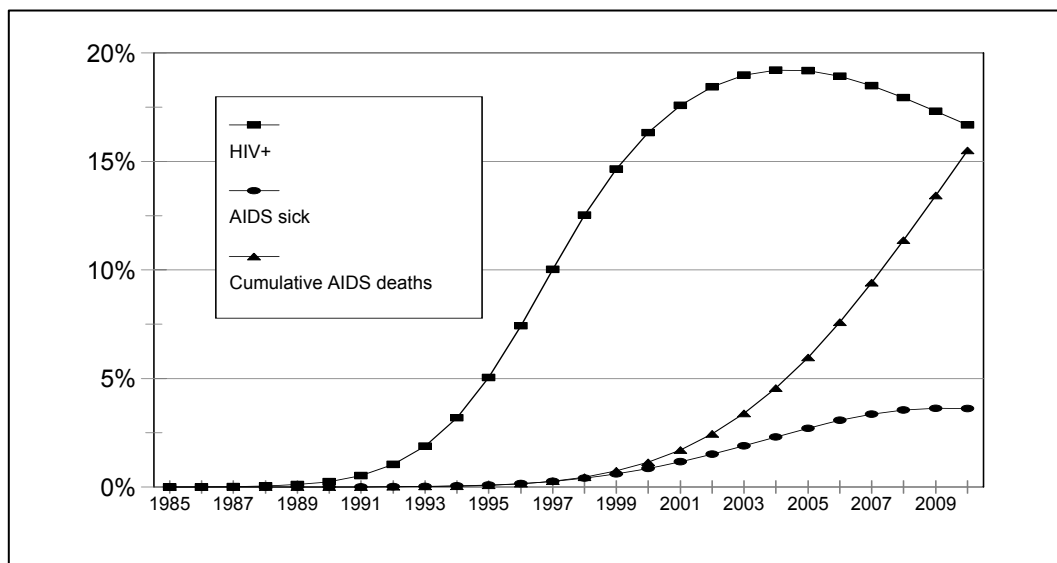
¹ For a concise historical overview of Ethiopia’s political landscape and policies towards land and agrarian change see Devereux, Teshome and Sabates-Wheeler, 2005.

associated with the HIV/AIDS epidemic (Barnett & Whiteside, 2002):

- i) The wave of HIV infection
- ii) The wave of opportunistic infections, most likely tuberculosis², which is usually the first visible wave of the epidemic
- iii) The wave of AIDS illness and death
- iv) The wave of impact, which includes household poverty, orphaning and many other effects.

Taken together, this long-wave event extends over many decades. HIV moves through a susceptible population, infecting some and missing others³. Epidemics follow an “S” curve, illustrated in Figure 1, starting slowly and gradually. At a certain stage, a critical mass of infected people is reached and the growth of new infections accelerates thereafter.

Figure 1: Past and predicted course of the HIV/AIDS epidemic in KwaZulu-Natal, South Africa



Source: Calculated from ASSA, 2002

In the final phase of the epidemic, where the “S” flattens off at the top of the curve and turns downwards, people are either getting better or deaths outnumber new cases so that the total number alive and infected passes its peak and begins to decline. HIV and AIDS is different from other epidemics in that there are two curves, as illustrated above.

Rather than infection being followed by illness within a short timeframe, such as with malaria, the HIV infection curve precedes the AIDS curve by between five and eight years. This reflects the long

² Many, perhaps half, of all adults in Ethiopia carry a latent TB infection, which is suppressed by a healthy immune system (MoH, 2002). When the immune system is weakened by HIV, it can no longer control the TB infection and overt TB disease can develop. The results from the projection model used by the Ministry of Health in collaboration with the Futures Group can be used as an example. In 1989 only 300 of 3300 new TB cases could be attributed to AIDS. By 1999, however, 13,000 of a projected 17,200 new TB cases would be AIDS-related, and by 2009 15,400 of a projected 21,200 new cases would be attributable to the AIDS epidemic. These are almost certainly underestimates, because these new TB cases will transmit the disease to others. Also, the emergence of drug-resistant strains of TB in eastern Africa is contributing to an ever-worsening epidemic.

³ The following paragraph is a summary of Barnett and Whiteside’s useful and accessible description and analysis of how the long-wave nature of HIV/AIDS moves through a population (2002).

incubation period between infection and the outset of illness, denying the warning to be on guard. The stealth of HIV enables infection to move through a population without sign until people start to leave the infected pool not by getting better but by death as a result of there being no cure.

Why AIDS is unique

- It is incurable and fatal.
- It kills the most productive members of society and kills them slowly, drawing others from the workforce to care for those who are sick.
- Life-prolonging treatment will remain inaccessible for the vast majority of people living with HIV/AIDS.
- It is socially invisible and mired in silence and stigma.
- It is a long-wave crisis with a very long incubation period between infection and full-blown symptoms, during which individuals are infective; and invisibility and long duration combine to increase chances of HIV transmission.
- It has both rural and urban dimensions and significant urban-rural linkages.
- It affects both the rich and the poor, though the poor are most severely exposed.
- It affects both sexes but it is not gender-neutral: women are physiologically, economically, and culturally more at risk of HIV infection and AIDS.
- Just as its impacts intensify, with a parallel need for action, the actual capacity to act is declining precipitously. The United Nations has recently drawn attention to the “triple threat” of food insecurity, AIDS and deteriorating capacity (UN, 2004).

Gillespie & Kadiyala, 2005

It is important that HIV/AIDS be considered in the overall development context, given the current and projected prevalence levels. In particular, rising HIV prevalence among farming communities could affect the overall effort to improve agricultural performance and needs to be investigated and incorporated into policy frameworks. AIDS is one of many stresses, but it is a distinct one that can exert its effects over a relatively long period of time while rendering other stresses/shocks both more likely and more severe in their effects.

2.2 “Unravelling” the Interaction between HIV/AIDS and Food Security in Ethiopia

At international level, numerous studies exist that have generated a wealth of information on both issues of HIV/AIDS and agricultural activities. An extensive literature also exists on issues and interactions as well as documentation of experiences of different countries. Given the sheer size and importance of the agriculture sector to the overall economy in Ethiopia, it is also absolutely crucial that the impacts of the epidemic particularly on small-scale farm households are studied in-depth and appropriate response measures are identified. Without doubt, HIV/AIDS has become the most important health problem in Ethiopia and a serious threat to social and economic well-being exacerbating poverty (Pankhurst & Gebre, 2002).

While agriculture is central to many African countries, not least of all for household survival, there are marked differences among countries with regard to current economic conditions and agricultural and economic potential. Generally, however, this sector is facing increasing pressure from rapid population growth, environmental degradation, heightened levels of poverty, dwindling inputs and a lack of support services, amongst other issues. The additional impact of HIV and AIDS on these agricultural systems is thus even more severe, and may include:

- A decrease in the area of land under cultivation at the household level (due to a lack of labour stemming from illness and death among household members);
- A decline in crop yields, due to delays in carrying out certain agricultural interventions such as weeding and other inter-cultivation measures, as well as cropping patterns;
- Declining yields may also result from the lack of sufficient inputs, such as fertiliser and seeds as non-productive expenditures draw resources away from productive endeavours;
- A reduction in the range of crops produced at the household level;
- A loss of agricultural knowledge and farm management skills, as a result of losing key household members to AIDS;
- The resultant psychosocial impact of the AIDS death/s (partly through stigma) and the long-term implications on agricultural production;
- Decline in livestock production as the need for cash and the loss of knowledge and skills may force families to sell their animals;
- Increasing stigma and discrimination that gradually erodes social capital in rural areas.

Despite a relative dearth of studies into HIV/AIDS, agriculture and food and nutrition security, there is a growing body of evidence that the epidemic is playing an increasingly deadly role in undermining livelihoods and the achievements of the agricultural sector in Ethiopia. A few key conclusions from a range of these studies have been cited below:

Bishop-Sambrook *et al* argue that at the household level, the impact of the disease diverts attention and resources from productive activities to caring for the sick and surviving the aftermath of the death of key household members (2005). If left unchecked, full blown AIDS reduces the availability and quality of household labour, changes the composition of rural communities and alters the priorities of farming households, thereby making many of the traditional production-oriented extension messages irrelevant. One significant aspect of the rural epidemic is therefore the extent to which it may undermine efforts to improve agricultural productivity and achieve market-led development.

Save the Children (UK) commissioned an Ethiopian led study that concluded that the HIV/AIDS epidemic is emerging as a major threat to food security and livelihood in the Sekota Woreda and thus, created an additional stress to the already poor and vulnerable rural households (Mekonnen *et al*, 2005). Despite the fact that most people in the study area had heard of HIV/AIDS, the knowledge on the various routes of HIV transmission and on the various ways of avoiding HIV infection was incomplete. Misconceptions about the transmission of HIV, as well as stigmatizing and discriminatory attitudes towards People Living with HIV/AIDS (PLWHAs), were other major findings of the study.

The Miz-Hassab Research Centre, undertaking research on behalf of the International Organization for Migration (IOM) for the Donor Vulnerability and HIV/AIDS Working Group in Ethiopia, investigated the relationship between HIV/AIDS and Government Resettlement Programmes (2005). They concluded that populations in many of the resettlement sites in Tigray, Oromiya, Amhara and SNNP Regional States exhibited problems associated with the rapid spread of HIV/AIDS. These conditions included cultural and religious traditions relating to sex and sexuality, gender disparities, early marriage, the tolerant attitude towards men practicing sexual relations with different women including those married, and the fact that women have less access to resources, information and services. The large numbers of military and demobilised soldiers, the increase in sex work due to economic factors, as well as cross-border traders also contributed to higher risk of HIV spread in these areas.

The United Nations, recognising the issue of HIV/AIDS impacts on household food security and the fact that food security policies and interventions may be undermined by rising HIV infection rates, undertook research to consider the added pressure that HIV/AIDS places on food security in Ethiopia. Two case studies on the impact of HIV/AIDS on household food security in rural Ethiopia undertaken by UNECA,

UNDP and WFP (2004) have generated important results that indicated HIV/AIDS affected households:

- Spent significantly more on health and funeral/mourning related expenditures than the general population as approximated by the control group. Households resorted to the sale of their assets and borrowing as well as reduction in consumption and investments on the farm to cover AIDS related expenditures;
- Realigned the meagre resources as the structure of farm households have changed with female and child-headed households becoming more common in at least one of the study sites;
- Tended more towards giving up land to sharecropping rather than to lease additional land;
- In some cases faced either male or female labour shortages, the constraint being more pronounced in the case of male labour. Labour constraints were particularly apparent among female and elderly headed households. It was evident that the number of female headed households was greater in communities having higher HIV/AIDS prevalence;
- Capital reserves such as ownership of livestock have been eroded.

The study recognised that although variables that are important in the interface between HIV/AIDS and food security are generally known from research throughout Africa, much of the effects of the disease are context specific and there is little knowledge on which variables are significant in Ethiopia. The study generally found that with the incidence of HIV/AIDS, labour can become a serious constraint to households' ability to continue agricultural production particularly where labour requirements are seasonal and where there is a rigid division of labour across gender and age categories. Similarly, it was found that households' asset base was eroded with the incidence of HIV/AIDS as expenditures related to health, funeral and mourning rose. As a result, an understanding of the manner in which HIV/AIDS impacts rural livelihoods is important for effective policy and programmes intended to address underlying vulnerability and increase household food security.

In a widely cited and respected account of destitution in Ethiopia, Lautzke *et al* have raised a number of concerns about the interplay of HIV/AIDS and vulnerability (2003). For instance they argue that many women and girls, facing destitution from asset losses, have moved to towns to begin making a living in the commercial sex worker industry; exposing themselves to diseases such as HIV/AIDS (2003: 21). However, they also caution that although HIV/AIDS is an important element of the recent and recurring emergencies, combating HIV/AIDS should not distract from the larger effort of establishing a functioning, basic public health system in Ethiopia. Nonetheless, Lautzke *et al* state that the complex interplay between HIV/AIDS and acute food insecurity is not well understood, a potentially dangerous lack of knowledge in engaging effectively with destitution (2003).

In another recent study undertaken for the Food and Agricultural Organization of the United Nations (FAO) into agricultural development, the issue of HIV/AIDS was recognised as a major cause of vulnerability in both urban and rural areas (Demeke *et al*, 2005). The attrition of the prime labour force of the country with serious social and economic implications was identified as a core concern. The study strongly held that the number of people who are chronically food insecure and vulnerable appears to be increasing due to climatic shocks, worsening land degradation and HIV/AIDS epidemic. This was reiterated by another major UN agency operating in Ethiopia with a long history of effective operations; the World Food Programme (WFP). In WFP training material for mainstreaming HIV/AIDS into the Ethiopian Productive Safety Net Programme, household and community level impacts were identified as major challenges for practitioners and policy makers working with the new reality of HIV/AIDS. Drawing largely on studies in Ambassel and Alaba, the WFP identified major impacts as increased spending on health care and funeral costs, reduced investments on farm and consumption (as a result of health care costs), increasing numbers of elderly headed households, a severe reduction in labour, a reduction in key skills, an increase in land under share cropping rather than leasing in additional land (due to labour constraints), a reduction in productive assets (plough oxen) to cover health expenses and increasing dependency ratios (2005).

Family Health International (FHI), a non-profit organisation working in reproductive health and HIV/AIDS prevention, care and support across Ethiopia, has facilitated a home and community based care (HCBC) programme that is part of a comprehensive, multi-sectoral HIV/AIDS approach (Coughlan, 2005). This includes grappling with nutrition issues, particularly in an urban context where antiretroviral therapy is being rolled out. The very high level of stigma and discrimination in Ethiopian society meant that programmes needed to target chronic illness, including cancer, rather than target people living specifically with AIDS. Stigma, therefore, is a major impediment to engaging specifically with HIV. Rather than promoting the “exceptionalism” of HIV/AIDS, in a context of high levels of stigma and multiple stressors affecting vulnerability, a more nuanced, accurate understanding is required to work effectively with the epidemic. FHI experiences with *idirs* (community structures that are traditional Ethiopian neighbourhood burial associations) are a superb example of where existing institutions can be mobilised to combat HIV/AIDS.

A multi-sectoral approach to HIV/AIDS has been laid out by the Ethiopian Government’s Ministry of Health in their “Road Map for 2004-2006” to harmonize the activities of all actors involved in reducing AIDS-related morbidity and mortality (MOH, 2005). This is essentially focused on scaling up effective ART to eventually achieve universal access to treatment for all Ethiopians. Despite detailing a comprehensive programme, the “Road Map” does not engage to any great extent with underlying vulnerability and the bi-directional relationship between HIV/AIDS and food and nutrition security, a crucial component to any effective ART strategy. Similarly the World Health Organisations (WHO) assessment of the ART programme and their own response also fails to elaborate on the nutrition / food aspect of HIV/AIDS programmes despite recognising it as “one of the major challenges for overall national development” (2004).

It is clear from these diverse studies that HIV/AIDS is being increasingly recognised as a key issue to be addressed within food security debates within government, civil society, academia, donor and multilateral communities. In order to better understand the relationship between HIV/AIDS, food and nutrition security in Ethiopia, an overview of general livelihoods should be provided.

3. Livelihoods in Ethiopia

Household livelihoods insecurity can be defined as inadequate and unsustainable access to income and resources to meet basic needs (or realise its basic rights). These needs include adequate food, health, shelter, minimal levels of income, basic education and community participation. Household livelihoods are insecure when they lack secure ownership of, or access to, resources and income earning activities, including reserves and assets, to off-set risks, ease shocks, and meet contingencies.

More narrowly, livelihood strategies are undertaken essentially to facilitate food security. People enjoy food security when they have access to sufficient, nutritious food for an active and healthy life. Achieving this involves:

- Availability: Ensuring that a wide variety of food is available in local markets and fields;
- Access: People have enough production or money to obtain a variety of foods that are nutritionally adequate and culturally acceptable;
- Stability: Availability and access are guaranteed at all times; and
- Utilisation: Food is stored, prepared, distributed and eaten in ways that are nutritionally adequate for all members of the household, including men and women, girls and boys, in an environment that supplies appropriate care, clean water, and good sanitation and health services.

Food insecurity exists if one or more of these conditions are not fulfilled. Further, different levels of food insecurity must also be considered if the underlying causes are to be effectively understood. National aggregate food security refers to the total food available from a range of different sources to cover the aggregate needs of the country. At local or community level, different categories of households are food secure if they have the capacity to obtain the food they require. Finally, at the individual level within a household or social unit, the actual food consumed must cover each person's specific nutritional needs for an active and healthy life.

3.1 Livelihoods in Ethiopia: poverty, food insecurity and famine

Ethiopians are managing the risks and vulnerabilities generated by a series of serious droughts, profound vulnerability to disease epidemics (human, crop and livestock), and a combination of local and international economic forces and domestic and international policies (Lautzke *et al*, 2003). Although recent crises, notably the 2002/2003 emergency, are predominantly considered food crises, vulnerable populations in Ethiopia are facing ongoing critical threats to their livelihoods, while vulnerability to morbidity is directly linked to a crisis in health care. The combined effects of a protracted depression in the world coffee markets, the ban on live livestock exports from Ethiopia to the Gulf States in 2003, the exploitation of a fragile agricultural base, the collapse of a range of key income earning opportunities in country, and an ambitious programme of political decentralisation all have coincided with and exacerbated the impact of the drought (Lautzke *et al*, 2003: 19). The resulting loss of access to and availability of food, and the collapse of economic entitlements have generated widespread vulnerability to malnutrition, morbidity, poverty, destitution and mortality. This has created an 'environment of risk' conducive to a rapid increase in HIV prevalence and the multiple impacts of full-blown AIDS. This environment continues to exist long after the emergency has passed.

According to standard international indicators for income, health and education, Ethiopia falls among the poorest countries globally (Pankhurst & Gebre, 2002). As depicted in the table below, Ethiopia ranks last globally in terms of GNP per capita, life expectancy is 20 years below the world average, infant mortality is almost double the world average, and the adult literacy rate is less than half the world rate. As a result the Human Development Index is thus well below half of the world average:

Basic Indicators and International Comparisons

<i>Indicator</i>	<i>Measure</i>	<i>Comparison</i>
GNP per capita (1999)	\$100	210 th out of 210 countries worldwide
Life expectancy (2001)	46	World 66
Infant mortality rate (2000)	97	World 54
Adult literacy rate (1999)	36.3%	SSA 58.5, LLDCs 50.7, World 78.8
Human Development Index (1999)	0.309	SSA 0.464, LLDC 0.435, world 0.7120

Sources: Pankhurst & Gebre 2002; UNDP (2002), FDRE (2002), EAE (2000/1), PRB (2002) CSA (2001)

Ethiopia's per capita GDP stood at US\$110 in 1997 falling to below US\$100 by 2001 (World Bank, 2002 cited in Sharp *et al*, 2003: 20). One reason for this low income is the high dependence of the population in low-input, low-output (and shock-prone) agriculture for their livelihood. A number of key studies indicate that there has been a decline in household resilience due to longer-term processes and the multi-faceted nature of the recent emergencies (Demeke *et al*, 2004; Lautzke *et al*, 2003; Sharp *et al*, 2003). Increasingly erratic and poorly distributed rainfall over the past decade, a lack of infrastructure, an inability to recover from previous crop failures, and years of economic decline have all contributed to the conditions of acute malnutrition now affecting Ethiopia.

Chronic food vulnerability is associated with demographic and environmental challenges, such as the southward expansion of the Sahara and population pressure, which are difficult to reverse. Both have contributed to serious land degradation, soil erosion and deforestation. Climatic changes have also aggravated this situation through erratic and irregular rainfall patterns and shortage of rain, which usually results in a severe drought. This situation combined with poor agricultural potential already under strain from population pressure and severe degradation usually leads to a famine situation. A key asset for most farming households is the plot of land on which to cultivate. The declining per capita agrarian base and related issues of land tenure for rural families has been the subject of much debate, especially since these assets form the foundation of the government's Food Security Strategy (Sharp *et al*, 2003). These problems, aggravated by poor technical know how and rainfall dependent agriculture, are some of the root causes of food insecurity in Ethiopia.

Chronic food insecurity in Ethiopia occurs when there is a constant failure of food acquisition while transitory food insecurity refers to a temporary failure of acquisition caused by drought, war, short-term variability in food prices, production, and incomes. The consequences of household food insecurity are as many as its causes, which require different responses. Poor households are the most food insecure households and they are highly prone to shocks. In rural areas, households who do not have land or oxen, or are female-headed, or who are comprised of the elderly or newly established settlers are food insecure households. In many instances unemployed people, single-parent-headed households, elderly people living alone, and destitute and homeless people are food insecure in urban Ethiopia.

Ethiopia has been facing serious food shortage at least once every 10 years since 1889, mainly due to drought and epidemics, with the result that famine and starvation have become a fact of life in many parts of the country. Drought is a recurring phenomenon in the country and certain locations regularly experience the vagaries of climatic stress. It was estimated in 2004 that up to 60 percent of the rural and 40 percent of the urban population faces risks of food insecurity (DPPC, 2004). The number of relief dependent population has increased from 4 million in 1995 to 10 million in 2000, with the reality that famine has become more prevalent. For example, DPPC reported that 11.6 percent and 16.7 percent of the total population was food insecure in 1999 and 2000 respectively (2004). The drought of 2002/2003 demonstrated clearly that in parts of the country that only experienced drought-induced or transitory food insecurity for a limited period of the year and who managed it at local or household level increasingly needed food aid to survive. Chronic food insecurity is appearing to be becoming more widespread.

Although famine has been widespread throughout the country, some areas are more frequently affected

and regional studies have tended to focus on the north and central areas, with attention to survival strategies, agro-ecological differences and regional and local variations (see Pankhurst & Gebre 2002: 6 for a list of these). Ethiopia has five agro-climatic classifications: *wurch*, *dega*, *woina dega*, *kolla*, and *bereha* (UNDP, 2005; Demeke *et al*, 2004). *Wurch* is found above 3,200 meters and has temperatures of less than 11.5° C. As it is cold and moist with frost in the coldest seasons, the zone does not normally sustain agricultural production. *Dega* is cool and humid found between 2,300 and 3,200 meters with temperatures ranging from 17.5 to 11.5°C. Crops produced in this agro-climatic zone are wheat, barley, pulses and *teff*. *Woina dega* is classified as cool sub-humid found in altitudes ranging from 1,500 to 2,300 meters and would have temperatures of 20 to 17.5°C. Normally, *teff*, millet, sorghum and maize would be produced in the *woina dega* climatic zone. *Kolla* is classified as warm and semi-arid situated in the lowlands at altitudes of 500 to 1,500 meters. Temperatures rise up to 27.5° C. Maize and sorghum as well as a variety of tropical fruits are the main products of the *kolla* zones. *Bereha* are desert conditions sustaining only pastoral communities with no cultivation.

These agro-climatic zones therefore provide diverse productive bases on which Ethiopians build their livelihoods. However, even within particular zones it should not be assumed that livelihoods are homogenous across households, or even among individuals within households. Livelihood strategies and outcomes are sensitive to combinations of age and gender, as well as to other socially constructed identities/institutions such as class, education, ethnicity, and religion. It is also clear that livelihood strategies in Ethiopia are becoming more diverse (Lautzke *et al*, 2003). In order to better understand these differences, a more detailed discussion on the different categories of the Ethiopian economy provides insights into the vulnerability of livelihoods in the country. These include the agricultural sector dominated by peasant agriculture, the livestock sector dominated by nomadic pastoralism and the modern sector, which largely revolves around towns and urban centres. Over 85 percent of the labour force is engaged in the first two sectors.

There is, however, a relationship between these sectors, particularly between the major urban areas, towns and villages and the peasant and pastoralist economies. This relationship has been described as *emburdenment*,⁴ which will increase the overall size of Ethiopia's poorest populations. The effects of recent emergencies have generated a class of newly destitute that will join the ranks of the existing destitute populations (Lautzke *et al*, 2003: 26). The newly destitute will include not only dispossessed pastoralists but also farmers displaced from their livelihoods because of successive crop failures and related debt burdens, resettled populations unable to establish viable livelihoods in their areas of resettlement, and increasing numbers of wage labourers competing for a diminishing number of jobs.

3.2 Peasant Agriculture

Given the inability of many Ethiopian farmers to make a living from agriculture alone due to resource constraints and recurrent shocks, increasingly policy attention of the Government has turned to supporting alternative livelihood activities. Such programmes include the Agriculture Development-Led Industrialisation strategy (ADLI), which recognises the reciprocal linkages between sectors, and "livelihoods packages" that aim to support secondary sources of income (beekeeping) to supplement and diversify household incomes. ADLI essentially aims to bring radical change in the lives of small rural households as a springboard for triggering a dynamic development process in the whole country. Food security for and through the Ethiopian peasantry is the primary goal of the government to which substantial scarce resources are devoted.

The social consequences of famine and peasant survival strategies are intimately related to poverty and inequality. Reduction of consumption affecting nutrition, distress sales of assets, the collapse of exchange

⁴ The cumulative effects of repeated disasters have been described by Ethiopian scholars as "emburdenment" (Lautzke *et al*, 2003: 15).

and the drop of livestock prices, distress migration, the dispersal of families and dependence on food aid are common consequences. Survival and rebuilding households and livelihoods and longer-term effects of famine shocks and dependence on aid have exacerbated the burden of poverty. Even without HIV/AIDS the problems of low levels of agricultural production and productivity are serious. Severe land degradation has taken place for decades and continues to take place expanding into new areas. Farm systems are also fragile from decades of intensive cultivation based on rudimentary technology and repeated exposure to natural calamities. Not only are farmers typically impoverished but also the degree and severity of vulnerability to disaster has grown in recent years.

Devereux *et al.* suggest that the destitute have less access to land, livestock and credit and are less involved in social institutions (2002). Although there is a tendency for female-headed households and households with older and illiterate heads to be destitute, neither gender, age nor education are good predictors of destitution, since there are larger numbers of men, as well as younger and literate heads who are destitute, and there are cases of female, older and educated heads who are better off. The best predictor is small family size, which also correlates with gender. Dercon and Krishnan, on the other hand, find that poorer households have larger sizes (1996). They also find that poorer households are likely to be female-headed and have older and less educated household heads. Likewise ownership of less livestock and access to less land characterise the poor. This apparent contradiction speaks directly to the contextual specificity of the impacts of AIDS, with variations being observed across cases.

Building on this, Lautzke *et al* argue that staple crop producers fall into two categories: those with access to land with high productive potential and (or no need for) credit who will be able to purchase fertilizers, seeds and other key inputs (labour), and those without access to credit, primarily because they already are deeply indebted (2003: 26). For farmers with poor or no access to credit, their production will be compromised by a lack of access to key inputs. The need to service existing loans from earlier seasons forces some to sell key productive assets, such as oxen, or to seek wage labour. Access to livestock is critical for farming communities, both for animal traction and transportation. Regardless of credit standing, some farmers may view staple crop production as too risky for such low returns and turn to alternative cropping, especially chat where cropping conditions are favourable.

There has been ongoing government opposition to the introduction of commercial principles to land transactions in rural areas. Prime Minister Meles has stated that allowing land to become a tradable commodity would inevitably result in an “urbanisation of rural poverty” (Devereux *et al*, 2005: 122). This is based on the argument that in a situation where land privatisation was a reality, the next major drought would trigger hungry families selling their land as they would have nothing else to exchange for food and their inevitable displacement and move to the squatter camps in Ethiopia’s cities. This is part of the rationale for the “land as a safety net” argument: even farms that are inadequate for self-sufficiency throughout the year, they do provide some proportion of subsistence needs. Yet the evidence in Ethiopia is that even without the privatisation of land, urbanisation is a persistent and growing phenomenon. The CSA reports an annual rate of urbanization of six percent which is expected to persist for decades to come (1999; see 3.4 Urban population).

An important question should be raised about the relationship between land, especially the prevailing tenure regime, and the impact of HIV and AIDS. This has become a significant area of debate in development arguments around the world. The FAO is increasingly concerned about women’s land rights in a context of HIV/AIDS, which has led to a number of studies, some implemented in nearby Kenya and throughout Southern Africa (see Aliber *et al*, 2004; Strickland). Indeed, a recent study in Tigray found that having independent control over land through informal land rental markets enhances women’s economic independence and enables access to new sources of income and food (Chiari 2002).

A national survey in 2001 found that the average landholding in rural Ethiopia was approximately one hectare per farming household, but just three-quarters of a hectare in Wollo and Tigray, where half of all

households owned less than one-half of a hectare and 10 percent were landless (Berhanu Nega and Samual Gebreselassie, 2002: 35). This does not, however, imply that households are limited to land of this size as a complex variety of community-based institutions around accessing land have been evolved including oxen-sharing mechanisms, land-labour exchanges and land rental arrangements. These allow the reallocation of key productive assets between different households. Evidence from Wollo suggests that a collapse in better-off groups within communities since the early 1990s has contributed to rising vulnerability and agricultural underperformance, partly due to the lack of wealthier “patrons” as providers of access to resources such as oxen and for assistance in difficult years for poorer community members (Devereux *et al*, 2003).

There are strong reasons for anticipating that AIDS will progressively decapitalise highly-afflicted rural communities, meaning a loss of savings, cattle assets, draft equipment, and other assets. Such decapitalisation may come to pose the greatest limits on rural productivity and livelihoods for these communities.

3.3 Pastoralists

Pastoral communities depend upon livestock for a range of production, consumption, social and political activities. However, recurring droughts combined with significant socio-economic changes are increasing the vulnerability of pastoralists over time. Currently the number of the pastoralists is estimated to be about eight million (PANE & CRDA, 2005). The pastoral areas are characterised as areas of rapid resource shrinkage and degradation, poor infrastructure and social service coverage, recurrent drought, growing conflict and low level of trained people. Pastoral communities are often marginalised and vulnerable to extremes of poverty and destitution resulting from drought and development projects.

Pastoralist food security will continue to be a function of access to and quality of pasture and water resources, animal health care, domestic and international markets and indigenous, domestic and international strategies for relief and recovery assistance (Lautzke *et al*, 2003: 26). Indeed, successive droughts coupled with population growth are showing an increasing trend in the decline of herds per household, while herd compositions have also changed (Lautzke *et al*, 2003: 83).

The climatic shock of drought is only one of many sources of vulnerabilities for Ethiopian pastoralists. A ban on the export of live livestock from Ethiopia to Saudi Arabia has had particularly deleterious effects on Somali pastoralists (Lautzke *et al*, 2003: 24). Livestock terms of trade for cereals and other staple commodities have collapsed, while pasture and water resource conflicts have increased. Livestock losses have been high for some communities due to a loss of access to water, pasture and effective, community-based animal health care. The loss of access to milk among vulnerable pastoral households has led to increases in malnutrition, morbidity and malnutrition.

Ayalew has documented a range of challenges facing pastoral communities in terms of cultural conceptions (2001). These include the non-economic value of livestock notably as sources of prestige and status, cultural prohibitions on using livestock products for sale, and cattle or camels for ploughing, changes resulting from marketisation, collective notions of property of land and natural resources and changes with enclosures and in-migration of labourers, strong inter-household dependencies, the importance of affinal links, linkages between collective and individual decision-making, the ethic of cooperation in times of distress.

3.4 Urban population

The urban population in Ethiopia is growing at a rate of around six percent per year. This figure could increase to 7.5 and 29.7 percent in 2015 and 2030 respectively (CSA, 1999). Moreover, increasing urbanisation poses a major issue of concern not only in Addis Ababa but also among the secondary cities

of Nazareth, Awassa, Bahirdar, Jimma, Mekelle and Dire Dawa. Generally, urbanisation is accompanied by new types of social problems and often worsening poverty.

In major urban areas, towns and villages, the momentum of emburdenment will increase the overall size of Ethiopia's poorest populations. A class of newly destitute are generated every time a major drought or famine affects pastoral or peasant communities. The newly destitute include not only disposed pastoralists but also farmers displaced from their livelihoods because of successive crop failures and related debt burdens, resettled populations unable to establish viable livelihoods in their areas of resettlement, and increasing numbers of wage labourers competing for a diminishing number of jobs (Lautzke *et al*, 2003: 26).

It is important to understand the charitable impulse and its manifestations in Ethiopian society that provides assistance to beggars, disabled people, church school students, wandering singers and minstrels (Pankhurst & Gebre, 2002: 20). The homeless and beggars often congregate around churches and monasteries and mosques especially on monthly and annual holidays, some even migrating to do so. The word "destitute" carries with it the notion of "the deserving poor", and Ethiopia has a tradition – drawn from both Christian and Islamic influences – of charitable support to beggars who are perceived as "deserving" the support of those more fortunate than themselves, especially those crippled by illnesses such as polio or leprosy (Sharp *et al*, 2003: 18). Thus Ethiopian society is segregated into the (undeserving) "working poor" and the (deserving) "incapacitated poor" with contrasting livelihood strategies:

"poor people have two strategies of survival. They can struggle for independence, scarping a living by any available means. Or they can struggle for dependence, seeking the favour of the fortunate. In practice, of course, many alternate between the two strategies, which are not entirely distinct" (Illife 1987, cited in Sharp *et al*, 2003: 19).

The homeless, street children and beggars, especially in urban areas are among the most destitute, living in wretched conditions in makeshift plastic and cardboard shelters, relying on charity, petty trade in the informal sector and crime (Pankhurst & Gebre, 2002: 20). In the urban context, many occupations are largely or exclusively carried out by poor women, such that gender and occupation exacerbate poverty. The most obvious case is that of commercial sex workers. Poverty may drive them to resort to prostitution, but the effects on their lives, the ways they are treated and viewed go far beyond a simple poverty analysis.

A major study by the government suggests that between the period 1995/1996 and 1999/2000, poverty, based on consumption measure, increased in urban areas by 11 percent (MOFED, 2002). The same study also indicated that access to food has deteriorated in urban areas as measured by real food expenditure per capita and/or adult, which also resulted in a decline of kilocalorie consumption per day per adult. This trend is likely to aggravate the impact of HIV/AIDS in urban areas. Yet it is also important to recognize that the concentration of populations in urban centres provides an opportunity to provide infrastructure, social services and support in the most cost-effective manner on a per capita basis which is not possible in the more dispersed rural areas of Ethiopia. For example, the WFP has been able to provide nutritional care packages in support of AIDS-affected people living in Addis Ababa, whereas the costs of providing the same in many rural areas remain prohibitive.

4. Nutritional Status

Another key issue is that of poverty, nutrition and HIV. Nutrition is the pivotal interface between food security and health security. An individual's susceptibility to any disease depends on the strength of the immune system, which among other factors is affected by nutrition, stress, and the presence of other infections and parasites. The risk of infection with HIV is heightened by high prevalences of such cofactor conditions, which decrease immune response in HIV-negative persons and increase viral load in HIV-infected persons. With the high rates of malnutrition, Ethiopia may be highly susceptible to HIV spread with a rapid escalation into full-blown AIDS; issues that require knowledge and understanding that are context specific in order to effectively respond.

As a result of these multiple challenges facing Ethiopian society, emerging evidence indicates that about 30 million Ethiopians live in absolute poverty, consuming below the recommended daily nutritional requirement and unable to satisfy basic non-food requirements (Demeke *et al*, 2005: 21). The level of malnourishment is high, particularly in rural Ethiopia, which directly results from either inadequate food intake, disease and other complex and diverse range of underlying causes (Lautzke *et al*, 2003: 23). Ethiopia's average per capita daily calorie consumption of 2211 is one of the lowest worldwide (Pankhurst & Gebre, 2002: 4). Children in particular are significantly affected during periods of food deficit and many have died during drought and famine. The effects of food shortage on children can be manifested in the form of wasting and stunting, which are indicators of child malnutrition.

According to recent evidence, wasting which is a short-run indicator of child malnutrition, increased from 9.2 percent in 1995/1996 to 9.6 percent in 1999/2000 (Demeke *et al*, 2005: 21). The situation is worse in rural areas where child wasting increased from 9.5 percent in 1995/1996 to 9.9 percent in 1999/2000. On the other hand, child stunting, a long-run measure of child malnutrition, declined from 66.6 percent in 1995/1996 to 56.8 percent in 1999/2000. Although it decreased in both rural and urban areas (see table below) it remained very high even by the standard of African countries.

Child wasting and stunting in Ethiopia (children aged between 6 and 59 months)

Location	Short run child malnutrition		Long run child malnutrition	
	1995/1996	1999/2000	1995/1996	1999/2000
Urban	9.5	9.9	68.4	57.9
Rural	6.8	6.1	55.9	44.5
National	9.2	9.6	66.6	56.8

Source: MOFED 2002 cited in Demeke *et al*, 2005: 21

The diverse causes of malnutrition, including the multiple threats to household food security, are limiting the effectiveness of selective feeding programs for vulnerable populations. The nutritional needs of populations living with a high prevalence of HIV/AIDS are also not generally considered within emergency programmes, although there is the potential for including this group as beneficiaries within the blanket supplementary feeding programmes (Lautzke *et al*, 2003: 159). HIV/AIDS was not identified as an important element in emergency programmes, which means that the complex interplay between the epidemic and acute food insecurity is not well understood. This raises significant challenges for organisations such as the WFP in their programmes distributing food parcels, particularly in urban areas, which are often sought by health officials to supplement ART.

5. HIV/AIDS in Ethiopia

Even though rural prevalence rates are lower than urban rates (2.6% and 12.6% respectively), they are rising and the potential scale of the rural epidemic requires an urgent response (Bishop-Sambrook et al, 2005).

Ethiopia has the 5th largest number of people living with the virus globally. The epidemic started from a low base in the 1980s which spread rapidly in the 1990s and reached the current level of 4.4% prevalence rate at national level with 12.6% in urban and 2.6% in rural areas (MOH, 2004). Already an estimated 1.5 million Ethiopian adults and 250,000 children are living with the virus. About 90 percent of the reported AIDS cases are between the age of 20 and 49, the most important years from the economic and social points of view (MOH, 2001)⁵.

National HIV/AIDS Related Indicators, 2003

	Total	Urban	Rural
Adult HIV Prevalence (15 – 49 yrs., %)	4.4	12.6	2.6
Adult HIV Incidence (%)	0.68	1.82	0.46
HIV Positive Pregnancies	128,000	50,000	78,000
HIV Positive Births	35,000	14,000	21,000
No. HIV-pos Persons Needing ART	245,000	140,000	105,000
AIDS Orphans	539,000	343,000	195,000
Total Orphans	4,554,000	766,000	3,788,000
People Living with HIV – All Ages	1,475,000	724,000	751,000
People Living with HIV – Children	96,000	46,000	50,000
New HIV Infections – All Ages	231,000	95,000	137,000
New HIV Infections – Children	35,000	14,000	21,000
New AIDS Cases – All Ages	122,700	70,000	53,000
New AIDS Cases – Children	25,000	12,000	13,000
AIDS Deaths – All Ages	115,000	69,000	46,000
AIDS Deaths - Children	25,000	12,000	13,000

Source: MoH, AIDS in Ethiopia 5th Report

Although the latest figures on HIV prevalence was estimated to be somewhat lower than in 2002, as these were lower than the previous national figures, this is not believed to reflect a decline in prevalence rates, but rather a modification in the methodology used in estimating national prevalence. In 2002, one sentinel site, Etsie, with a relatively high prevalence of 10 percent, was re-classified from a rural to an urban site. Using estimated and projected prevalence rates reported in the 5th Edition of “AIDS in Ethiopia”, the figures published officially by HAPCO, it clearly shows that there is an increasing trend in HIV prevalence and also that, while initially an urban phenomenon and limited to high-risk groups, HIV/AIDS is now generalised and spreading to the rural areas.

⁵ Given that the age range encompasses the most economically productive segment of the population, the epidemic impacts negatively on labour productivity. Work time is lost through frequent absenteeism, and decreased capacity to do normal work as the disease advances. There are also social consequences of the epidemic as caregivers and income generating members of the family die leaving behind orphans and other dependents. These events lead to an aggravation of the problems of poverty and social instability. The data also show that the number of females infected between 15 and 19 years is much higher than the number of males in the same age group. This discrepancy is attributable to earlier sexual activity among young females with older male partners.

Estimated and Projected Adult HIV prevalence/1982-2008

	1982	1985	1990	1995	2000	2001	2002	2003	2008
National	0.0	0.2	1.6	3.2	3.9	4.1	4.2	4.4	5.0
Male	0.0	0.2	1.5	2.8	3.4	3.5	3.7	3.8	4.4
Female	0.0	0.2	1.7	3.6	4.4	4.8	4.8	5.0	5.7
Urban	0.0	0.7	7.0	13.4	13.0	12.8	12.7	12.6	12.6
Rural	0.0	0.1	0.3	0.8	1.9	2.1	2.4	2.6	3.4

Source: MoH, AIDS in Ethiopia 5th Report

6. HIV/AIDS and Food and Nutrition Security

The relationship between the HIV epidemic and the food security situation in Ethiopia is complex. However, it is likely that the epidemic will contribute to worsening widespread food insecurity, and conversely, food insecurity will increase vulnerability of the population to HIV infection. Currently, the absence of evidence of the bidirectional impact of HIV on food security is hindering programme response.

At a household level, there is a two-way relationship between livelihoods and HIV/AIDS. Insecure livelihoods exacerbate the risk and vulnerability environment for HIV/AIDS. At the same time, illness and death associated with AIDS undermine livelihoods options. Vulnerable people are forced to make decisions, often involving trade-offs among basic needs. For example, a family with insecure livelihoods, but with a fair amount of food on hand, may have to sell stocks of food now in order to raise cash for school fees or medical care - even though they know they will have to buy back food later at a higher cost. In this environment, insecure livelihoods exacerbate the risks and vulnerabilities of HIV and AIDS. Lack of options can push some people into activities or situations that put them and others at high risk of HIV, such as sex work. Lack of food, money and health care are key factors in rapid progression from HIV infection to onset of AIDS. People with insufficient resources find it harder to properly take medications, including anti-retrovirals. Finally, those with weak livelihoods are more vulnerable to social and economic impacts of illness and death in their families and communities.

The current HIV prevalence rate in rural areas together with the likely progression rate poses serious problem within the context of Ethiopia's attempt to bring national development through rural centred development programmes. As indicated above, what is most unfortunate is the fact that deteriorating agriculture and rapidly expanding HIV epidemic reinforce each other, worsening what is already a disaster. This has the potential to escalate into what has been described, in *extremis*, as a "new variant famine" by De Waal and Tumushabe (2003)⁶. The advent of a generalised HIV/AIDS epidemic in combination with drought and food crises threatens to create this 'famine' across many parts of Africa. This hypothesis posits that HIV/AIDS-affected regions are facing a new kind of acute food crisis in which there is no expectation of a return to either sustainable livelihoods or a demographic equilibrium. To the contrary, the impacts of HIV/AIDS on agrarian households mean that they are (a) more susceptible to external shocks and (b) less resilient in the face of these shocks. This "famine" also threatens a vicious cycle of increasing mortality from multiple causes.

The literature on the impact of adult illness and death on household livelihoods or coping strategies suggests that individuals and households go through processes of experimentation and adaptation as they attempt to cope with immediate and long-term demographic change (see SADC FANR VAC, 2003). It is believed that households under stress from hunger, poverty or disease will adopt a range of strategies to mitigate their impact through complex multiple livelihood strategies. These entail choices that are essentially "erosive" (unsustainable, undermining resilience) and "non-erosive" (easily reversible). The distinction between erosive and non-erosive strategies crucially depends on a household's assets (for example, natural capital, physical capital, financial capital, social capital and economic capital), which a household can draw upon to make a livelihood. As an example of the distinction between erosive and non-erosive strategies, the sale of livestock is revealing. Sales of chickens, goats or cattle are classic coping strategies that households throughout sub-Saharan Africa employ. Some level of livestock sales is

⁶ De Waal and Whiteside highlight four new factors, which characterise those affected by the HIV/AIDS epidemic; household labour shortages, loss of assets and skills due to adult mortality, the burden of care for sick adults and orphans and the vicious interactions between malnutrition and HIV (2002). The impact of these new factors is that the effectiveness of traditional strategies used to cope with famine are reduced and in some cases rendered impossible or dangerous. They conclude that in this 'new variant famine' the prospects for a sharp decline into famine are increased, and the possibilities for recovery are reduced (Harvey, 2003).

normal and does not result in increased poverty. At a certain point, however, household livestock holdings reduce to the level where they are no longer sustainable, generally leaving the household with too few animals to regenerate the herd in the post-shock period. At this point, livestock sales become erosive.

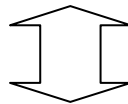
The challenge posed by HIV/AIDS extends well beyond food security issues as it affects the overall capacity of the agriculture sector in terms of employment, export and provision of inputs to the industrial sector. The adverse effects of HIV and AIDS on the agricultural sector can be largely invisible, since what distinguishes the impact from that on other sectors is that it can be subtle enough so as to be undetectable (Topouzis, 2000). In the words of Rugalema, “even if [rural] families are selling cows to pay hospital bills, [one] will hardly see tens of thousands of cows being auctioned at the market...Unlike famine situations, buying and selling of assets in the case of AIDS is very subtle, done within villages or even among relatives, and the volume is small” (cited in Topouzis, 2000). This clearly has implications for analysis. Furthermore, the impact of HIV and AIDS on agriculture, both commercial and subsistence, are often difficult to distinguish from factors such as drought, civil war, and other shocks and crises. It is thus important to remember that HIV and AIDS is only one of a complex web of factors that impact on rural people’s livelihoods and that it is often difficult to disentangle the effects of AIDS from other environmental, political and economic events and trends.

Baylies notes that HIV/AIDS can, on one hand, be treated in its own right as a shock to household food security, but on the other, it has such distinct effects that it is a shock like none other (2002). Among others, AIDS tends to strike people in their most productive years, leading to loss of assets and reduced options for livelihoods activities in the household.

The intertwined relationship between food (in) security and HIV/AIDS

Insecure livelihoods exacerbate the risk and vulnerability environment for HIV/AIDS, through:

- increased risk of HIV infections;
- faster progression from HIV infection to onset of AIDS;
- difficult environments for proper treatment of HIV; and
- increased socio-economic impacts of AIDS.



Illness and death associated with AIDS in turn undermine livelihoods options by:

- weakening or destroying human capacity (human skills, knowledge, experience, and labour)
- depleting control and access to other key assets: financial, social, natural and physical; and
- constraining options for productive activities, reducing participation in community activities, and increasing time needed for reproductive and caring activities.

An understanding of the negative two-way relationship between livelihoods and HIV/AIDS opens up opportunities. Policy makers, government officials and development practitioners can pursue livelihoods objectives in ways that also address major aspects of HIV and AIDS. This includes attention to the four main categories of work on HIV and AIDS.

Food and Livelihoods Security can Support Objectives of Work on HIV and AIDS

Prevention: increasing options for safe secure sources of food and nutrition security to avert new infections

Positive Living: enabling longer, healthier life for those with HIV

Treatment Support: facilitating access and adherence to proper treatment

Impact Mitigation: improving resilience to social and economic impacts of illness and death.

There are various definitions of mainstreaming HIV/AIDS. Rather than debate these, this paper address some of the main concepts needed to make livelihoods and food security programmes in Ethiopia relevant to the realities of HIV and AIDS. The challenge for Ethiopian analysts, policy makers, donors and implementers is to understand how the rural socio-economy is being affected; how development interventions have intended and unintended impacts on the course of the epidemic; how those at risk and affected are being supported, undermined or ignored; and consequently how development policy and programming should be modified to better achieve their objectives. As a result of the long-wave nature of the AIDS epidemic, the full impact of the disease will not manifest until the next several decades (Barnett & Whiteside, 2002). For this reason, efforts to address the social and economic causes and consequences of HIV and AIDS must be flexible, and based on an approach of continued learning and improvement.

7. Policy Needs in Ethiopia: Responding to HIV/AIDS

The agricultural sector is characterised as stagnant and acutely vulnerable to recurrent drought and other livelihood shocks (Devereux et al, 2005).

The following section provides an HIV/AIDS audit of all food security, poverty and development strategies and policies in Ethiopia in order to identify the policy gaps that exist in relation to HIV/AIDS and food and nutrition security. Several key policies have emerged recently, which have significant implications for Ethiopian food security. The most prominent of these are the Poverty Reduction Strategy, the Productive Safety Nets Programme and the Voluntary Resettlement Programme. Despite vigorous debates about the prospects of these, most stakeholders agree that there are no obvious remedies for the crisis in Ethiopian agriculture (Devereux *et al*, 2005: 123), let alone the emerging crisis around HIV and AIDS.

Overarching Policy Framework

Millennium Development Goals (MDGs) such as universal primary education, reducing child mortality and improving child health, combating HIV/AIDS and ensuring environmental sustainability are reflected in existing government policies albeit in different degrees and specificity of targets. However, by participating in the making of UN declarations, Ethiopia has committed itself towards the achievement of these targets. Ethiopia in the past has also ratified a number of international agreements made to advance the causes of humanity and was signatory to UN resolutions made at different points in time. An MDG Task Force involving relevant government ministries and donors has been set up and major activities are planned to review progress and to place the MDGs in the context of Ethiopia. The government has also agreed to integrate monitoring of progress on MDGs in the annual progress report on PRSP.

The overarching policy framework that guides development intervention currently in the country is the Sustainable Development and Poverty Reduction Programme (SDPRP). The SDPRP was developed in 2002 following the first Poverty Reduction Strategy Programme (PRSP) consultation and design process in the country. The SDPRP is built on four pillars:

- i) The Agricultural-Development Led Industrialisation Strategy (ADLI),
- ii) Reform of the Justice System and the Civil Service,
- iii) Decentralization and empowerment; and
- iv) Capacity building in public and private sectors.

Sectoral policies also emphasise poverty reduction and accord a priority focus on rural areas. Ethiopia has generally adopted national policies which are in line with the major goals of the Millennium Declarations and there is no doubt that poverty reduction is the priority development goal of the Government of Ethiopia. The Government has committed itself, therefore, to working towards meeting the MDGs by 2015. Given the fact that the majority of the people reside in rural areas in Ethiopia, there seems to be appropriate recognition of the importance of rural development, agriculture and food security to overall poverty reduction.

HIV/AIDS is identified as a crosscutting issue in the SDPRP. This is in recognition of the fact that HIV/AIDS could have implications for all other sectors for poverty reduction. For example, increasing numbers of orphans may increase drop out rates in schools as children are forced to look after siblings or earn money after the death of a parent(s). The links between food security and HIV/AIDS are recognized, as poor nutrition will increase the opportunistic infections from HIV/AIDS, while hunger may increase people's vulnerability to the disease. What needs to be emphasised, however, is that HIV/AIDS could aggravate vulnerability leading to worsening food insecurity. For example, with the incidence of HIV/AIDS, labour can become a serious constraint to households' ability to continue agricultural

production particularly where labour requirements are seasonal and where there is a rigid division across gender and age categories. Yet, because of general underemployment, Ethiopia's approach to rural development is based on expanding employment opportunities, applying labour-intensive technology and building the productive capacity of the rural labour force. Thus, with the rapid spread of HIV/AIDS, it is critical to the effective implementation of development policy that the resulting labour constraints at the household level are properly understood and mitigating action incorporated into the ensuing strategies and programs. Despite recognising HIV/AIDS as a crosscutting issue, the dimensions detailed above illustrate that more needs to be considered when actually responding, particularly when there are no HIV/AIDS and food and nutrition security indicators included.

Agricultural Sector

The long-term development strategy of the government is known as the Agricultural-Development Led Industrialization Strategy (ADLI). The strategy aims to bring radical economic change to the lives of small, rural households as a springboard for triggering a dynamic development process in the whole country. Hence, the broad thrust of the Government's strategy is rural growth with agricultural development conceived as a vehicle for industrialization by providing a market base, as a resource of raw materials and capital accumulation. ADLI thus focuses on creating the conditions for national food self-sufficiency, which relates to the Food Security Strategy (FSS) with its' focus on ensuring national food security measured at the household level.

The Ethiopian Government has adopted an extension programme that essentially intends enhancing smallholder access to inputs such as improved seeds, fertilisers and draught power. However, improved inputs may not be enough to deal with the binding asset constraints and variability of yields that Ethiopian farmers face. A prevailing focus on survival and managing shocks from season to season provides little hope in reality that agricultural intensification will enable poor farmers to escape poverty. Given the certainty of erratic weather and failed harvests every few years, Ethiopian smallholders are trapped in a low productivity trap, with plots that are too small to generate livelihoods from agriculture alone, and recurrent pressure to convert their dwindling assets into food (Devereux *et al*, 2005).

Apart from these challenges identified by Devereux and his colleagues, an agricultural-led programme will have to take cognisance of the impact of HIV/AIDS on the sector. The various dynamics of this interplay have been identified earlier in this paper and elsewhere, and the impacts on labour, asset depletion and erosion of rights (access to land) may all seriously undermine the effect of the strategy.

Food Security Strategy

The objective of the FSS is to ensure national food security at household level, targeting chronically food insecure, moisture deficit and pastoral areas. The FSS has a clear focus on environmental rehabilitation as a measure to reverse the level of degradation and also as a source of income generation for food insecure households through a focus on biological measures. These include water harvesting, the introduction of high value crops, and livestock and agro-forestry development. Institutional strengthening and capacity building are core elements of the strategy in recognition of the long-term and multi-sectoral dimension of the problem.

The strategy also envisages a more consolidated agricultural extension programme by offering farmers a choice from a menu of market-orientated technological packages. Extension packages reflect the diversity of agricultural zones and encourage specialisation where appropriate. This is intended to assist with diversification of the household economy and realise the transformation from subsistence to commercial agriculture. Thus off-farm income generating activities also plays an important supplementary role to enhance self-sufficiency.

Once again, this strategy has a limited response to the realities that HIV/AIDS poses for food security and the bi-directional relationship identified earlier in this paper. Apart from the more obvious impacts, the issue of AIDS eroding the very workforce that provides the extension services may pose a serious challenge to the strategy – and indeed as a possible vector for increased prevalence rates.

Productive Safety Nets Programme

The Productive Safety Nets Programme (PSNP) is a three to five year programme, which forms one segment of the larger Food Security Programme managed by the Food Security Coordination Bureau under the Ministry of Agriculture and Rural Development. The programme includes two components, a labour-intensive public works component, and a component that offers ‘direct support’ or cash and/or food transfers to support households who have no labour, no means of support and are chronically food insecure. The new programme represents a shift from the previous emergency oriented approach to addressing chronic food insecurity, with the goal of moving to predictable programming with predictable resources. Essentially the PSNP intends to provide transfers to the food insecure population in chronically poor and insecure woredas in way that prevents asset depletion at the household level and create assets at the community level. Simultaneously the programme will support rural development, aiming to prevent long-term consequences of acute short-term consumption shortages, to promote household production and investment and to promote market development by increasing purchasing power.

It has been shown that in the context of droughts in Ethiopia, households that fall below a minimum “asset threshold” are unable to engineer successful asset accumulation (Carter *et al*, 2004). This has implications for attempts to stimulate growth in poorly endowed areas particularly where there is a density of population. Furthermore, the impacts of HIV/AIDS on household level assets and the resultant decline in the asset base for the poor has been well documented in many contexts. The PSNP is an example of a public works programme which addresses orphans and vulnerable children (OVC’s) and PLWHA’s social protection needs through their membership of the broader community, on the basic assumption that where a household benefits from participation in such a programme, the children in that household will also benefit. Children’s social protection needs are not addressed in isolation from the household unit, which is the basis for support in public works interventions. Children are considered in the context of their household’s vulnerability, and the PSNP aims to provide a ration for all members of participating households, if sufficient labour is supplied, conditional on sufficient resources being available for distribution. Where households are labour constrained, children are eligible for rations under the direct support component of the PSNP, although this again depends on the adequacy of food or cash resources available in a given woreda.

As a result of own concerns regarding the comprehensiveness of the PSNP, UNICEF and WFP have developed a complementary programme for children, the Enhanced Outreach Strategy (EOS). The EOS aims to provide additional social protection provision for children whose households may have been excluded from participation in the PSNP, or for whom the transfers resulting from participation were too limited to bring about child welfare benefits.

Many of the major donors support the national programme directly with financial aid, including the European Commission, the Canadian International Development Agency (CIDA), Britain’s Department for International Development (DFID), and Development Cooperation Ireland (DCI). However, there are others such as USAID, work through NGOs such as CARE and Catholic Relief Services, which implement public works programmes alongside the government programme, in geographically targeted areas. Other donors are funding independent innovative public works pilots such as the Save the Children-UK, Meret (WFP’s land rehabilitation project) and Legambe programmes, which conform to the national public works norms, but include additional complementary components, to promote livelihoods, and include action research programmes. All these programmes have to conform to the framework provided by the PSNP, including the prioritisation of cash transfers.

In terms of identifying the policy gaps that exist in relation to HIV/AIDS, it is evident that the PSNP may have a number of unintended consequences in terms of spreading HIV infection. By its very nature, the PSNP mobilises large numbers of people for participation in the public works, which implies an increase in the frequency and intensity of contact between people. This may lead to exposure to HIV infection by, for example, increasing the possibility of contact with sex workers in a context where social institutions that may inhibit or limit sexual interaction may not be present. The availability of disposable income may encourage people to visit liquor houses and commercial sex workers more frequently. A similar situation may arise amongst PSNP beneficiaries due to increased access to food and cash resources, particularly if women do not have control over their use.

Another major policy gap in the PSNP is that of stigma. Considering the levels of discrimination that HIV/AIDS affected people face in rural Ethiopia, efforts to single out such households for special treatment through the PSNP could be problematic. Unless complemented by sensitisation activities, such targeting could lead to the stigmatisation of some vulnerable households, and is an issue that requires further investigation.

A key opportunity exists to turn these risks around by responding to such issues early. Through protecting people from infection early in the programme, many beneficiaries will be in a position to graduate off the PSNP over time. By engaging with the risks associated with HIV early, there is far less chance of dependency on the PSNP in the long run. Thus the importance of a mainstreamed approach becomes imperative.

Resettlement Programme

The Resettlement Programme is a policy response to the issue of land scarcity as the binding constraint on highland agriculture. It involves the relocation of farmers from “drought areas” to lowland areas where there is “sufficient land and rainfall” as one of the basic means of ensuring food security (FDRE, 2003). This involves the resettlement of 2.2 million people in three years to alleviate pressure in the land-stressed highlands and providing access to improved land to those who agree to move. Serious questions remain about the impact of this programme in improving food security (Dessalegn Rahmato, 2003; Pankhurst & Gebre, 2002), not least for those affected by HIV/AIDS and as a possible driver of increased infection rates. The resettlement process often involves the temporary separation of families, as the family heads, mainly men, move to the new areas to establish themselves before their families arrive. As in any population movement, there is the potential for increased vulnerability to risks such as HIV/AIDS.

Having conducted a preliminary study of the programme, the Miz-Hassab Research Centre concluded that many of the resettlement sites exhibited problems associated with the rapid spread of HIV/AIDS. For example, international and Ethiopian experience is clear that resettlement disrupts the social institutions, networks and relationships that are an essential dimension of survival for the poor. Research in Africa has long demonstrated that the prevalence and patterns of spread of infectious disease are closely associated with patterns of human mobility (SAMP, 2002). Thus the continuous movement of people is an underlying factor in the spread of HIV/AIDS. Numerous studies have established a clear link between elevated HIV sero-prevalence and short duration of residence in a locality, settlement or travel along major transportation routes, immigrant status, and international travel to the region (Brockerhoff and Biddlecom, 1999). In addition, the large numbers of military and demobilised soldiers, the increase in sex work due to economic factors, as well as cross-border traders also contributed to higher risk of HIV spread in these areas. Poor access to information about the disease and poor services further compounds the creation of an environment of risk in the resettlement sites.

There is therefore a need to inform policy about both the implications of the epidemic for the success of the programme as well as it becoming a driver of increased infection. Apart from an urgent need to

accompany such a programme with information about HIV/AIDS, this requires informed decisions about anticipating any unintended consequences of the programme. Certainly urgent research is needed to properly inform the design of HIV/AIDS prevention and risk management strategies and their incorporation into such programmes which are inherently HIV/AIDS promoting.

Pastoralist Areas

In livestock dominant areas, the Ethiopian Government has begun to argue for sedentarisation of pastoralists along rivers or in small towns in response to recent signs of stress in the pastoral economy – famine and/or drought in three of the last five years (Devereux *et al*, 2005). This is reflected in the Pastoral Development Policy, which aims to transform pastoral societies into an agro-pastoral system, from a mobile to a sedentary life, from rural dispersion to small pastoral towns and urbanisation (*Ibid*: 125).

In response to this policy, Devereux and other food security specialists working on Ethiopia, believe that “settlement” of pastoralists and “resettlement” of farmers both respond to an assumption of binding natural resource constraints by introducing measures that are inappropriate and come close to social engineering (*Ibid*: 125). They cite a pastoralist from the Somali Region in response to the possibility of a sedentary future:

The Government wants to settle us, to turn us into farmers. But we look at the problems of the farmers in the highlands and we ask why the Government hasn't solved their problems. Every year millions of tons of food aid goes to those farmers, who are supposed to be growing their own food. Does the Government want to turn us into beggars like them? (quoted in Devereux et al, 2005: 125).

Apart from serious concerns about this policy, both in the eyes of the “beneficiaries” and conceptually, the settlement of people in concentrated populations and the disruption of a well-developed and adapted socio-economic system may develop an environment of risk for HIV spread. The increase in frequency and intensity of contact between people may become a fertile ground for increasing prevalence rates amongst (once) pastoralist communities.

Policy Needs: Mainstreaming HIV/AIDS

The various programmes that the government is implementing such as safety net and resettlement programs could themselves create a conducive environment for expansion of the HIV disease whereas they also constitute opportunities for implementing parallel or integrated HIV prevention and control activities. However, currently there does not seem to be much understanding and action regarding both the opportunities and risks associated with these programmes with respect to HIV/AIDS epidemic in the country.

Ethiopian policy recognizes the general vulnerability of much of the population to food insecurity caused by low levels of annual production due to drought, soil erosion, small land holdings, and the application of rudimentary technologies. Indeed, the relevant policies commit the Government to continue with direct assistance to supplement household income while initiatives to increase rural income and diversify productive activities take root. However, because HIV/AIDS is another source of vulnerability, an understanding of the manner in which it impacts rural livelihoods is important for effective delivery of such assistance.

Comprehensive understanding about possible impacts of HIV/AIDS on local level agriculture, which are many and diverse, needs to be facilitated into policy discourse. Impacts range from reduction of quantity and quality of labour, to depletion of resources and assets such as land and plough oxen, erosion of

income and deterioration of consumption. Final consequences include the disintegration of families and social networks as well as exposure of orphans and vulnerable girls and women to further destitution.

Similarly, it has been found that households' asset base is eroded with the incidence of HIV/AIDS as expenditures related to health, funeral and mourning rise. Given that Ethiopia's development strategy envisages capital formation primarily in agriculture, it is important that rural households' productive assets are protected as households fall victim to the disease and associated increases in vulnerability and poverty. An understanding of the social relationships that develop in the event of prolonged sicknesses and death of productive household members (as in the case of HIV infection and AIDS) is an important step towards developing strategies that would enable asset protection. Present policy considers asset protection in the event of drought related shocks. HIV/AIDS adds another dimension to the issue.

The spread of HIV and its impacts are also likely to be governed by specific local conditions with respect to both the nature and characteristics of farm and social systems, including factors such as farming techniques, social norms and culture. For example, in many cultures agricultural knowledge is passed on from one generation to the next. However, in communities hard-hit by AIDS this transfer of knowledge may be truncated by the widespread morbidity of the parent generation. One way to mitigate this outcome is to support the older generation (grandparents) to provide this knowledge transfer to the younger generation (Alumira, et al., 2005) It is important to understand, therefore, specific channels through which HIV/AIDS impacts on agriculture, including intra- and inter-generational social dynamics, and the factors that govern these linkages. There is a need therefore, to investigating which of these effects are more important and under what circumstances their effects are likely to escalate in the Ethiopian context.

The challenges should also not be left within the policy debates in distant urban centres. Whereas policies and strategies are formulated at national level and countrywide sector programs are designed, their implementation is fully delegated to regional authorities. Hence, it is important to understand the implications of the on-going decentralization process in the country and the challenges as well as the opportunities it creates for multi-sectoral and integrated intervention by different stakeholders at woreda level. Engaging with the policy process in order to mainstream HIV/AIDS requires a coherent commitment to the translation of the policy framework into programmes, strategies and interventions at various levels, all of which requires political will and commitment.

Considering, in principle, that new strategic approaches are needed to address this new challenge, the nature and depth of the problem needs to be understood firsthand. There are potential roles, for example, for a reinvigorated agricultural extension approach. The extent of revisiting existing approaches and the need for new measures depends on good appreciation and understanding of the facts on the ground.

8. Key Knowledge Gaps: Building on the Durban Conference, April 2005

The “International Conference on HIV/AIDS and Food and Nutrition Security: From Evidence to Action” was held 14-16 April in Durban, South Africa. The conference was organized by IFPRI following broad consultation with a range of partners within national governments, the Consultative Group for International Agricultural Research (CGIAR), the United Nations, civil society, academia, along with bilateral and international donors. Fifty four papers were presented in a series of parallel and plenary sessions. These papers, drawn from experiences mostly from Eastern and Southern Africa, but also from Asia, reflect some of the most recent and scientifically robust thinking about HIV/AIDS and food security. Despite many regional differences and the specificity of Ethiopia, many of these lessons have resonance for the HIV/AIDS and food and nutrition security situation in Ethiopia.

This section therefore draws on Gillespie’s assessment and report of the Durban Conference (forthcoming) and Gillespie and Kadiyala’s comprehensive review on research on HIV/AIDS and food and nutrition security (2005). Additional gaps have been identified through a review of the literature and from key informant interviews.

Food and nutrition security, and the risk of being infected with HIV

Considering the very real opportunity that Ethiopia has with its comparably low prevalence rates, particularly in rural areas, policy makers and practitioners need to consider what social, economic, political, cultural factors and processes are responsible for the spread of HIV in the country (and specifically how is food and nutrition implicated, if at all), who is most susceptible, and why they are susceptible. These were questions engaged at the Durban Conference with some important findings for Ethiopia. These questions need to be tackled within the context of Ethiopia if responses to the epidemic are to be effective.

The relationship between poverty and HIV continues to be a major area of research. At the macro level there is no obvious relationship between national wealth and HIV infection prevalence (Gillespie, 2005: 3). For example, southern Africa is richer than other regions in Sub-Saharan Africa but has countries with particularly high prevalence rates such as Botswana, Namibia and South Africa. However, poverty does seem to be a crucial factor in the spread of HIV/AIDS, particularly at the household level, and it is the poor who have the fewest resources to buffer themselves and their dependents from the negative social and economic impacts of AIDS morbidity and mortality. There is strong evidence that a) inequalities (socio-economic, gender) drive the spread of HIV infection, and b) that HIV/AIDS itself increases these inequalities.

It should be emphasised that poor people infected with HIV are considerably more likely to become sick and die faster than the non-poor since they are likely to be malnourished, in poor health, and lacking in health attention and medications. In effect, all factors, which predispose people to HIV infection, are aggravated by poverty, which “creates an environment of risk”. According to Balyamujura *et al*, poverty relates to the spread of HIV in three interrelated ways (2000: 8):

1. Deep-rooted structural poverty, arising from such things as gender imbalance, land ownership inequality, ethnic and geographical isolation, and lack of access to services.
2. Developmental poverty, created by unregulated socio-economic and demographic changes such as rapid population growth, environmental degradation, rural-urban migration, community dislocation, slums and marginal agriculture.

3. Poverty created by war, civil unrest, social disruption and refugees⁷. High levels of rape and the breakdown of traditional sexual mores are associated with military destabilisation, refugee crisis and civil war (Walker, 2002: 7).

All three have severe effects on individuals' and communities' vulnerability to the spread of HIV, their ability to handle risks, and opportunity to participate in prevention and care activities⁸. For example, the link between poverty and HIV risk may be mediated through the need to move in search of work. Mobility here is not inherently risky, but it is a marker of increased risk. In Ethiopia, though there are significantly lower levels of HIV infection in rural communities than in urban areas, the disease is concentrated in higher-risk "bridging populations" that have substantial links with other more risk-averse sub-populations (Bishop-Sambrook *et al.*, 2005).

Vulnerable groups that may be more susceptible to HIV include women, particularly younger women. There are a number of interlocking reasons why women are more vulnerable than men to HIV/AIDS, which include female physiology, women's lack of power to negotiate sexual relationships with male partners, especially in marriage, and the gendered nature of poverty, with poor women particularly vulnerable (Walker, 2002). Inequities in gender run parallel to inequities in income and assets. Thus women are vulnerable not only to HIV/AIDS infection but also to the economic impact of HIV/AIDS. This is often a result of the gendered power relations evident in rural households (Waterhouse and Vifjhuizen, 2001)⁹, which can leave women prone to the infection of HIV. With increasing economic insecurity women become vulnerable to sexual harassment and exploitation at and beyond the workplace, and to trading in sexual activities to secure income for household needs (Loewenson and Whiteside, 1997). Sex work may be combined with other economic or livelihood activities or as a coping mechanism for those who cannot access other opportunities

As a result, women have experienced the greatest losses, and bear the greatest burdens associated with economic and political crises and shocks, the following being some examples:

- *Breakdown of household regimes and attendant forms of security*: decades of changes in economic activity and gender relations have placed many women in increasingly difficult situations, including greater household responsibilities. For example, more active care-giving for sick and dying relatives have been added to the existing workload. Children have been withdrawn from school, usually girl-children first, to save both on costs and to add to labour in the household. In this way, HIV and AIDS facilitates a further and fairly rapid differentiation along gender lines.
- *Loss of livelihood*: whether women receive remittances from men working away from home, are given "allowances", or earn income themselves, HIV and AIDS has made the availability of cash more problematic. This has been discussed in the livelihoods section above.
- *Loss of assets*: although poorly documented, fairly substantial investments in medical care occur in many households affected by HIV/AIDS. These costs may be met by disinvestments in assets. Household food security is often affected in negative ways. Furthermore, in many parts of Africa, women lose all or most household assets after the death of a husband.
- *Survival sex*: low incomes, disinvestments, constrained cash flow – all place economic pressures on women. Anecdotal evidence and some studies indicate that these pressures push a number of women into situations where sex is coerced in exchange for small cash or in-kind payments.

⁷ Obbo has also drawn attention to the link between the spread of HIV/AIDS and social instability and conflict, such as was found in Uganda during the 1970s and 1980s (1995, cited in Walker 2002: 7).

⁸ The latter is related to the relatively poor public health education and inadequate public health systems found in most Sub-Saharan African countries.

⁹ Waterhouse & Vifjhuizen have edited a detailed account of gender, land and natural resources in different rural contexts in Mozambique, which rigorously addresses the power relations women face in the context of the rural household.

In rural areas, women tend to be even more disadvantaged because of reduced access to productive resources and support services. A number of studies have shown that women who are widowed due to AIDS sometimes lose rights to land, adding to an already precarious situation (see Aliber *et al*, 2004; Drimie, 2002). These problems of land tenure overlap with the issues of gender disparity. Some research has documented that widows and their dependents in patrilineal societies are in a more tenuous position with regard to maintaining control over land (Barnett & Blaikie, 1992). When combined with evidence that female-headed households tend to be poorer in general than their male-headed household neighbours, governments and donors face a serious challenge to devise means to protect the rights of poor households (and particularly poor female-headed households) to land within future poverty alleviation and rural development strategies (Jayne *et al*, 2004).

Many of these issues are not documented or researched in Ethiopia. Lessons from elsewhere indicate that although prevalence rates are low, Ethiopia has many of the conditions that contribute to an “environment of risk” that could contribute to the continued spread of HIV infection.

HIV impacts on food and nutrition security

The impact of HIV/AIDS on food and nutrition security has been well researched and grown very rapidly in recent years (numerous studies are reviewed in Gillespie and Kadiyala 2005). Impacts are multiple and often inter-related¹⁰, with case studies indicating the complexity and the context-specificity of impacts.

Many of these experiences, some documented in Ethiopia (UNDP, 2004), have been used to inform the “mainstreaming” literature, which is emerging in Ethiopia, largely through multilaterals such as the World Food Programme (WFP, 2005). Rather than assess these here, gaps in understanding these impacts have been elaborated. For example, it is not clear what happens when households, already subjected to multiple stresses over the longer term, experience an HIV and/or AIDS impact. Experiencing multiple impacts is the reality for the majority of Ethiopian households (Sharp *et al*, 2003; Lautzke *et al*, 2003) but understanding of the interaction with the epidemic remains largely undocumented. Building on this, it is also unclear what happens at a community level when the proportion of households trying to cope increases significantly. As has been articulated throughout this paper, HIV/AIDS is different in several important ways to other shocks and stresses although it is one among many concurrent stresses in Sub-Saharan Africa where it is most prevalent. Throughout Southern Africa and probably in Ethiopia, an increasing number of households and communities are struggling to respond to multiple overlapping vulnerabilities and interacting processes of change. These interactions remain unclear in Ethiopia and should form the basis of major research.

Stigma and vulnerability

Discussions with Family Health International in Addis Ababa reiterated the issue of stigma as a major developmental challenge in Ethiopia. Stigma itself is an impact of HIV/AIDS that may adversely affect the ability of individuals or households to respond. Depending on the social environment, disclosure of HIV status may lead to stigma, or it may open up other response options. While the societal rejection of certain social groups such as sex workers may predate HIV/AIDS, the disease has, in many cases, reinforced this stigma. By blaming certain individuals or groups, society can excuse itself from the responsibility of caring for and looking after such populations. This is seen in how such groups are denied access to the services and treatment they need. Stigma may not be primarily associated with promiscuity

¹⁰ For example, Onyango *et al*. (2005) for example, found a variety of impacts on rural agricultural households in western Kenya struggling with the illness or death of an adult. Death-affected households spent US\$462 per year, as compared to \$199 for illness-affected households and just \$21 for non-affected households. Illness-affected and death-affected households spent 56 percent and 61percent respectively of the amount spent by non-affected households on agricultural inputs.

and reckless behaviour, but may be increasingly linked to the sense of being overwhelmed by the work, expense and emotional strain of having to care for sick people, in the context of declining household resources (Bond, 2005). In a few examples of CHBC in Addis Ababa, FHI demonstrated the destructive force of stigma, as infected individuals faced discrimination and neglect, and the possibility of turning this around through community mobilisation. This remains a serious research area for both advocacy and programming objectives.

Scaling up, mainstreaming and a multi-sectoral approach

A challenge facing most organisations in responding to HIV/AIDS is scaling up programmes to be widely effective. This is a challenge facing organisations such as Family Health International and their CHBC initiative, which, although the biggest of its kind in Ethiopia, has a fairly limited range. Other organisations such as WFP face the demand for a scaling up of its nutritional support to urban HIV/AIDS affected households. The challenge is that while responses have to recognise the diversity of contexts and impacts, they also need to be large-scale to adequately address the problem. This requires sensitivity to contextual issues (specificity), an enabling environment and government commitment. To be truly effective under these varied conditions, detailed knowledge and understanding is required to develop appropriate policies and programmes, raising the necessity for action research. Examples from elsewhere indicate that successful scaling up occurred where there was the adoption of a community mobilisation model through capacity strengthening of existing institutions (similar to FHI's approach to *idirs*), a commitment to documenting and disseminating lessons learned, and the drive to reach more affected populations through establishing partnerships were key organisational factors. Community-specific factors include leadership within the community and the history and culture of the communities with respect to collective action. The development of networks for research and action, such as that proposed by RENEWAL, is a key opportunity to simultaneously increase capacity, communications and the coherence and scale of response.

As has been argued throughout this paper, AIDS is a multi-sectoral issue requiring a multi-sectoral response. Several rationales have been raised in the literature, many of which were reiterated and emphasised at the Durban Conference (Gillespie, 2005: 17):

- To increase the organisational scale of the response to HIV/AIDS;
- Because the difference between behaviours of people in high and low prevalence areas is smaller than that between their environments, which in turn are shaped by many sectors;
- Many sectors both affect, and are affected by, AIDS. The fact that HIV epidemics are endogenous to livelihood systems, not exogenous, implies a responsibility for different sectors to be part of the solution.
- Because there are positive synergies between prevention, care and treatment, and mitigation which may be better exploited in a multi-sectoral approach;
- Because original international and sectoral goals (for example Ethiopia's Millennium Development Goals) may not be achieved unless HIV/AIDS implications are taken on board; and
- Because it is not enough to only mainstream HIV/AIDS within one or two sectors (e.g. just health and agriculture).

Multi-sectoral approaches to HIV/AIDS control will involve (but not be limited to) mainstreaming of HIV implications into the policy and practice of many sectors. As argued in section six, mainstreaming HIV/AIDS can be defined as carrying out the organisation's core business in ways that better address the causes and consequences of HIV/AIDS, as well as addressing the epidemic through all elements of the organisation, including within the workplace, and throughout all programming. This cannot be limited to mainstreaming within policies and programming as communities should be part of multi-sectoral responses. Mainstreaming involves development of partnerships (especially with communities and

existing institutions), programme work in communities, and policy analysis and advocacy. Essentially, if a development programme does not recognise the fact that HIV/AIDS affects all aspects of society, then it will be “mopping with the tap running”, or treating the symptoms of a problem without addressing the cause’ (Drimie & Mullins, 2005).

As has been documented elsewhere, mainstreaming involves both focusing on the internal and external environment of institutions when engaging with the reality of HIV/AIDS (Drimie & Mullins, 2005). External mainstreaming focuses on the workplace, which reinforces an understanding of programming and working externally of the institution. This is absolutely essential as HIV/AIDS affects all sectors of society and requires recognising that it is not an “us and them” situation. Some of the more damaging impacts for farm households and communities may be those arising from wider processes, including the likely reduction in public services to support agriculture resulting from loss of key staff and pressure on budgets.

In service-oriented sectors such as ministries of agriculture, which generally comprise the largest staff components of governments, AIDS deaths reduce the quality and quantity of services. In addition to the direct loss of skills and institutional memory, there are increased financial costs for training new staff, increased demand for health care, funeral payouts and pensions. This weakened government capacity impacts on its ability to not only meet its mandate, such as the provision of extension services and other agricultural support, but also to meet the new demands emanating from AIDS-affected communities. Critical examples include the growing numbers of orphans and vulnerable children who require a whole range of services; changing demographic patterns in communities that place more burdens on the elderly and children; and an increased disease burden. Finally, the impoverishing effect of AIDS on households significantly heightens the services demanded of the state and its partners (United Nations, 2003).

Interventions: Agriculture

When it comes to interventions aimed at combating the HIV/AIDS-food insecurity nexus, the evidence base remains weak (Gillespie, 2005: 20). Where organizations have launched such interventions, they are usually isolated, small-scale with minimal monitoring, and they are rarely well-evaluated. The Durban Conference made a plea for more rigorous evidence of what works, where and why. Better links are needed between programmers and researchers to achieve informed action. This is an opportunity within Ethiopia as an evaluation can be planned up-front as institutions begin to focus more holistically on HIV/AIDS, and this can be done while national prevalence rates are still relatively low.

It is widely accepted through Sub-Saharan Africa that raising living standards of households and communities over the long-run will improve their ability to withstand the social and economic stresses caused by HIV/AIDS (and other poverty-related economic and health stresses). Ethiopian development policies already have this as a core objective. However, particular kinds of interventions might stimulate resilience to HIV/AIDS. For example, productivity-enhancing investments in agricultural technology generation and diffusion, improved crop marketing systems, basic education, infrastructure, and governance would all have particular effects (Jayne *et al.* 2005).

In the agricultural sector, conventional wisdom prioritises technologies and crops that save labour in the context of HIV/AIDS. Research focused largely on Malawi and Zambia by Jayne *et al* believe, however, that this has been over-generalised, although such technologies may be appropriate for certain types of households and regions (2005). Dorward and Mwale concur, arguing that labour-saving technologies may even be harmful if they further drive down wage rates that are already falling due to HIV-induced cash-constraints on ability to hire¹¹ (2005). Emphasis may need to be placed on other ways of assisting these

¹¹ With high population density and very small average agricultural holdings, Donovan and Bailey (2005) found Rwandan households appear to use labour replacement strategies rather than labour-saving technologies to deal with

households, such as cash transfers to help them with labour hire.

Ethiopia has recognised the centrality of labour as the driving force behind rural development and food security. The impact of HIV/AIDS on many households, particularly in terms of reducing or eliminating labour, needs to be clearly understood and existing responses, including ADLI and the productive safety nets programme, should respond with a range of options for different needs. However, questions should be asked about what types of modifications are needed to ensure that agriculture is “HIV-responsive” and that these programmes play their part in strengthening resistance and resilience to HIV/AIDS and avoid increasing the risk of infection as an unintended programme externality.

Bishop-Sambrook *et al* have addressed this question through applying an HIV/AIDS lens to the commercialization of agriculture in Ethiopia (2005). Initiatives to strengthen the market orientation of agricultural production present both an opportunity and a threat in the context of a rural HIV/AIDS epidemic. Whilst any contributions towards reducing poverty and the need to migrate may reduce susceptibility to HIV/AIDS, the authors state there are very real risks that the additional cash and the stimulus to travel further afield to market produce could result in increasing the risk of exposure to HIV. Hence activities associated with promoting the marketing of agricultural products need to be designed with care to ensure they play a role in arresting, rather than hastening, the spread of the disease in rural communities. They go on to outline several opportunities for addressing HIV/AIDS through market-led growth strategies (see Gillespie, 2005: 21). Examples include:

- Raising awareness and understanding about HIV/AIDS. For example, working with groups associated with agricultural production and marketing initiatives who are traditionally overlooked by HIV/AIDS awareness and outreach activities because they do not usually belong to formal associations, such as petty traders and retailers, ambulant traders, transporters, owners of hotels and drinking houses; using occasions when people are gathered together (for example, market days, seasonal migrants working on farms or commercial sex workers moving into an area during harvesting season) to educate them about HIV/AIDS and its prevention;
- Reducing risk of exposure to HIV infection. For example, reducing the need and desire to migrate through improving food and nutrition security by increasing agricultural output, improving the quality of produce, widening the range of products and making more efficient use of inputs (including labour); improving livelihood options in and around the community and extending the growing season through developing small-scale irrigation, product diversification, agro-processing, strengthening existing and creating new market linkages, and developing the farm input supply chain;
- Reducing vulnerability to AIDS impacts. For example, overcoming barriers to participating in agricultural production and marketing by infected and affected households, such as their depleted resource base, their need to be close to home to tend to the sick, loss of key skills and their inability to undertake risk; using cooperatives and farmer organisations as entry points for mitigation, care and support activities in communities. For example, by developing income-generating activities, savings, health insurance, or establishing a social fund to provide care for orphans.

Another key opportunity for addressing HIV/AIDS is that of Community Conversations:

- The process is one of the UN's core contributions to the HIV/AIDS response which utilizes a methodology involving trained local facilitators, who facilitate a process of developing the capacities of communities and the organizations working with them to effectively respond to the

labour shortages. They found a disturbing trend of households shifting away from crops that provide erosion control, thus endangering future soil fertility. Since affected households *ex post* tend to be in the lower income groups, agricultural policy that can generate rural income growth from diverse sources will assist these and other poor households (Gillespie, 2005).

HIV/AIDS epidemic. Where already implemented in Ethiopia there has been relative success in providing people with the means of identifying their own problems and finding their own solutions. Facilitators trained from their own communities have helped enable people to openly begin talking to each other about 'taboo' subjects, exploring the implications of HIV/AIDS, identifying cultural norms and values that might be fuelling the epidemic and the social capital within the community to overcome them.

Interventions: Nutrition

The WHO Consultation on Nutrition and HIV/AIDS in Africa held in Durban between the 10th and 13th of April 2005, directly before the IFPRI Conference, concluded with several key recommendations aimed at:

- Strengthening political commitment and improving the positioning of nutrition in national policies and programmes;
- Developing practical tools and guidelines for nutritional assessment for home, community, health facility-based and emergency programmes;
- Expanding existing interventions for improving nutrition in the context of HIV;
- Conducting systematic operational and clinical research to support evidence-based programming; and
- Strengthening, developing and protecting human capacity and skills, and incorporating nutrition indicators into HIV/AIDS monitoring and evaluation plans (Gillespie, 2005: 23).

With the high levels of malnutrition in Ethiopia practically all key respondents to this paper highlighted the importance of nutrition interventions. In a context of rising HIV prevalence, nutrition becomes a major intervention to reduce the spread (see previous section) and slowing the development of full-blown AIDS for infected people.

It is widely held that interactions between antiretroviral therapy (ART) and food and nutrition can affect medication efficacy, nutritional status, and adherence to drug regimens. Drug-food interactions consist of the effects of food on medication efficacy, the effects of medication on nutrient utilization, the effects of medication side effects on food consumption, and unhealthy side effects caused by medication and certain foods. As ART interventions scale up in Ethiopia, addressing food and nutrition implications will increasingly become a critical component of care and support programmes and services, particularly given the context of wide-spread, chronic and acute food insecurity which already exists. This has already been recognised within the drafting of the National HIV/AIDS and Nutrition Guidelines. Service providers can help address these implications by working with people living with HIV/AIDS and caregivers to identify the specific food and nutrition requirements of the medications being taken and to develop feasible food and drug plans to meet these requirements. Programmes working with people taking ART may need to strengthen human capacity to address nutritional issues, establish linkages to food and nutrition programmes, and incorporate information about drug-food interactions into communication materials, staff training and orientation, and supervision strategies.

Home gardening offers potential for households to raise income and ensure access to nutritious food, close to home. This becomes particularly important in the context of urban malnutrition and in support of ART. Urban gardening may become an option to support health initiatives if access to land for a homestead garden on residential plots can be secured. This is an obvious challenge in cities such as Addis Ababa where there is a scarcity of such land. Water for supplementary irrigation is another challenge but might be available in residential areas. The proximity of home gardens being close to the house and relatively small means labour-scarce households are able to maintain some food production and to maintain comparatively labour-intensive production techniques. Such gardening should also focus on a range of vegetable crops rather than the single grain staple usually grown in fields, which has important potential for enhanced household nutrition, especially significant for HIV- positive household members with special nutritional needs. In the experience of CARE-Lesotho, there was significant scope for

marketing homestead garden produce, enabling vulnerable households to raise some cash income (Abbot et al. 2005). Such initiatives should be “twinned” with clinics offering VCT or hospitals distributing ART to provide a comprehensive response to HIV infection. Few, if any, AIDS treatment programs have incorporated nutrition care, yet most prescription refills are followed by instructions to take drugs after meals.

Annexure One

Potential Role of RENEWAL in Ethiopia

Building on the knowledge and policy gaps identified in section nine, RENEWAL can facilitate addressing these at national level. Although HAPCO has the core mandate to coordinate different sectors under a comprehensive framework, there is a need for an organisation such as RENEWAL to help facilitate coordination and integration of sectoral policies and programmes on HIV/AIDS and food and nutrition security. In particular there are opportunities to establish links with IFPRI's Ethiopia Strategy Support Programme (ESSP) and other Government of Ethiopia food security programmes, the Productive Safety Nets Programme (PSNP), and national AIDS programmes.

Facilitating a multi-sectoral and mainstreamed approach to HIV/AIDS and food security

Drawing on the networks' ongoing experience and policy-oriented research in Southern and Eastern Africa, RENEWAL can provide facilitation/coordination around action research that mobilises mainstreaming and to broaden thinking about a multi-sectoral approach. This essentially would involve building on and developing research into HIV/AIDS impacts on food and nutrition security in order to inform a comprehensive response that encompasses prevention, positive living, treatment and care, and mitigation.

In the face of the challenges posed by the interactions between HIV/AIDS, food and nutrition security, there is no convenient magic bullet intervention and no blueprint. The fact that "business as usual" does not work in many contexts however does not mean that everything needs to change. Such 'AIDS exceptionalism' would be counterproductive in the long run. Rather, a truly multi-sectoral involvement is required. This is fundamentally different to simply adding more HIV activities on to sectoral plans. Mainstreaming starts with decision-makers internalizing HIV/AIDS as a development issue, leading in turn to a critical review of existing policies and programmes through the lens of their growing knowledge of AIDS interactions. It is a process involving continual reflection, and the progressive application of principles and processes for responding - rather than pulling pre-designed interventions off the shelf. RENEWAL can help facilitate this by, firstly, developing knowledge of food security and HIV/AIDS interventions and secondly, through sharing lessons on mainstreaming and best practices from elsewhere. A practical starting point would be the World Food Programme's mainstreaming framework, which could benefit from exposure to broader experience, as well as provide a useful starting point for other mainstreamed programmes in Ethiopia. Another opportunity lies with the UNDP's mandate by HAPCO to mainstream HIV/AIDS in a number of government programmes in Ethiopia, including agriculture. The UNDP is actively searching for partners in this endeavour and voiced a desire to learn from practical experiences from elsewhere. RENEWAL could add greater impetus and depth to the UNDP approach.

Mainstreaming, when conceptualised and implemented coherently and effectively, would involve a three-pronged approach: a) strengthening household and community resistance and resilience to HIV/AIDS; b) enhancing and expanding livelihood opportunities for affected communities; and c) ensuring appropriate safety nets for those households that require them. These three strategies should be pursued simultaneously, based on the different comparative advantages of all stakeholders from households to national governments and international agencies.

Facilitating capacity strengthening through knowledge creation and networking

By facilitating an effective mainstreaming approach that could be replicated, RENEWAL would be building capacity in Ethiopia through knowledge creation. This would involve bringing organisations from other regions to share experiences. For example, RENEWAL could ensure lessons are learnt from

existing linkages between organisations with regional and international links. International NGOs such as Save the Children-UK and CARE-International can learn from other country offices where mainstreaming has taken place. Already significant interest in mutual learning has been expressed by a range of organizations in Ethiopia, and RENEWAL is already facilitating this within the region (although not as yet in Ethiopia). It is widely recognised that there is a need to mobilise the efforts of the government, non-governmental organisations, community based organisations and other civil society organizations in providing care and support to people infected and affected by HIV/AIDS. However, this should be taken much further to looking at mitigation of AIDS impacts.

Apart from the creation of knowledge through research, capacity strengthening can also take place through sharing of experiences and building networks and partnerships. By its very mandate, RENEWAL will achieve this by bringing together different sectors into “safe spaces” where different organisations can discuss issues. In order to create such an environment, it may be necessary to instil a “Chatham House Rules” approach where people can talk freely, openly and critically and constructively about food security and HIV/AIDS issues, without fear of reproach.

Facilitate “action research” methodologies in Ethiopia

The concept of action research has recently arisen as a “desirable” methodology across disciplines partly as a response to criticisms against research that fails to feed into or engage with policy-making processes. Many individuals and representatives of organisations interviewed for this paper indicated the need for action research with a range of understandings of what this entailed. RENEWAL’s core principle and experience is around action research that has the following dimensions:

- A commitment to an integrated methodology for combining research and its strategic and practical applications;
- A commitment to rigour and innovation in conducting research on ‘vulnerability’, which recognises the complex spatial and temporal dynamics of threats to human welfare in the region; and
- A commitment to the sharing and transferring knowledge through seeking further collaboration between overlapping research and intervention programmes.

Built into this perspective is recognition of people as both agents and subjects of their conditions of existence; hence, this research would address ‘resilience’ as well as ‘vulnerability’ (Gillespie and Kadiyala, 2005). RENEWAL could actively promote these principles and facilitate different methodologies utilising such an approach across Ethiopia in developing the evidence base upon which an effective response to the epidemic could be further strengthened and built.

Facilitating action research around key policy gaps

Building on policy gaps identified in this paper and the recommendations of the Durban Conference, the following constitute critical knowledge gaps that RENEWAL in Ethiopia could address:

Research Priority 1: HIV Spread and Food Insecurity:

Considering the very real opportunity that Ethiopia has with its comparably low prevalence rates, particularly in rural areas, policy makers and practitioners need to consider what social, economic, political, cultural factors and processes are responsible for the spread of the disease, as well as who is most susceptible, and why are they susceptible.

What is the role of poverty and food insecurity in driving risky behaviours? How prevalent is transactional sex, and how linked is it to food poverty? Is food insecurity a major determinant of migration, and are migrants at heightened risk of being exposed to HIV? Can efforts aimed at enhancing

food security and livelihood options of susceptible groups make a cost-effective and timely contribution to preventing the spread of HIV? Can options be identified that are economically and environmentally sustainable, that makes use of local opportunities?

Research Priority 2: HIV/AIDS, Multiple Stresses and Overlapping Vulnerabilities:

In many ways, HIV/AIDS is exposing the fragility of people's livelihoods -- this fragility derives from multiple sources of vulnerability, many of which interact and are worsened by AIDS. There is a growing body of knowledge on the links between poverty and the spread of HIV/AIDS. However, there are still large gaps in understanding of how and why the intersection and interaction of forces vanquish some while others survive and, at the same time, create opportunities for others to adapt livelihoods to their benefit. Understanding and distinguishing the effects of HIV/AIDS within this complex set of forces is a key problem for scientists and policy-makers. Without that knowledge, it is not possible to understand the dynamics and nuances of vulnerability and, hence, to revise interventions as necessary. Such an approach also ensures that a framework is developed that recognises HIV as one amongst many issues and so not to overstate the issue.

How does HIV/AIDS -- as a source of vulnerability to food and nutrition insecurity -- intersect and interact with other sources of vulnerability? How to go beyond identifying who is “vulnerable” to better understand why households are, or why they become, vulnerable? Conversely, why are certain households more resilient than others in similar situations? What are the implications of this for vulnerability monitoring systems? How to develop approaches to identify options for households to reduce their vulnerability? What are the implications of overlapping vulnerabilities for approaches to addressing HIV/AIDS and food and nutrition insecurity?

Research Priority 3: Nutrition Security and HIV/AIDS:

In addition to food security, nutrition security has emerged as an important dimension in the prevention, care, treatment and mitigation of HIV/AIDS. A focus on nutrition security can help reveal opportunities for effectively linking health services with food and nutrition policy in the context of HIV/AIDS. Current research indicates that good nutrition is important to the efficacy of medical interventions as it is to peoples’ ability to resist and mitigate infection. There is currently a strong focus on clinical nutrition and HIV/AIDS in the context of issues such as infant feeding, and the efficacy of antiretroviral therapy among malnourished populations. This relates primarily to interactions within the individual body and their implications for health policy. Yet there have been few attempts to link nutritionists with agricultural economists and/or programme managers to investigate the broader issue of community- level nutrition security and broader food policy and programming in the context of HIV/AIDS. There is therefore a real opportunity to engage with the emerging Ethiopian nutrition policy.

Many of the food responses in Ethiopia to date have revolved around delivery of food aid. It is thus important to consider what other longer-term options exist for ensuring nutrition security within affected communities. Other questions include what does nutrition “through an HIV lens” look like, and what are the operational implications of rethinking nutrition from this perspective? Does nutrition offer an entry point for forging better links between public health and agricultural responses to AIDS?

Research Priority 4: Migration, Urbanisation and Urban-Rural Links

Research has established that migrant populations have higher rates of HIV/AIDS compared to less mobile groups, and this is true for Ethiopia. Yet all types of migration in the region are on the rise, including local rural-rural migration, rural-urban migration and cross-border migration. The implications and impacts of increasing mobility for the prevention and mitigation of HIV/AIDS are felt from individual, household and community levels, through to the regional scale. In Ethiopia, where

urbanization rates are high and likely to persist over the coming decades, it is important that development policy is examined through an HIV/AIDS lens with the aim of introduce possible policy reforms that help to address the specific circumstances and needs of migrant and mobile populations. What are the unique risks facing mobile populations and how can these be controlled or mitigated without undermining the very livelihoods that migration strategies often promote? How do national and regional development policies take cognizance of migration and HIV/AIDS in an integrated manner?

Urban-rural links are fundamental to food and nutrition security in the region. In most situations, the bulk of food available and consumed in the city is produced in rural areas. HIV/AIDS may thus have a direct negative impact on urban food security, most notably through the consequent reduction in physical capital and production of food in rural areas, and the increased burden of dependence of people living with HIV/AIDS on both urban and rural social units (precipitating a deepening of poverty at the household level). To what extent is HIV/AIDS in the rural areas impacting the production and transfer of food to urban households? What policy changes can be made in the rural and urban areas that could help offset household vulnerability and food insecurity?

Research Priority 5: Longitudinal Studies and the Dynamics of HIV/AIDS and Food and Nutrition Security

Another research challenge in Ethiopia lies in the handling of the temporal aspects of HIV epidemics and their impacts that cannot be accommodated by cross-sectional studies (Gillespie, 2005: 12). The three principal stages of the epidemic that a community may pass through can only be discerned through longitudinal data sets that can help “unravel” the complexity of HIV/AIDS entangled within other stressors to expose underlying vulnerability. These phase include AIDS-initiating with very low HIV prevalence rates and no AIDS impacts; AIDS- impending where HIV prevalence rates are rising but the majority of infected people are still in the asymptomatic phase before becoming ill; and AIDS-impacted when households and communities feel the impact of AIDS as infected people succumb to AIDS-related illnesses and eventual death. HAPCO has also raised the question of improving the knowledge base about the bi-directional relationship between HIV/AIDS and food insecurity, which can best be provided through longitudinal studies involving panel datasets. Such studies could either be supported or enhanced by RENEWAL through the inclusion of relevant questions or facilitated in partnership with other research organizations.

Immediate Steps for RENEWAL in Ethiopia:

There are already initiatives underway that could be supported by RENEWAL in the short term. These would be a way of starting the process in a way that would yield quick results to enable RENEWAL to establish itself in the country.

An example of such an initiative is the planned research that Save the Children UK intends to implement in the North-Eastern Highlands in 2006. This research explicitly seeks to understand the relationship between livelihood strategies and HIV/AIDS in order to inform and improve programming. RENEWAL has already been invited to engage with SC-UK in developing the terms of reference for the research and could play a role in helping research teams to develop appropriate methodologies, drawing on experiences from elsewhere, and to help facilitate partnerships between different types of researchers in undertaking this kind of initiative. Furthermore, RENEWAL could help facilitate “research uptake” beyond that of SC-UK by building linkages with appropriate government departments and HAPCO and mobilising other civil society organisations to learn from this process. Once the research is ready RENEWAL could also facilitate the preparation of the main findings into policy briefs and other forms of communication for rapid use by decision makers.

Another opportunity exists with Family Health International and looking critically at food security in Addis Ababa. FHI already has a wealth of experience in this area, particularly around nutrition support and ART, mobilising social capital through the CHBC initiative, and building skills amongst PLWHAs to facilitate stronger livelihoods. Such experiences could be documented for broader dissemination and advocacy purposes, and to provide a basis on which serious consideration for scaling up in other contexts could be provided. The United States Government already supports urban agriculture in Ethiopia through Development Alternatives Incorporated. Such research could lead to better linkages between programmes to ensure that consideration is given to urban food insecurity and HIV/AIDS. Other initiatives RENEWAL could support in this vein in creating better understanding of these issues for the Health Centres providing VCT and which are supporting ART distribution points. Such knowledge could feed into the WFP food distribution programme in urban areas as nutrition aspects of fighting HIV are considered. Finally, an important paper looking at the “geography of stigma in Addis Ababa” would provide material for a necessary advocacy document.

Another important short-term research project is to begin investigating the role of the Ethiopian Church and its role in engaging with HIV/AIDS and food insecurity. In particular the issue of vulnerability and the church is important. Such research might emanate from the University of Addis Ababa, as a trusted research institute working within the country, with conceptual support from RENEWAL.

The creation of policy briefs from existing and ongoing research would be another task that RENEWAL could undertake in the short-term to ensure knowledge is disseminated widely. Other forms of communication could also be produced to ensure that lessons from Ethiopia were shared with other countries as well as for internal purposes. This is particularly relevant for the field of social protection, the danger of “exceptionalising AIDS” in a context of multiple stressors and vulnerability, and experiences such as those of FHI in mobilising burial societies.

Other forms of capacity building and knowledge creation could be facilitated through setting up reading groups with the HAPCO offices, the Food Security Directorate and academia and civil society. These could be held on a regular basis as a form of networking, sharing information and experiences and generally building confidence to engage with the bi-directional relationship between HIV/AIDS and food insecurity.

Longer Term Steps for RENEWAL in Ethiopia:

Although some work still remains in discussing entry points for such collaboration, a real opportunity exists for RENEWAL to gain impetus through IFPRI’s Ethiopia Strategy Support Programme (ESSP). This programme is a collaboration between IFPRI and the Ethiopian Development Research Institute (EDRI) and other institutions, which is funded by donors with a direct interest in RENEWAL. The ESSP recognises as a starting point that ‘despite the articulation of a rural development and food security strategy and the commitment of the government and donors to the broader framework of pro-poor rural development, *many complex issues remain to be resolved* regarding the design, implementation, and monitoring of the progress of this strategy’ (ESSP, 2004, *italics added*). These complex issues must include HIV/AIDS, as recognised by many government officials, despite not been articulated as such within the ESSP.

An opportunity to engage with HIV/AIDS through the ESSP will be through supporting the capacity development of the policy research community in Ethiopia. The programme objectives of the ESSP could be firmly supported by the RENEWAL agenda to:

- Generate policy research results to fill key policy gaps (as identified by RENEWAL) on a needs basis that would help strengthen the design and implementation of Ethiopia’s rural development strategy;
- Build a stronger and more integrated knowledge support system to underpin food policy analysis and

help inform key rural development strategy decisions (through, for example, RENEWAL's commitment to multi-sectoral networking and analysis);

- Strengthen the capacity of Ethiopian policy research institutions through active collaboration in applied rural development policy research and through targeted training programmes (both of which match core mandate of RENEWAL around HIV/AIDS and food security);
- Contribute to the design and implementation of a national monitoring and evaluation system for the rural sector to track progress against goals and to provide feedback on how the strategy and its implementation can be improved (particularly through the interest RENEWAL has in enhancing and building existing longitudinal studies in Ethiopia).

Apart from the obvious links with IFPRI and the EDRI, there is also an opportunity to collaborate with the Ethiopian Science and Technology Commission, which is a key organisation in Ethiopia with which to develop a national research agenda. RENEWAL could facilitate the integration of an HIV/AIDS and food security component into such an agenda focused on rural (and urban) development with the objective of supporting policy needs in the country. There is also scope to link with ongoing longitudinal surveys in Ethiopia, and to assist in developing HIV-sensitive indicators within those surveys.

In terms of both initiatives, the following five research priority areas have been suggested as strategic entry points into the Ethiopian research process. These three areas were identified after the international conference in Durban, discussions within the RENEWAL network, as it already exists across southern and east Africa, and were strongly reiterated throughout the compilation of this background paper. RENEWAL could drive these research areas in Ethiopia in collaboration with IFPRI, EDRI and the Commission:

- Research Priority 1: HIV Spread and Food Insecurity
- Research Priority 2: HIV/AIDS, Multiple Stresses and Overlapping Vulnerabilities
- Research Priority 3: Nutrition Security and HIV/AIDS
- Research Priority 4: Migration, Urbanisation and Urban-Rural Links
- Research Priority 5: Longitudinal Studies and the Dynamics of HIV/AIDS and Food and Nutrition Security

It is important that such a research agenda is conducted in collaboration with relevant government departments responsible for executing particular programmes including land resettlement, nutrition programme, and productive safety nets. Part of this agenda would be to document what works, what does not, and why within an Ethiopian context through researching shorter-term case studies and the establishment of longer-term and more comprehensive research projects.

Finally RENEWAL has a role to play in facilitating better linkages between government, civil society, academia and communities in the area of food insecurity and HIV/AIDS. This will be partly achieved through action research and capacity building, but also through a concerted effort to build linkages that are trusted and supported.

A major development in 2004 was the launch of the Coalition of Food Security, which recognises the contributions of different actors in a long-term approach to address chronic food insecurity. RENEWAL could work with the Coalition, bringing an important dimension to engaging with food insecurity in the country. Another opportunity lies with the National HIV/AIDS Forum of NGOs, many of which also engage directly with food security interventions at grassroots. Such interaction is already leading to demands for action research to underpin activities in the field as evidenced by Save the Children's call for research teams to support their programming.

Annexure Two

Stakeholder Mapping

Different stakeholders in Ethiopia are involved in HIV/AIDS prevention, care, treatment, and support activities. These include the government, NGOs, donors, civil society groups, and voluntary youth associations. HIV/AIDS has fast become a key agenda focused primarily on intervention and within a short period, it has become considered a major socio-economic problem along with malaria, gender inequalities, unemployment, and poverty. It has received this attention as a result of a general recognition of its widespread impact. However, the “silence” that accompanies the epidemic and the long incubation period between infection and the onset of AIDS is seriously challenging the Ethiopian response.

HIV/AIDS interventions can be categorised in three broad areas: prevention, treatment and care, and impact mitigation. Different stakeholders have intervention programmes across these categories, which are being implemented at different levels of the country's administrative structure. Similarly, sources of funds for the programmes have been provided by external donors, the government treasury, and local civic organisations. Here it should be emphasised that significant contributions have been being made by voluntary youth and community associations, which are established around HIV/AIDS issues.

Table: Stakeholder Mapping

Stakeholders	Interests	Activities	Role for RENEWAL	Importance for RENEWAL
Federal Government	-Minimising impact <i>on people and on development effort</i>	- Policy guidance -Strategic framework -Resource mobilisation -Prevention, care & treatment, intervention - Surveillance -Legislation -Monitoring & evaluation	-Policy communication -Gap identification -Capacity building -Networking/ coordination	-Official/ formal operation -Facilitation of operation -Guidance of operational framework/ strategic directions
Regional Governments	-Minimising impact <i>on people and on development effort</i>	-Resource mobilisation -Prevention, care & treatment, intervention -Data collection -Monitoring & evaluation	-Capacity building & networking & coordination of activities -Action research -Monitoring & impact evaluation	-Facilitation of operation
Donors	-Minimising impact <i>on people and on development effort</i> -Coordination of interventions -Effective & efficient resource utilization	-Resource allocation -Experience sharing -Technical support	-Coordination/ integration of current activities -Increased attention to HIV/ AIDS issues -Channel of resource transfer	-Funding RENEWAL activities -Facilitation of its recognition & operations

Non-governmental organisations	-Protection of low income groups -Equity, justice -Satisfaction of basic needs	-Implementation of preventive measures -Provision of care and support	-Networking -Information exchange -Coordination & integration	-Partnership facilitation -Implementation facilitation
International NGOs	-Minimising impact - -Coordination of interventions -Effective & efficient resource utilisation	-Financing HIV/AIDS related programmes -Implementation of preventive, care & support programs -Monitoring & evaluation	-Networking -Information exchange -Coordination & exchange -Facilitation of experience sharing	-Making funds available -Partnership facilitation -Implementation facilitation
Professional Associations	-Understanding the epidemiology feature/ character. -Understanding HIV/AIDS effect transmission mechanisms	- Studies/ research -Round table discussions -Policy debates -Advocacy -Information dissemination/ publications	-Developing research agenda -Articulating knowledge gaps -Financing studies	-Partnership -Implementation facilitation -Policy communication
Private sector	-Minimizing labour cost -Effective mgmt. of health benefit -Mgmt of staff/ employees turnover	-Facilitating awareness creation -Facilitation VCT -Sponsoring/ implementing studies	-Sharing experience of other countries -Identifying research agenda -Identifying capacity needs	-Partnership -Implementation facilitation -Policy communication
Labour unions	-Protection of the rights of workers -Employees benefits/ job security	-Facilitating awareness creation -Facilitation VCT -Facilitation of studies	-Sharing experience of other countries -Knowledge of HIV/AIDS issues such as nutrition	-Partnership -Implementation facilitation -Policy communication
Media	-News -Information	-Information dissemination -Debate facilitation	-Sharing experience of other countries -Knowledge on HIV/AIDS issues such as nutrition	-Publicising RENEWAL -Partnership -Information dissemination -Policy communication
PLWHA	-Treatment -Care and support -Mitigation	-Association/ networking -Advocacy -Resource mobilization -Implementation	-Sharing experience of other countries -Knowledge on HIV/AIDS issues such as nutrition -Capacity building -Networking	-Partnership in studies -Advocacy -Information dissemination
Youth groups	-Moral obligation -Volunteerism -Societal protection,	-Association/ networking -Advocacy/	-Sharing experience of other countries	-Partnership in studies -Advocacy

	care & support	awareness -Community mobilisation -Prevention, care and treatment	-Knowledge of HIV/AIDS issues such as nutrition -Capacity building -Networking	-Information dissemination
Women's groups	-Absence of discrimination of women's rights -Protection of women's rights -Appropriate support for women	-Association/networking -Advocacy/awareness -Prevention, care and treatment -Human rights -Justice	-Sharing experience of other countries -Knowledge on HIV/AIDS issues such as nutrition -Capacity building -Networking	-Partnership in studies -Advocacy -Information dissemination

The Multi-Sectoral Response:

In the last 20 years, the Ethiopian Government has tried to address some of the challenges posed by HIV/AIDS through instituting HIV/AIDS policies, strategies and programmes. A National Task Force on HIV/AIDS was established by the government in 1985, which was followed by two medium term prevention and control programmes designed and implemented focusing on condom promotion, surveillance, patient care and HIV screening laboratories at different health service delivery posts. The National HIV/AIDS Policy was issued by the government in 1988 to provide an enabling environment for a multi-sectoral approach for the prevention and control of the epidemic.

In 2000, the National HIV/AIDS Council and the National AIDS Council Secretariat, which has since become HIV/AIDS Prevention and Control Office (HAPCO), were established with the objective of overseeing, coordinating and evaluating the national response to HIV/AIDS. The Council issued a five-year (2001-2005) strategic framework for the national response to HIV/AIDS in Ethiopia as well as HIV/AIDS drug policy. HAPCO was initially organised under the Prime Minister's Office. The office has recently been restructured and placed under the Ministry of Health, which has led to some confusion regarding the respective roles and responsibilities of the institutions and raised a question mark over who will manage and oversee the multi-sectoral approach.

The importance of HIV/AIDS has subsequently been recognised in many government programmes, recently exemplified in the release of an HIV/AIDS Mainstreaming Handbook. Preventative measures complemented by treatment and care, particularly through accessible antiretroviral treatment (ART), are clearly core strategies in the fight against AIDS. However, these measures are often undertaken under the mantle of health whilst other key sectors, such as agriculture, can play an equally important role in mitigating the multiple impacts of HIV/AIDS, particularly those directly affecting people's livelihood strategies. A national HIV/AIDS partnership forum has been established to provide linkages and avoid duplication of efforts. The National Strategic Plan and Management identify this importance of partnership but does not, however, make explicit the roles of the private sector, community-based organisations (CBOs), NGOs, the media and other actors. A coherent response involves all sectors being "mainstreamed" to engage effectively with the multiple development impacts of AIDS.

In the strategic framework, the multi-sectoral response to the epidemic requires each sector involved to respond to the epidemic by developing specific plans based on its role/mandate in the society and its capacity. Each sector is expected to effectively mainstream HIV/AIDS in its sectoral policy and plan to establish a focal taskforce/person responsible for advocating, managing and coordinating the implementation of HIV/AIDS activities within the sector and also to network with other sectors. The scope of work recommended for each sector is:

- Launch workplace intervention for its staff and clients
- Identify the major determinants of the spread of HIV/AIDS specific to the sector
- Identify major obstacles to the response within the sector
- Integrate HIV/AIDS activities in the annual plans and ensure implementation
- Develop specific HIV/AIDS sectoral plans and budget
- Document best practices within the sector and share experiences
- Prepare and submit regular reports to the respective authorities and coordinating bodies.

The government's intervention and enabling tools and implementation mechanisms include:

- HIV/AIDS policy
- The revised strategic framework
- The different institutional arrangements for leadership
- Coordination and monitoring activities
- Mobilizing resources and
- National Sentinel Surveillance Report (NSSR)

The major intervention areas are:

1. IEC/BCC
2. Condom promotion and distribution
3. VCT
4. Management of STI
5. Blood safety
6. Universal precaution
7. PMTCT
8. Care and support for PLWHA and OVC
9. Legislation and Human Rights
10. Surveillance and Research
11. Monitoring and Evaluation
12. Mainstreaming

CSOs are generally engaged in service provision, relief and development activities, advocacy, research, human right issues amongst other issues. The category accordingly encompasses wide ranging development actors including NGOs, professional associations, research institutes, trade unions, chamber of commerce, media, the parliament and community based organisations. There are many NGOs that are involved in HIV prevention activities and care and treatment.

The key implementing agencies and stakeholders and their respective HIV/AIDS policies and intervention programmes are the following:

1. The Ministry of Health

The health sector, both public & private, and from the national to the grassroots level, is the major institution that is responding to HIV/AIDS. The MOH has the responsibility of guiding the overall response to the epidemic while the majority of intervention areas are directly linked with the mandate of the health sector. The focus of the ministry's response include:-

- Guiding the overall response to the epidemic
- Organizing and providing health services
- Providing a regulatory and implementation role

- Setting out and implementing health standards and health service delivery systems
- Informing policy, strategy and program development
- Training different categories of health workers including Health Agents
- Procuring drugs and medical and medical supplies.
- Conducting research and surveillance.
- Ensuring quality control (QC) and quality assurance.
- Developing laboratory capacity
- Producing/updating relevant guidelines protocols and manuals.
- Monitoring, evaluating and providing backstop services for health providers.

2. The Ministry of Education

Besides managing the human resource development and molding the productive citizen of the county, the Ministry is actively engaged in the following HIV/AIDS related activities:

- Mainstreaming HIV/AIDS into the educational system.
- Developing IEC/BCC, including expanding and strengthening the educational mass and school mini-media.
- Expanding and strengthening school anti-AIDS clubs and peer education.
- Promoting adolescent reproductive health service.
- Including HIV/AIDS issues in the curriculum and life skill programs.
- Encouraging research/surveillance activities.

3. The Ministry of Agriculture and the Rural Development

The Ministry has the advantage of direct exposure to the farmers and pastoralists through its rural development agents. The ministry focuses on:

- Mainstreaming HIV/AIDS issues in all rural development, agricultural and food security policies and activities.
- Raising awareness through the development agents.
- Enhancing the capacity of kebele farmers associations in HIV/AIDS related project development and implementation.
- Incorporating HIV/AIDS training in DA training packages
- Facilitating access to extension services for affected families and empowering female farmers
- Assessing and reporting the impact of the epidemic on the sector.

4. The Ministry of Labour and Social Affairs

The Ministry is mainly responsible developing and following up of work place intervention and social rehabilitation schemes. Its roles include:

- Mainstreaming HIV/AIDS into the sectors over all policy and plan.
- Drawing strategies for prevention, control and impact mitigation of HIV/AIDS in production and service giving facilities and developing workplace interventions.
- Regularly updating the labour law and other social legislations.
- Promoting social services (care and support) for PLWHA and OVCs.

5. The Women's Affairs Bureau

The gender inequality in rural and urban communities has had contributed to the spread of the virus among women. Hence, the Bureau's primary responsibilities are:

- Advocating for the empowerment of women and creating enabling environment to build their skills and thereby reduce risks
- Promoting and expanding reproductive health services in rural areas
- Enhancing the participation of women in all interventions mainly in prevention, HBC and support services, and PMTCT
- Advocating for and promoting vulnerability and risk reduction programs against rape, early marriage and harmful traditional practices

6. The Disaster Prevention and Preparedness Commission/DPPC

The commission has the role of designing interventions tailored to the needs and realities of the displaced people as a result of recurrent drought and food insecurity. This commission, in collaboration with relevant sectors provides:

- Providing IEC/BCC
- Ensuring care and support and
- Ensuing access to VCT services

7. The Trade, Industry, Transport and Communications Sectors

These sectors have the role of developing and implementing interventions targeted at transport workers (land and air), factory workers migrant labourers and other groups practicing high-risk behaviour by focusing on:

- Expanding workplace interventions
- Enhancing IEC/BCC activities
- Expanding user friendly VCT services (including mobile services)
- Promoting and distributing condoms

8. The Ministry of Information, Media and Information

The Ministry has comparative advantage of guiding and developing the use of the mass media in disseminating HIV/AIDS related information and messages to the general public and special target groups in different languages. It plays a role by:

- Producing and regularly updating the natural glossary of terms related to HIV/AIDS
- Developing and facilitating the expansion of educational programs through mass media, etc
- Developing guidelines for the involvement of the media in the fight against HIV/AIDS

9. The Ministry of Youth, Culture and Sports

Recognizing the youth both in and out of school, and both in rural and urban who are among the most vulnerable groups, the sector is conceived to develop, promote and expand innovative vulnerability reduction approaches that can provide for better life alternatives. In doing so, it has the role of:-

- Advocating and facilitating for the productive engagement of the youth
- Developing strategies to establish comprehensive youth centres and edutainment facilities
- Advocating for the expansion of youth friendly health services

- Enhancing youth focused IEC and Care and support activities

10. The Justice Ministry

The ministry has the responsibility of respecting the rights of PLWHA, since it is one of the effective responses to HIV/AIDS. In so doing, the Ministry's policy interventions include:

- Periodically reviewing and modifying HIV/AIDS related legislation,
- Facilitating legal services for the PLWHA and their families
- Creating forum for dialogue on human right and other legal issues

11. The Ministry of Finance and Economic Development

This ministry has the responsibility of assisting the multi-sectoral national response in:

- Fund raising and resource utilization
- Ensuring that relevant government line ministries and agencies have included HIV/AIDS prevention and impact mitigation activities in their annual work plans and budget and
- Facilitating the streamlining of HIV/AIDS in the overall development strategies

12. The Parliament

Being the supreme legislative power of the country, the parliament has the responsibility of issuing relevant HIV/AIDS related legislation and demanding and enforcing:

- Mainstreaming of HIV/AIDS into government agencies annual work plans and budgets,
- Assigning special taskforces/committees to closely follow HIV/AIDS
- Ensuring accountability

13. Uniformed Services

HIV/AIDS is not only a socio-economic problem but also becoming a security threat. Hence it is important to mainstream HIV/AIDS in the general activity of defence, militia and police force at all levels. Accordingly, the sector intervenes in:

- Fighting the epidemic within their domain and mitigating the security impact of the epidemic
- Playing the additional role of expanding the services to remote areas

14. The Foreign Affairs Sector

The fact that HIV/AIDS is a global issue created the requirement of the response to the pandemic in need of international collaboration. Accordingly, the sectors role rests in:

- Keeping the diplomatic community informed on the status of the epidemic
- Facilitating networking for accessing external resources and building diplomatic skills.

15. The Ethiopian Science and Technology Commission

The commission has the role / mandate of:

- Initiating and directing applied and basic research activities and disseminating findings to stakeholders.
- Enhancing the capacity of regional research institutions researchers
- Creating networks with international and regional research institutions, academic centres and resource centre
- Setting out a national research agenda and serve as a centre for QC and QA

16. Civil Society Organisations

These are the principal stakeholders/ partners in the multi-sectoral response to the epidemic. They have the comparative advantages of mobilising their constituencies and organizing and implementing community initiatives mainly at the grassroots levels. They intervene among others in:

- Organising and implementing prevention activities,
- Providing of community-base care and social support services for PLWHA and OVCs,
- Sensitising communities, mobilising resources, and policy advocacy.

Civil society has recognised the importance of poverty reduction, food security and HIV/AIDS in Ethiopia. CSOs involved in engaging with the poverty reduction strategy felt that a permanent structure would increase the level of engagement possible. Hence, the Poverty Action Network Ethiopia (PANE) was established in March 2004 involving more than forty NGOs who work on a diverse set of issues in different parts of the country. PANE represents, therefore, a network of civil society organisations that have to come together to work for poverty reduction in Ethiopia and which would provide an important opportunity to engage with food security and HIV/AIDS issues.

PANE, working as a part of CRDA, has actively sought increased partnership between civil society, the government and our international partners in the SDPRP process. The challenge of reducing poverty and reaching the Millennium Development Goals by 2015 in Ethiopia is considerable, only possible if all actors work together as equal and fully engaged partners. Civil society contribution to food security is reflected in the fact that about half of food assistance and almost half of non-food humanitarian assistance came through NGOs in 2003. This role could be furthered strengthened by working even more closely with the government to exploit synergies and avoid duplication. In terms of engaging with HIV/AIDS, CSOs have recognized the pressure being placed on health services. An immediate priority has therefore been identified as reducing prevalence rates, as well as supporting the Ministry of Health's expanded ARV programme. However, limiting factors such as poor infrastructure and nutrition have been identified as major challenges to this programme.

17. Association of PLWHA

PLWHA are the key actor of the national response. They are expected to organise themselves in as many associations and at all levels as they find it fit and a joint forum. They are expected to focus on:

- Protecting the rights of their members
- Educating the public at large through sharing their life experiences
- Promoting and participation in the provision of compassionate home based care.
- Fighting stigma and discrimination.
- Advocating for responsible behaviour among their members.
- Advocating for access to ART and policy formulation and legislation.
- ICE/BCC.

18. Faith Based Organisations

FBOs have the advantage of unleashing the potentials and initiatives of their followers through their well structured and cohesive systems. Included are the Ethiopian Orthodox churches, the Ethiopian Islamic Affair Supreme Council, the Ethiopian Catholic Secretariat, the Ethiopian Evangelical Church Mekane Yesus and other groups. These FBOs play active role in the prevention, care, and support activities specifically:

- IEC/BCC (promoting abstinence before marriage and faithfulness after getting marriage.
- Counselling (spiritual support)
- Providing welfare support to the infected and affected including hospice service
- Providing care and support for OVC
- Promoting VCT before marriage

19. The Ethiopian Red Cross Society

Being one of the oldest voluntary organizations in the country, this society has played very important role in expanding blood bank and a safe blood supply system, in providing relief and rehabilitation operations and now providing HIV/AIDS prevention, care and support. It is expected to focus on:

- Expanding and improving the safe blood supply system
- Establishing sustained non-remunerated voluntary donors
- Training health personnel and building the capacity of service giving institutions
- advocating for the formulation of blood policy
- intensifying its youth focused prevention and care support activities

20. The Private sector

The sector has the responsibility for:

- Mainstreaming HIV/AIDS into the business sector
- Mobilizing resources for combating the epidemic
- Lobbying for the revision of labour laws
- Organising and operating workplace interventions (IEC/BCC, care and support) for their workers and clients

21. International partners

The international development partners (bilateral, multi-lateral, NGOs, foundations and others) improve and expand the response to the epidemic by rendering financial support, technical backstopping, training, exposure and experience sharing visits. In 2005, a rapid data collection exercise on current HIV expenditure among bilateral and multilateral agencies was initiated by the HIV/AIDS Donor Forum Finance Sub-group.

Thirty-five donor agencies were contacted. Nineteen questionnaires were collected for a response rate of 54 percent. From the agencies who participated in the survey, donors are supporting 100 projects and provide US\$75,277,943 in funding. The largest donor is USAID followed by the Royal Netherlands Embassy, DfID, DCI and the Royal Norwegian Embassy. USAID also has the greatest number of projects followed by DCI, the Packard Foundation, the Royal Norwegian Embassy and CIDA.

Donor	Funding Total (in USD)	# of projects
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USAID	24,611,000	20
Royal Netherlands Embassy	15,394,000	1
DfID	12,770,359	7
DCI	3,663,338	19
Royal Norwegian Embassy	3,480,547	11
Italian Development Cooperation	3,342,310	3
CIDA	3,270,567	10
EC	2,225,312	3
Packard	2,077,084	12
UNDP	1,500,000	1
ILO	1,294,633	3
SIDA	1,239,000	1
WFP	1,048,230	3
UNAIDS	502,160*	2
JICA	203,899	1
FAO	133,000	1
UNFPA	108,770	1
Embassy of Finland	22,504	1
African Union	Responded but no programming at this time.	
Embassy of France	Responded but no programming at this time.	
IMF	Responded but no programming at this time.	

*partly funded by the Netherlands local HIV/AIDS fund

22. Professional Associations

Professional Associations including the Ethiopian Teachers' Association, the Ethiopian Medical Association, the Ethiopian Economists Association, amongst others, have the key roles to play in their respective domains. They are responsible for focusing on:

- Providing professional backup services by mobilizing their professional members at all levels
- Providing consultancy services
- Actively participating in research and surveillance activities
- Organizing workplace interventions

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